Revised September 2017

COLORADO SEX OFFENDER MANAGEMENT BOARD

STANDARDS AND GUIDELINES FOR THE ASSESSMENT, EVALUATION, TREATMENT AND BEHAVIORAL MONITORING OF ADULT SEX OFFENDERS

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INTRODUCTION

In 2011 the legislature declared that, "to protect the public and to work toward the elimination of sexual offenses, it is necessary to comprehensively evaluate, identify, treat, manage, and monitor adult sex offenders who are subject to the supervision of the criminal justice system and juveniles who have committed sexual offenses who are subject to the supervision of the juvenile justice system. Therefore, the general assembly declares that it is necessary to create a program that establishes evidence-based standards for the evaluation, identification, treatment, management, and monitoring of adult sex offenders and juveniles who have committed sexual offenses at each stage of the criminal or juvenile justice system to prevent offenders from reoffending and enhance the protection of victims and potential victims. The general assembly does not intend to imply that all offenders can or will positively respond to treatment (§16-11.7-101)." In 1992, the Colorado General Assembly passed legislation[1] that created a Sex Offender Treatment Board to develop standards and guidelines for the assessment, evaluation, treatment and behavioral monitoring of sex offenders. The General Assembly changed the name to the Sex Offender Management Board (SOMB) in 1998 to more accurately reflect the duties assigned to the SOMB. The *Standards and Guidelines for the Assessment, Evaluation, Treatment and Behavioral Monitoring of Adult Sex Offenders (*hereafter *Standards and Guidelines)* were originally drafted by the SOMB over a period of two years and were first published in January 1996. The *Standards and Guidelines* were revised in 1998, 1999, 2004, 2008 and 2011 for two reasons: To address omissions in the original *Standards and Guidelines* that were identified during implementation, and to keep the *Standards and Guidelines* current with the developing literature in the field of sex offender management.[2] The *Standards and Guidelines* apply to adult sexual offenders[3] under the jurisdiction of the criminal justice system.[4]

These Standards govern the practice of treatment providers, evaluators and polygraph examiners approved by the SOMB. Standards are mandatory and designated by "shall", while guidelines are distinguished by the use of the term "should." Although the SOMB does not have purview over other entities involved in the supervision of defendants convicted of a sexual offense (for example, probation, parole, and the judiciary), it offers these guidelines as a tool to assist in the management of offenders and to enhance collaboration[5] among stakeholders and to provide guidance on best practices.

The SOMB is required to maintain the *Standards and Guidelines* for the evaluation and treatment of criminal defendants with a current or past sex offense conviction.[6] The evaluation shall make recommendations for the management, monitoring, and treatment of the defendant based upon his or her individual risk factors. Recommended interventions shall prioritize the physical and psychological safety of victims and potential victims, and meet the assessed needs of the particular defendant.[7] The *Standards and Guidelines* apply to treatment provided both in the community and during imprisonment.[8] Treatment providers shall be as flexible as possible and shall include a continuum of options which may include, but

[1] Section §16-11.7-101 through Section §16-11.7-107, C. R. S.
[2] Center for Sex Offender Management. (2008). The Comprehensive Approach to Sex Offender Management. Washington, DC: U.S. Department of Justice, Office of Justice Programs; Yates, P. (2013). Treatment of Sexual Offenders: Research, Best Practices, and Emerging Models. *International Journal of Behavioral Consultation and Therapy, 8*(3-4): 89-94.
[3] Pursuant to C.R.S. §16-11.7-102
[4] Pursuant to statutory purview (§16-11.7-102) including guilty plea, *nolo contendre*, conviction by trial, deferred sentences, and stipulation/finding of sexual factual basis. Pre-trial and pre-plea matters are not under the purview of the *Standards.*
[5] McGrath, R.J., Cumming, G.F., Burchard, B.L., Zeoli, S., & Ellerby, L. (2010). Current Practices and Emerging Trends in Sexual Abuser Management: The Safer Society 2009 North American Survey. Brandon, VT: Safer Society Press; Shingler, J. & Mann, R. E. (2006). Collaboration in clinical work with sexual offenders: Treatment and risk assessment. In W. L. Marshall, Y. M. Fernandez, L. E. Marshall, & G. A. Serran (Eds.), Sexual Offender Treatment: Controversial Issues (pp. 173-185). Hoboken, NJ: Wiley.
[6] §16-11.7-103(4) (a, b); *see also* §§16-11.7-102, – 104, C.R.S.
[7] §16-11.7-103(4)(a), C.R.S
[8] §16-11.7-103(4)(b), - 105, C.R.S

are not limited to, group counseling. To the extent possible, programs shall be accessible to all defendants, including those with mental illness and co-occurring disorders. The SOMB is required to revise the *Standards and Guidelines* based upon comprehensive research and analysis of evidence-based practices and the effectiveness of its policies and procedures.[9] It is not the intention of the legislation, or the SOMB, that these standards and guidelines be applied to the treatment of juveniles who have sexually offended. Despite many similarities in the behavior and treatment of juveniles and adults, important differences exist in their developmental stages,[10] the process of their offending behaviors,[11] and the context for juveniles who must be addressed differently in their diagnosis and treatment. Please see the current publication of the *Standards and Guidelines for the Evaluation, Assessment, Treatment and Supervision of Juveniles Who Have Committed Sexual Offenses.*

In 1998, the Colorado General Assembly passed legislation directing the SOMB, in collaboration with the Department of Corrections, the Judicial Branch and the Parole Board, to also develop standards for community entities that provide supervision and treatment specifically designed for sex offenders who have developmental or intellectual disabilities.[12] At a minimum, the Legislature mandates that these standards shall determine whether an entity would provide adequate support and supervision to minimize any threat that the sex offender may pose to the community.[13] The treatment and management of sex offenders with developmental or intellectual disabilities (DD/ID) is a highly specialized field.[14] The intent of the DD/ID *Standards and Guidelines* is to better address the specific needs presented by sex offenders with developmental or intellectual disabilities. They are based on best practices known today for managing and treating sex offenders with developmental or intellectual disabilities. To the extent possible, the SOMB has based these Standards on current research in the field. Materials from knowledgeable professional organizations have also been used to direct the *Standards and Guidelines*. The *Standards and Guidelines* that are designated with the letters "DD/ID" after the Standard number are not intended to stand alone, but must be used in conjunction with the other *Standards and Guidelines for the Assessment, Evaluation, Treatment and Behavioral Monitoring of Adult Sex Offenders*.

Sex offender treatment and management is a developing specialized field.[15] The Colorado Legislature has directed, in the SOMB's enabling statute, that: "The board shall revise the guidelines and standards for evaluation, identification, and treatment, as appropriate, based upon the results of the board's research and analysis." The SOMB is committed to remaining current on the emerging literature and research and periodically modifying the *Standards and Guidelines* on the basis of new findings. The previous revisions to the *Standards and Guidelines* were undertaken with that goal in mind. The current revisions of the *Standards and Guidelines* are continuing evidence of this commitment. In 2013 the Colorado Legislature additionally appropriated funding for an independent external evaluation of the *Standards and Guidelines*.

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[9] §16-11.7-103(4)(e), C.R.S

[10] Center for Sex Offender Management. (2013). Transition-Aged Individuals Have Committed Sex Offenses: Considerations for the Emerging Adult Population. Silver Spring, MD: Author; Riser, D., Pegram, S., & Farley, J. (2013). Adolescent and Young Adult Male Sex Offenders: Understanding the Role of Recidivism. *Journal of Child Sexual Abuse, 22*(1): 9-31.

[11] Huang, D., Murphy, D., & Hser, Y. (2012). Developmental Trajectory of Sexual Risk Behaviors From Adolescence to Young Adulthood. *Youth & Society, 44*(4) 479–499; Keelan, C., & Fremouw, W. (2013). Child versus peer-adult offenders: A critical review of the juvenile sex offender literature. *Aggression and Violent Behavior, 18*(6):732–744; Piquero, A., Farrington, D., Jennings, W., Diamond, B. & Craig, J. (2012). Sex Offenders and Sex Offending in the Cambridge Study in Delinquent Development - Prevalence, Frequency, Specialization, Recidivism, and (Dis)Continuity Over the Life-Course. *Journal of Crime and Justice, 35*(3):412-426; Pullman, L., Lerouxb, E., Motayne, G., & Seto, M. (2014). Examining the developmental trajectories of adolescent sexual offenders. *Child Abuse & Neglect 38*(7):1249–1258; Seto, M., & Lalumie`re, M. (2010). What Is So Special About Male Adolescent Sexual Offending? A Review and Test of Explanations Using Meta-Analysis. *Psychological Bulletin. 136*(4), 526-575.

[12] Lindsay, W., Hastings, R., Griffiths, D., & Hayes, S. (2007). Trends and challenges in forensic research on offenders with intellectual disability. *Journal of Intellectual & Developmental Disability, 32*(2): 55–61; Lindsay, W., & Michie, A. (2013). Individuals With Developmental Delay and Problematic Sexual Behaviors. *Current Psychiatry Reports, 15*(4):1-6.

[13] Section §18-1.3-1009 (1)(c), C.R.S.

[14] Heaton, K., & Murphy, G. (2013). Men with Intellectual Disabilities who have Attended Sex Offender Treatment Groups: A Follow-Up. *Journal of Applied Research in Intellectual Disabilities, 26*(5): 489-500.

[15] Gallo, A., Belanger, M., Abracen, J., Looman, J., Picheca, J., & Stirpe, T. (2014). Treatment of High-Risk High-Need Sexual Offenders - The Integrated Risk Need Responsivity Model (RNR-I). *Annals of Psychiatry and Mental Health 3*(1): 1018.

The results of this evaluation were published in January 2014.[16] The current revision of the *Standards and Guidelines* has been partially based in response to the external evaluation and, in addition, on research and analysis conducted by the SOMB independent of the external evaluation. It is the commitment of the SOMB to incorporate best practices and evidence based practices for sex offender management in Colorado.

[16] D'Orazio, D., Thornton, D, & Beech, A. (2014). An External Evaluation of Colorado Sex Offender Management Board Standards and Guidelines. *Central Coast Clinical & Forensic Psychology Services, Inc.*

GUIDING PRINCIPLES

Purpose of the Guiding Principles is to establish the core foundation principles from which the *Standards and Guidelines* are created and to provide guidance in the absence of a specific standard or guideline.

1. The highest priority of these Standards and Guidelines is to maximize community safety[17] through the effective delivery of quality evaluation, treatment and management of sex offenders.[18]

2. Sexual offenses are traumatic and can have a devastating impact on the victim and victim's family.

Sexual offenses violate victims, and can lead to common and serious consequences across all areas of victims' lives, including chronic and severe mental and physical health symptoms,[19] as well as social, family, economic, and spiritual harm.[20] Research and clinical experience indicate that victims of sexual abuse often face long-term impact and continue to struggle for recovery over the course of their lifetime.[21] The impact of sexual offenses on victims varies based on numerous factors. By defining the offending behavior and holding offenders accountable, victims may potentially experience protection, support and recovery.[22] Professionals working with sexual offenders should be alert to how offenders' behaviors may inflict further harm on persons they have previously victimized.[23]

3. Community safety and the rights and interests of victims and their families, as well as potential victims, require paramount attention when developing and implementing assessment, treatment and management of sex offenders.

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[17] Center for Sex Offender Management (2007). Enhancing the Management of Adult and Juvenile Sex Offenders: A Handbook for Policymakers and Practitioners. *Center for Effective Public Policy, U.S. Department of Justice, Office of Justice Programs*, 2005-WP-BX-K179 and 2006-WP-BX-K004; C.S.R. 16.11.7-101, "To protect the public and to work toward the elimination of sexual offenses, it is necessary to comprehensively evaluate, identify, treat, manage and monitor convicted adult sex offenders who are subject to the criminal justice system…"

[18] Dowden, C., & Andrews, D. A. (2004). The importance of staff practices in delivering effective correctional treatment: A meta-analysis of core correctional practices. *International Journal of Offender Therapy and Comparative Criminology, 48*(2), 203-214; Hanson et al. (2009). The Principles of Effective Correctional Treatment Also Apply To Sexual Offenders; Mann, R. (2009). Sex offender treatment: The case for manualization. *Journal of Sexual Aggression, 15*(2): 121-131; Schmucker, M. & Losel, F. (2015). The effects of sexual offender treatment on recidivism: an international meta-analysis of sound quality evaluations. *Journal of Experimental Criminology, 11*(4):597-630.

[19] Chen et al. (2010). Sexual abuse and lifetime diagnosis of psychiatric disorders: Systematic review and meta-analysis. *Mayo Clinic Proceedings, 85*, 618–629; Tjaden, P. & Thoennes, N. (2006). Extent, nature, and consequences of rape victimization: Findings from the National Violence Against Women Survey. *Washington, DC: U.S. Dept. of Justice, Office of Justice Programs, National Institute of Justice*; Walsh et al. (2012). National prevalence of posttraumatic stress disorder among sexually re-victimized adolescent, college, and adult household-residing women. *Archives of General Psychiatry, 69(9)*:935-942; Wilson, D. (2010). Health Consequences of Childhood Sexual Abuse. *Perspectives in Psychiatric Care. 46*(1): 56-64.

[20] Morrison, Z. (2007). Caring about sexual assault: the effects of sexual assault on families, and the effects on victim/survivors of family responses to sexual assault. *Family Matters, 76*: 55-63; Tjaden & Thoennes (2006). Extent, nature, and consequences of rape victimization: Findings from the National Violence Against Women Survey. Washington, DC: U.S. Dept. of Justice, Office of Justice Programs, National Institute of Justice.

[21] Campbell, R., Dworkin, E., & Cabral, G. (2009). An ecological model of the impact of sexual assault on women's mental health. Trauma, Violence, & Abuse, 10, 225-246; Cuevas et al. (2010). Psychological Distress as a Risk Factor for Re-Victimization in Children; Tjaden, P. & Thoennes, N. (2006). Extent, nature, and consequences of rape victimization: Findings from the National Violence Against Women Survey. *Washington, DC: U.S. Dept. of Justice, Office of Justice Programs, National Institute of Justice*; Finkelhor, D. (2009). The Prevention of Childhood Sexual Abuse. *Future of Children, 19*(2):169-194.

[22] Whittle et al. (2015). A Comparison of Victim and Offender Perspectives of Grooming and Sexual Abuse. *Deviant Behavior, 36*(7): 539-564.

[23] Briere, J. & Scott, C. (2006). Principles of trauma therapy: A guide to symptoms, evaluation, and treatment. Thousand Oaks, CA: Sage Publications; Feiring, C. & Taska, L. (2005). The Persistence of Shame Following Sexual Abuse: A Longitudinal Look at Risk and Recovery. *Child Maltreatment, 10*(4): 337-349; Littleton, H. (2010). The impact of social support and negative disclosure reactions on sexual assault victims: A cross-sectional and longitudinal investigation. *Journal of Trauma & Dissociation, 11*, 210-227; O'Doherty et al. (2001). Recovery work with child victims of sexual abuse: A framework for intervention. *Child Care in Practice, 7*(1):78-88; Patterson, D. (2011). The Linkage Between Secondary Victimization by Law Enforcement and Rape Case Outcomes. *Journal of Interpersonal Violence, 26*(2): 328– 347.

4. Offenders are capable of change.

Responsibility for change ultimately rests with the offender. Individuals are responsible for their attitudes and behaviors and are capable of eliminating abusive behavior through personal ownership of a change process. While responsibility for change is the offender's, the therapeutic alliance between the offender and the therapist is a predictive and important facet of responsivity leading to behavioral change.[24] A warm, direct, and empathic therapeutic approach contributes to an offender's motivation to change, as does the supervising officer's positive working alliance with the offender. [25]

5. The treatment and management of sex offenders requires a coordinated response by the Community Supervision Team (CST) and will be most effective if SOMB providers and the entirety of the criminal justice and social services systems apply the same principles and work together.[26]

Community safety is enhanced when treatment providers and community supervision professionals practice in their area of specialization and work together. This collaboration should include frequent and substantive communication about information that will assist in reducing an offender's risk to the community. When the CST members respect the individual roles and mutually agree upon their goals, the offender can be treated and managed more effectively.[27]

6. Community supervision is an opportunity, the success of which is dependent upon a sexual offender's willingness and ability to cooperate with treatment and supervision, and be accountable for their behaviors.[28] Accordingly, members of the Community Supervision Team should employ practices designed to maximize offender participation and accountability.[29]

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[24] Beech, A. R., & Hamilton-Giachritsis, C. E. (2005). Relationship between therapeutic climate and treatment outcome in group-based sexual offender treatment programs. *Sexual Abuse: A Journal of Research and Treatment, 17*(2):127–140; Blasko, B., & Jeglic, E. (2014). Sexual offenders' perceptions of the client–therapist relationship: The role of risk. *Sexual Abuse: A Journal of Research and Treatment, 28*(4):1–20; Harkins, L. & Beech, A. (2007). A review of the factors that can influence the effectiveness of sexual offender treatment: Risk, need, responsivity, and process issues. *Aggression and Violent Behavior, 12*(6):615–627; Looman, J., Dickie, I., & Abracen, J. (2005). Responsivity Issues in the treatment of sexual offenders. *Trauma, Violence, & Abuse, 6*(4):330–353; Skeem et al. (2007). Assessing relationship quality in mandated community treatment: Blending care with control. *Psychological Assessment, 19*(4), 397–410.

[25] Labrecque, R. M., Schweitzer, M., & Smith, P. (2014). Exploring the Perceptions of the Offender-Officer Relationship in a Community Supervision Setting. *Journal of International Criminal Justice Research, 1*: 31-46; Ross, E., Polaschek, D., & Ward, T. (2008). The therapeutic alliance: A theoretical revision for offender rehabilitation. *Aggression and Violent Behavior, 13*(6):462–480; Skeem et al. (2007). Assessing relationship quality in mandated community treatment: Blending care with control. *Psychological Assessment, 19*(4):397–410.

[26] Center for Sex Offender Management (2007). Enhancing the Management of Adult and Juvenile Sex Offenders: A Handbook for Policymakers and Practitioners. *Center for Effective Public Policy, U.S. Department of Justice, Office of Justice Programs*, 2005-WP-BX-K179 and 2006-WP-BX-K004; Dowden, C., & Andrews, D. A. (2004). The importance of staff practice in delivering effective correctional treatment: A meta-analytic review of core correctional practices. *International Journal of Offender Therapy and Comparative Criminology, 48*(2):203–214; Lowenkamp, C., & Latessa, E. (2004). Increasing the effectiveness of correctional programming through the risk principle: Identifying offenders for residential placement. *Criminology and Public Policy, 4*(1):501-528.

[27] McGrath, B., Cummings, G., & Holt, J. (2002). Collaboration Among Sex Offender Treatment Providers and Probation and Parole Officers: The Beliefs and Behaviors of Treatment Providers. *Sexual Abuse: A Journal of Research and Treatment, 14*(1):49-65; Shingler, J. & Mann, R. E. (2006). Collaboration in clinical work with sexual offenders: Treatment and risk assessment. In W. L. Marshall, Y. M. Fernandez, L. E. Marshall, & G. A. Serran (Eds.), Sexual Offender Treatment: Controversial Issues (pp. 173-185). Hoboken, NJ: Wiley.

[28] Carter, M., Bumby, K., & Talbot, T. (2004). Promoting offender accountability and community safety through the Comprehensive Approach to Sex Offender Management. *Seton Hall Law Review, 34*, 1273-1297.

[29] D'Orazio, D., Thornton, D, & Beech, A. (2014). An External Evaluation of Colorado Sex Offender Management Board Standards and Guidelines. *Central Coast Clinical & Forensic Psychology Services, Inc.;* Woldgabreal et al. (2016). Linking Positive Psychology To Offender Supervision Outcomes: The Mediating Role of Psychological Flexibility, General Self-Efficacy, Optimism, and Hope. *Criminal Justice and Behavior, 43*(6):697-721.

7. Treatment and supervision are most effective when they are individualized, and incorporate evidence-based and research informed practices.[30]

8. Risk for future sexual offending varies and may increase or decrease. The intensity and duration of treatment and supervision should respond to these variations in risk.[31]

Individual assessment and evaluation of risk should be an ongoing practice. Treatment approaches and supervision plans should be modified accordingly. Effective management of risk balances the use of external controls with the development of individual protective factors and self-regulation in order to reduce risk, enhancing the offender's ability to live safely in the community.

9. Victims have the right to safety, to be informed and to provide input to the Community Supervision Team (CST).

Physical and psychological safety is a necessary condition for victims to begin recovery related to sexual abuse. Victims experience additional trauma when they are blamed or not believed, which may be more damaging than the abuse itself.[32] Victim impact is substantially reduced when victims are believed, protected and adequately supported.

The CST can assist the victim in this by providing information and affording the victim representation in the supervision and management of the offender. Victim input and knowledge of the offender are valuable information for the supervision team.[33] Victims are empowered to determine their level of participation.

10. 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 conflicting parental or family interests.

11. The SOMB Standards and Guidelines are based on current and emerging research and best practices.[34]

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[30] Ward, T., Gannon, T., & Yates, P. (2008). The Treatment of Offenders: Current Practice and New Developments with an Emphasis on Sex Offenders. *International Review of Victimology*. *15*(2):183–208; Hanson et al. (2009). The Principles of Effective Correctional Treatment Also Apply To Sexual Offenders. *Criminal Justice and Behavior, 36*(9):865-891; Ward, T. & Gannon, T. (2014). Where has all the Psychology Gone: A Critical Review of Evidence-Based in Correctional Settings. *Aggression and Violent Behavior, 19*(4):435–446.

[31] Bonta, J., & Wormith, J. S. (2013). Applying the risk-need-responsivity principles to offender assessment. In L.A. Craig, L. Gannon, L., & T. A. Dixon (Eds.), What works in offender rehabilitation: An evidence-based approach to assessment and treatment (pp. 71–93). Hoboken, NJ: Wiley-Blackwell; Gallo et al. (2014). Treatment of high-risk high-need sexual offenders: The integrated risk need responsivity model (RNR-I). *Annals of Psychiatry and Mental Health, 3*(1), 1018:1-2; Hanson et al. (2009). The principles of effective correctional treatment also apply to sexual offenders: A meta-analysis. *Criminal Justice and Behavior, 36*(9), 865–891. Harkins, L., & Beech, A. R. (2007). A review of the factors that can influence the effectiveness of sexual offender treatment: Risk, need, and responsivity, and process issues. *Aggression and Violent Behavior, 12*(6):615–627; Parent, G., Guay, J., & Knight, R. (2011). An Assessment of Long-term Risk of Recidivism by Adult Sex Offenders: One Size Doesn't Fit All. *Criminal Justice and Behavior, 38*(2):188-209.

[32] Feiring, C. & Taska, L. (2005). The Persistence of Shame Following Sexual Abuse: A Longitudinal Look at Risk and Recovery. *Child Maltreatment, 10*(4): 337-349; Littleton, H. (2010). The impact of social support and negative disclosure reactions on sexual assault victims: A cross-sectional and longitudinal investigation. *Journal of Trauma & Dissociation, 11*(2):210-227; Najdowski, C., & Ullman, S. E. (2011). The effects of re-victimization on coping in women sexual assault victims. *Journal of Traumatic Stress, 24*(2): 218-221; Patterson, D. (2011). The Linkage Between Secondary Victimization by Law Enforcement and Rape Case Outcomes. *Journal of Interpersonal Violence, 26*(2): 328– 347; Ullman & Peter-Hagene (2016). Longitudinal Relationships of Social Reactions, PTSD, and Re-victimization in Sexual Assault Survivors. *Journal of Interpersonal Violence, 31*(6) 1074-1094.

[33] Center for Sex Offender Management (2007). The Role of the Victim and Victim Advocate in Managing Sex Offenders (training curriculum). Silver Spring, MD.

[34] C.S.R. 16-11.7-103(e)(I), "The board shall research, either through direct evaluation or through a review of relevant research articles and sex offender treatment empirical data, and analyze, through a comprehensive review of evidenced-based practices, the effectiveness of the evaluation, identification, and treatment policies and procedures for adult sex offenders developed pursuant to this article."

Treatment, management, and supervision decisions should be guided by empirical findings when research is available. Since there is limited and emerging empirical data specific to sexual offending, decisions should be made cautiously to minimize unintended consequences.

12. A continuum of treatment and management options for sex offenders should be available in each community in the state. Additionally, efforts should be made to maximize continuity of care whenever a client transitions from one treatment setting to another to maximize positive treatment progress.[35]

It is in the best interest of public safety for each community to have a continuum of management and treatment options so that treatment is appropriately matched to the client.

13. Successful treatment and management of sex offenders is enhanced when the Community Supervision Team (CST) models and encourages family, friends, employers and other members of the community in pro-social support of the offender.[36]

Families, friends, employers and members of the community who have influence in the lives of offenders can meaningfully contribute to their successful functioning in society. Family and friends should be included in the supportive network in a manner that is sensitive to the possible negative impact of the offense on them.[37]

14. Information sharing among CST members is vital to public safety and offender success.

Sexual offense-specific treatment is not conducted with the same degree of confidentiality as non-mandated treatment.[38] Sex offenders waive confidentiality with regard to therapeutic and/or public safety goals. When sensitive and private information is shared, the dignity and humanity of all involved must be respected.

15. Sex offense-specific assessment, evaluation, treatment, behavioral monitoring and supervision should be humane, non-discriminatory and bound by the rules of ethics and law.[39]

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[35] Boer, D. (2013). Some essential environmental ingredients for sex offender reintegration. *International Journal of Behavioral Consultation and Therapy, 8*(3-4):8–11; Scoones, C., Willis, G., & Randolph, G. (2012). Beyond static and dynamic risk factors: The incremental validity of release planning for predicting sex offender recidivism. *Journal of Interpersonal Violence, 27*(2), 222–238.

[36] Miller (2015). Protective Strengths, Risk, and Recidivism in a Sample of Known Sexual Offenders, *Sexual Abuse: A Journal of Research and Treatment, 27*(1) 34-50; Robbé et al. (2015). An Exploration of Protective Factors Supporting Desistance From Sexual Offending. *Sexual Abuse: A Journal of Research and Treatment, 27*(1):16–33; Tharp et al. (2013). A systematic qualitative review of risk and protective factors for sexual violence perpetration. *Trauma, Violence & Abuse, 14*(2):133-67.

[37] Wilson, R., & McWhinnie, A. (2013). Putting the 'Community' Back in Community Risk Management of Persons Who Have Sexually Abused. *International Journal of Behavioral Consultation and Therapy, 8*(3-4):72-79.

[38] Levinson J. & Prescott, D. (2010), Sex Offender Treatment Is Not Punishment, *Journal of Sexual Aggression, 16(3); 275-285;*McGrath et al. (2010). Current Practices and Emerging Trends in Sexual Abuser Management: The Safer Society 2009 North American Survey. Brandon, VT: Safer Society Press; Sawyer, S. & Prescott, D. (2011). Boundaries and Dual Relationships. *Sexual Abuse: A Journal of Research and Treatment, 23*(3):365-380.

[39] Birgden, A. & Cucolo, H. (2011). The Treatment of Sex Offenders: Evidence, Ethics, and Human Rights. *Sexual Abuse: A Journal of Research and Treatment, 23*(3) 295–313; Harrison, K. & Rainey, B. (2013). Legal and ethical aspects of sex offender treatment and management, Chichester, K, John Wiley & Sons, Ltd.

DEFINITIONS

Accountability: Accurate attributions of responsibility, without distortion, minimization, or denial.

Adjudication: The legal review and determination of a case in a court of law. In criminal cases, a juvenile who is convicted of a sexual offense is deemed "adjudicated." An adult convicted of a similar offense is deemed "convicted." An adult can be adjudicated with an Imposition of Legal Disability. "Adjudication" means a determination by the court that it has been proven beyond a reasonable doubt that the juvenile has committed a delinquent act or that a juvenile has pled guilty to committing a delinquent act. In addition, when a previous conviction must be pled and proven as an element of an offense or for purposes of sentence enhancement, "adjudication" means "conviction" (refer to section 19-1-103, C.R.S.).

Approved Supervisor: A person who is authorized to supervise the sex offender's contact with a specified child or children per 5.760. This person is an individual who has met the criteria described in 5.771-5.775, has been approved by the community supervision team (CST), and has signed the approved supervisor contract.

Approved Community Support Person: A person who provides positive support for the sex offender's efforts to change and who may accompany the sex offender in approved activities that do not involve children. Someone significant to the offender and/or a roommate who attends treatment with the offender, has a positive relationship with the probation officer and treatment provider, and is well versed in the offender's probation and treatment requirements.

At Risk Adult: An individual who is less able to protect him/herself based on diminished capacity or position of trust (refer to section 18-6.5-102, C.R.S.).

Authorized Representative: An individual designated by the person receiving services, or by the parent or guardian of the person receiving services, if appropriate, to assist the person receiving services in acquiring or utilizing services and support (refer to section 27-10.5-102, C.R.S.).

Assessment: The collection of facts to draw conclusions which may suggest the proper course of action. Although the term "assessment" may be used interchangeably with the term "evaluation," in this document assessment generally has the broader usage, implying the collection of facts by a variety of agencies or individuals (e.g. pre-sentence investigator), while evaluation is generally used to mean the sex offense-specific evaluation conducted by a therapist (see also Evaluation).

Behavioral Monitoring: A variety of methods for checking, regulating and supervising the behavior of sex offenders.

Caregiver: Person whose primary caretaking responsibilities include meeting the various daily needs (e.g. physical, emotional, and financial) of his/her child.

Case Management: The coordination and implementation of the cluster of activities directed toward supervising, treating and managing the behavior of individual sex offenders.

Child Contact Assessment: A comprehensive evaluation conducted by a SOMB approved evaluator to assist the CST in determining the appropriateness of contact between a sex offender and his/her own child. Also known as a CCA.

Clinical Experience: Those activities directly related to providing evaluation and/or treatment to individual sex offenders, e.g. face-to-face therapy, report writing, administration, scoring and interpretation of tests; participation on case management teams of the type described in these *Standards and Guidelines*; and clinical supervision of therapists treating sex offenders.

Community Centered Board (CCB): A private non-profit corporation that provides case management services to persons with developmental disabilities. The CCB determines eligibility of such persons within a specified geographical area, serves as the single point of entry for persons to receive services, determines the needs of eligible persons, prepares and implements long-range plans, and annual updates to those plans. Other responsibilities include: establishing a referral and placement committee, obtaining or providing early intervention services, notifying eligible persons and their families regarding the availability of services and supports, and creating a human rights committee (refer to section 27-10.5-105, C.R.S.).

Community Supervision Team: A team of professionals including a minimum of the supervising officer, the treatment provider, and the polygraph examiner who collaborate to make decisions about the offender. Also known as the CST.

Containment Approach: A method of case management and treatment that seeks to hold offenders accountable through the combined use of both offenders' internal controls and external control measures (such as the use of the polygraph and relapse prevention plans). A containment approach requires the integration of a collection of attitudes, expectations, laws, policies, procedures and practices that have clearly been designed to work together. This approach is implemented though interagency and interdisciplinary teamwork.

Defense Mechanisms: Normal adaptive self-protective functions which keep human beings from feeling overwhelmed and/or becoming psychotic, but which become dysfunctional when overused or over-generalized.

Denial: In psychological terms denial means a defense mechanism used to protect the ego from anxiety-producing information.

Denier Intervention: Denier Intervention is designed primarily for those in Level 3 Denial (please refer to Standard 3.500). It occurs separately from regular group therapy that is provided for offenders who have, at a minimum, admitted the crime of conviction. Denier Intervention may include a variety of modalities specifically designed to reduce denial, minimization and resistance to treatment and supervision.

Department: The Colorado Department of Public Safety.

Developmental Disability Provider List: The list published by the SOMB, identifying treatment providers, evaluators, and polygraph examiners who meet the criteria set forth in the *Standards and Guidelines* (see Section 4.000).

Developmental Disability: A disability that is manifested before the person reaches twenty-two of age, which constitutes a substantial disability to the affected individual, and is attributable to mental retardation or related conditions which include cerebral palsy, epilepsy, autism, or other neurological conditions when such conditions result in impairment of general intellectual functioning or adaptive behavior similar to that of a person with mental retardation. Unless otherwise specifically stated, the federal definition of "developmental disability" found in 42 U.S.C. sec. 6000 et seq., shall not apply (Section 27-10.5-102 (11) (a), C.R.S.).

This definition is further explicated in the *Colorado Department of Human Services Developmental Disabilities Services Rules and Regulations* as follows:

1.2.10.1 *Impairment of general intellectual functioning* means that the person has been determined to have an intellectual quotient equivalent which is two or more standard deviations below the mean (70 or less assuming a scale with a mean of 100 and a standard deviation of 15), as measured by an instrument which is standardized, appropriate to the nature of the person's disability, and administered by a qualified professional. The standard error measurement of the instrument should be considered when determining the intellectual quotient equivalent.

1.2.10.2 *Adaptive behavior* means that the person has overall adaptive behavior which is significantly limited in two or more skill areas (communication, self-care, home living, social skills, community use, self-direction, health and safety, functional academics, leisure, and work), as measured by an instrument which is standardized, appropriate to the person's living

environment and administered and clinically determined by a qualified professional.

1.2.10.3 "Similar to that of a person with mental retardation" means that a person's adaptive behavior limitations are a direct result of or are significantly influenced by impairment of the person's general intellectual functioning and may not be attributable to only a physical impairment or mental illness.

Discussion: Some sexual offenders have intellectual and/or functional deficits that indicate a need for revised assessment, evaluation, treatment or behavioral monitoring even though they do not meet the federal definition for developmental disabilities. Evaluators, treatment providers, polygraph examiners, and supervising officers shall provide services appropriate to each sex offender's developmental level.

Direct Clinical Contact: Includes intake, face-to-face therapy, case/treatment staffing, treatment plan review, and crisis management with adult sex offenders.

Evaluation: The systematic collection and analysis of psychological, behavioral and social information; the process by which information is gathered, analyzed and documented.

In this document the term "sex offense-specific evaluation" is used to describe the evaluation provided for sex offenders under the jurisdiction of the criminal justice system (see also Assessment).

Evaluator: An individual who conducts sex offense-specific evaluations of sex offenders according to the *Standards and Guidelines* contained in this document, and according to professional standards.

Guardian: A person who is appointed by the court to make decisions on behalf of an incapacitated person (refer to Section 15-14-102, C.R.S.).

Guideline: A principle by which to make a judgment or determine a policy or course of action. Within the context of this document, a guideline should be read as a suggestion of best practice; a standard shall be read as required by Colorado statute.

Imposition of Legal Disability (ILD): A determination made in a court of law that an individual is required to receive services through a specified service provider. The process, described in Section 27-10.5-110 C.R.S., by which a petition can be filed with the Court and the Court can impose a legal disability on an individual with a developmental disability in order to remove a right or rights from the person. Prior to granting the petition the Court must find that the person has a developmental disability and that the request is necessary and desirable to implement the person's supervised individualized plan. If place of abode is involved, the court must also find based on a recent overt act or omission that the person poses a serious threat to themselves or others or is unable to accomplish self-care

safely, and that the imposed residence is the appropriate, least restrictive residential setting for the person (refer to Section, 27-10.5-110, C.R.S.).

Incapacitated Person: A person who lacks the ability to manage property and business affairs effectively by reason of mental illness, mental deficiency, physical illness or disability, chronic use of drugs, chronic intoxication, confinement, detention by a foreign power, disappearance, minority, or other disabling cause (refer to Section 15-1.5-102 (5), C.R.S.).

Incidental Contact: Any verbal or physical contact.

Incompetent To Proceed (ITP): The defendant suffers from a mental disease or defect which renders him or her incapable of understanding the nature and course of the proceedings against him or her, or of participating or assisting in the defense, or cooperating with his or her defense counsel.(refer to Section 16-8-103, C.R.S.)

Informed Assent:[40] Assent is a declaration of willingness to do something in compliance with a request; acquiescence; agreement. The use of the term "assent" rather than "consent" in this document recognizes that sex offenders are not voluntary clients, and that their choices are therefore more limited.

Informed means that a person's assent is based on a full disclosure of the facts needed to make the decision intelligently, e.g. knowledge of risks involved, alternatives.

Informed Consent: Consent is a voluntary agreement, or approval to do something in compliance with a request.

Informed means that a person's consent is based on a full disclosure of the facts needed to make the decision intelligently, e.g. knowledge of risks involved, alternatives.

Interdisciplinary Team (IDT): A group of people convened by a community centered board which shall include the person with a developmental disability receiving services, the parent or guardian of a minor, a guardian or an authorized representative, as appropriate, the person who coordinates the provision of services and supports, and others as determined by such person's needs and preferences, who are assembled in a cooperative manner to develop or review the individualized plan (refer to Section 27-10.5-102, C.R.S.).

Minor Child/Children: A child under the age of 18 years.

Non-Deceptive Polygraph Examination Result: A non-deceptive polygraph examination result must include a deceptive response to control questions and only non-deceptive responses to all

[40] The purpose of defining "informed assent" and "informed consent" in this section is primarily to highlight the degree of voluntariness in the decisions which will be made by a sex offender. No attempt has been made to include full legal definitions of these terms.

relevant questions. Any inconclusive or deceptive response to any relevant question disallows a non-deceptive examination result.

Plethysmography: In the field of sex offender treatment, plethysmography is the use of an electronic device for determining and registering variations in penile tumescence associated with sexual arousal. Physiological changes associated with sexual arousal in women are also measured through the use of plethysmography. Plethysmography includes the interpretation of the data collected in this manner.

Polygraphy: The use of an instrument that is capable of recording, but not limited to recording, indicators of a person's respiratory pattern and changes therein, galvanic skin response and cardio-vascular pattern and changes therein. The recording of such instruments must be recorded visually, permanently and simultaneously. Polygraphy includes the interpretation of the data collected in this manner, for the purpose of measuring physiological changes associated with deception.

Potential Victim: Any person at risk of abuse or manipulation by the sex offender.

Provider List: The list, published by the SOMB, identifies the treatment providers, evaluators, and polygraph examiners who meet the criteria set forth in these Standards. The determination that the providers meet the criteria is made by the SOMB based on an application submitted by the provider, outlining their experience, training and credentials, a criminal history check and background investigation, written references and reference checks and a review of relevant program materials and products. Placement on the list must be renewed every three years.

Regional Center: A facility or program operated directly by the Department of Human Services, which provides services and supports to persons with developmental disabilities (refer to Section 27-10.5-102, C.R.S.).

Safety Plan: A written document derived from the process of planning for community safety. The document identifies potential high-risk situations and addresses ways in which situations will be handled without the offender putting others at risk. The plan requires the approval of the community supervision team.

Secondary Victim: A **s**econdary victim is a relative or other person closely involved with the primary victim who is impacted emotionally or physically by the trauma suffered by the primary victim.

Sex Offender: The following definition is based on Section 16-11.7-102, C.R.S. For purposes of this document a sex offender is:

1. Any (adult) person convicted of a sex offense (defined below) in Colorado on or after January 1, 1994, or;
2. Any person convicted in Colorado on or after July 1, 2000, of any criminal offense with the underlying factual basis being a sex offense, or;

3. Any person who is adjudicated as a juvenile or who receives a deferred adjudication on or after July1, 2002, for an offense that would constitute a sex offense if committed by an adult or for any offense, the underlying factual basis of which involves a sex offense, or;
4. Any person who receives a deferred judgment or deferred sentence for the offenses specified in below is deemed convicted, or;
5. Any (adult) person convicted of any criminal offense in Colorado on or after January 1, 1994, and;

    a. who has previously been convicted of a sex offense in Colorado, or;
    b. who has previously been convicted in any other jurisdiction of any offense which would constitute a sex offense in Colorado, or;
    c. who has a history of any sex offenses as defined in the *Sex Offense* definition below.

The determination of the legal status of a sex offender as either an adult or a juvenile is defined by statute.

A sex offender is also referred to as an "offender" in the body of this document; a sex offender is also referred to as a "client" and an "examinee" in sections relating to treatment and polygraph examinations respectively.

Sex Offense:

The following definition is based on statute.[41] For the purposes of this document, a sex offense is:

1. Sexual Assault;
2. Sexual Assault in the first, second and third degree as it existed prior to July 1, 2000;
3. Unlawful Sexual Contact;
4. Sexual Assault on a child;
5. Sexual Assault on a child by one in a position of trust;
6. Sexual Assault on a client by a psychotherapist;
7. Enticement of a child;
8. Incest;
9. Aggravated Incest;
10. Trafficking in children;
11. Sexual Exploitation of children;
12. Procurement of a child for sexual exploitation;
13. Indecent Exposure;
14. Soliciting for child prostitution;
15. Pandering of a child;
16. Procurement of a child;
17. Keeping a place of child prostitution;
18. Pimping of a child;
19. Inducement of child prostitution;

[41] Section 16-11.7-102 (3), C.R.S., 2006. It is important to refer to the most current edition of the Colorado Revised Statutes.

20. Patronizing a prostituted child;
21. Internet luring of a child;
22. Internet sexual exploitation of a child, or;
23. Criminal attempt, Conspiracy, or Solicitation to commit any of the above offenses.

Sex Offender Polygraph: A criminal specific-issue polygraph examination of a suspected or convicted sex offender. Refer to section 6.000 for details.

Sex Offense-Specific Treatment: Consistent with current professional practices, sex offense-specific treatment is a long term comprehensive set of planned therapeutic experiences and interventions to change sexually abusive thoughts and behaviors. Such treatment specifically addresses the occurrence and dynamics of sexually deviant behavior and utilizes specific strategies to promote change. Sex offense-specific programming focuses on the concrete details of the actual sexual behavior, the fantasies, the arousal, the planning, the denial and the rationalizations. Due to the difficulties inherent in treating sex offenders and the potential threat to community safety, sex offense-specific treatment should continue for several years, followed by a lengthy period of aftercare and monitoring. Much more importance is given to the meeting of all treatment goals than the passage of a specific amount of time, since offenders make progress in treatment at different rates. The primary treatment modality for sex offense-specific treatment is group therapy for the offenders. Adjunct modalities may include partner or couples therapy, psycho-education, and/or individual therapy. However, such adjunct therapies by themselves do not constitute sex offense-specific treatment. Refer to section 3.000 for details.

Sexual Paraphilias/ Sexual Deviance: A subclass of sexual disorders in which the essential features are "recurrent intense sexually arousing fantasies, sexual urges, or behaviors generally involving (1) nonhuman objects, (2) the suffering or humiliation of oneself or one's partner, or (3) children or other non-consenting persons that occur over a period of at least 6 months. The behavior, sexual urges or fantasies cause clinically significant distress or impairment in social, occupational, or other important areas of functioning. Paraphilic imagery may be acted out with a non-consenting partner in a way that may be injurious to the partner. The individual may be subject to arrest and incarceration. Sexual offenses against children constitute a significant proportion of all reported criminal sex acts" (DSM-IV, pages 522-523). This class of disorders is also referred to as "sexual deviations." Examples include pedophilia, exhibitionism, frotteurism, fetishism, voyeurism, sexual sadism, sexual masochism and transvestic fetishism. This classification system includes a category labeled "Paraphilia Not Otherwise Specified" for other paraphilias which are less commonly encountered.

Shared Living Arrangement: A separately contained living unit in which more than one adult

	sex offender in treatment resides for the purpose of increased public safety, increased accountability, intensive containment, and more consistent treatment interventions, provided by treatment providers who are approved by the SOMB. Also known as a SLA. Refer to section 3.170 for details.
SOMB:	The Colorado Sex Offender Management Board.
Special Populations:	Persons subject to federally mandated protections and accommodations under the *Americans with Disabilities Act (1990*), *Section 504 of the Rehabilitation Act (1973),* or who were subject to the *Education of All Handicapped Act (1975)* and the subsequent *Individuals with Disabilities Education Act (1990)* and *Individuals with Disabilities Education Improvement Act (2004),* are clearly identified as special populations according to those legislative guidelines.
Standard:	Criteria set for usage or practices; a rule or basis of comparison in measuring or judging.
Standards and Guidelines:	The S*tandards and Guidelines for the Assessment, Evaluation, Treatment and Behavioral Monitoring of Adult Sex Offenders.*
Supervising Officer:	The probation or parole officer or community corrections case manager to whom the offender's case is assigned.
Treatment:	According to Section 16-11.7-102(4), C.R.S. treatment means therapy, monitoring and supervision of any sex offender which conforms to the *Standards and Guidelines* created by the SOMB (see also Sex offense-specific treatment).
Treatment Provider:	A person who provides sex offense-specific treatment to sex offenders according to the *Standards and Guidelines* contained in this document.
Victim:	Any person against whom sexually abusive behavior has been perpetrated or attempted.
Victim Clarification Process:	A process designed for the primary benefit of the victim, by which the offender clarifies that the responsibility for the assault/abuse resides with the offender. The process will clarify that the victim has no responsibility for the offender's behavior. It also addresses the damage done to the victim and the family. This is a lengthy process that occurs over time, including both verbal and written work on the part of the offender. Although victim participation is never required and is sometimes contraindicated, should the process proceed to an actual clarification meeting with the victim, all contact is victim centered and based on victim need. Refer to section 5.000 for details.

1.000
GUIDELINES FOR PRE-SENTENCE INVESTIGATIONS

1.100 Per C.R.S. 16-11-102, each sex offender shall be the subject of a presentence investigation (PSI) which shall include a sex offense-specific evaluation. This report should be prepared in all cases where it has been ordered by the court.

Discussion: The purpose of the PSI is to provide the court with relevant information upon which to base sentencing decisions. The sex offense-specific evaluation *establishes a baseline of information about the offender's risk and protective factors, treatment needs and amenability to treatment. The PSI may include recommendations about an offender's suitability for community supervision.*

The PSI report, including the sex offense-specific evaluation, *should be provided by the Probation Department to the Department of Corrections when applicable and should follow the sex offender in placements within the criminal justice system (see Section 7.000 – Continuity of Care and Information Sharing).*

1.200 The PSI report should be completed by a pre-sentence investigator specially trained in sex offender management (See 5.215 for required training).

1.300 A PSI report shall address all the criteria pursuant to C.R.S.16-11-102.

1.400 When referring an offender for the sex offense-specific evaluation, the referral packet may include but is not limited to the following:

- Police reports
- Victim impact statements
- Child protection reports
- A criminal history
- Summary of available risk assessment information
- Prior evaluations and treatment reports
- Prior supervision records
- Release of Information
- Any other information requested by the evaluator

1.500 Sex offense-specific evaluations received by the pre-sentence investigation writer that have been performed prior to an admission of guilt by the sex offender (pre-plea) may not meet the requirements of these Standards.

If the PSI writer receives a pre-plea evaluation and finds that the evaluation does not contain the information required under these Standards (see Section 2.000), the PSI writer may inform the court and provide recommendations upon request from the court. The PSI writer may seek supplemental information from the evaluator to collaboratively resolve any outstanding issues.

2.000
STANDARDS FOR SEX OFFENSE-SPECIFIC EVALUATIONS

2.000 The purpose of a mental health sex offense-specific evaluation (hereafter evaluation) is to assess a client's need for treatment, determine what type of treatment is needed, and identify the risk level and any additional needs the client may have[42] (for the client whose instant offense conviction is for a non-sexual crime but has a history of a sex offense conviction or adjudication, see Appendix E: Guidelines for the Evaluation and Treatment of Sex Offenders with a Current Non-Sex Conviction). Treatment considerations should be based on the conclusions and recommendations of the evaluation. While the evaluation provides valuable information and recommendations, it should be viewed as fluid. As new information emerges, or risk level changes within the course of treatment, a client's treatment should be tailored to address those changes.[43] Because of the importance of the initial information to subsequent sentencing, supervision, treatment, and behavioral monitoring, each client shall receive a thorough assessment and evaluation[44] that examines the interaction between the client's mental health, social/systemic functioning, family and environmental functioning, and offending behaviors. Sex offense-specific evaluations are not intended to replace more comprehensive psychological or neuropsychological evaluations. Evaluators have an ethical responsibility to conduct evaluations in a comprehensive and factual manner, regardless of the client's status within the criminal justice system.

Evaluations recommending sex offense-specific treatment should suggest the use of research-informed treatment, management, and monitoring interventions that are appropriate for the risk level, needs, and responsivity[45,46] of each individual client and that minimize that client's likelihood to sexually reoffend.[47] Consequently, evaluators will prioritize the physical and psychological safety of victims and potential victims in making recommendations that are appropriate to the assessed risk and needs of each client.[48] Various stakeholders, including lawyers, judges, supervising officers, treatment providers and others, rely upon evaluations to make informed decisions at multiple points in time. Evaluators should not assume that readers possess clinical training or expertise in mental health treatment, and should attempt to minimize overemphasis on any single test or aspect of the assessment.

Approved Evaluators who provide evaluations to clients with developmental disabilities shall be SOMB approved with the qualifications required by the *Standards and Guidelines*, Section 4.400 (G), 4.510 (I) and 4.600 (K).

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[42] McGrath, R.J. (2016). Clinical strategies for evaluating sexual offenders. In Phenix, A., Hoberman, H.M. *Sexual Offending* (pp. 265-278). New York: Springer.

[43] Bonta, J., & Wormith, J. S. (2013). Applying the risk-need-responsivity principles to offender assessment.

[44] Each evaluation shall be sensitive to the functioning, skills, and mental and physical capabilities of each client.

[45] Bonta, J., & Wormith, J. S. (2013). Applying the risk-need-responsivity principles to offender assessment. In L.A. Craig, L. Gannon, L., & T. A. Dixon (Eds.), What works in offender rehabilitation: An evidence-based approach to assessment and treatment (pp. 71–93). Hoboken, NJ: Wiley-Blackwell; Gallo et al. (2014). Treatment of high-risk high-need sexual offenders: The integrated risk need responsivity model (RNR-I). *Annals of Psychiatry and Mental Health, 3*(1), 1018:1-2; Hanson et al. (2009). The principles of effective correctional treatment also apply to sexual offenders: A meta-analysis. *Criminal Justice and Behavior, 36*(9), 865–891. Harkins, L., & Beech, A. R. (2007). A review of the factors that can influence the effectiveness of sexual offender treatment: Risk, need, and responsivity, and process issues. *Aggression and Violent Behavior, 12*(6):615–627; Parent, G., Guay, J., & Knight, R. (2011). An Assessment of Long-term Risk of Recidivism by Adult Sex Offenders: One Size Doesn't Fit All. *Criminal Justice and Behavior, 38*(2):188-209.

[46] Effective service delivery of treatment and supervision requires individualization that matches the client's culture, learning style, and abilities, among other factors.

[47] CRS § 16-11.7-103(4) (a).

[48] Id.

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

2.110 Recommendations from the evaluation should be the starting point of developing the treatment plan. Assessment is an ongoing process and should continue through each transition of supervision and treatment. Re-evaluation by Community Supervision Team (CST) members should occur as needed to ensure recognition of changing levels of risk.

2.120 Evaluators are expected to stay current with special considerations available in the SOMB *Standards and Guidelines* for the clients they are evaluating. Evaluators should use appropriate tools, including but not limited to those contained in the SOMB appendices. Applicable appendices include the following:

1. Appendix C: Young Adult Modification Protocol

2. Appendix E: Guidelines for the Evaluation and Treatment of Sex Offenders with a Current Non-Sex Conviction

3. Appendix F: Sex Offense-Specific Intake Review for Clients who have been in Prior Treatment

4. Appendix M: Female Offender Risk Assessment

2.130 Evaluators shall be attentive to potential concerns about a client's competency to provide informed assent and sign any legal releases, cooperate in the evaluation process, or participate in any recommended treatment or sentence. The status of competency can change over time, regardless of prior findings. Competency is always contingent on the *present* condition of a defendant.

2.140 An evaluator who suspects a defendant may not have a reasonable degree of rational or factual understanding[49] of the releases, evaluation process, legal proceedings, or potential sentences should notify the referral source, who may then alert the criminal court.[50]

Discussion Point: Prosecuting an incompetent defendant is prohibited throughout the execution and satisfaction of the sentence.[51]Additionally, a defendant who is incompetent cannot be sentenced. Thus, the court is required to determine whether the defendant is competent before imposing a sentence.[52]

2.150 The evaluator shall obtain the informed assent of the client for the evaluation, by advising the client of the assessment and evaluation methods to be used, the purpose of the evaluation, and to whom the information will be provided. The evaluator's role shall be explained to the client. Results of the evaluation should be shared with the client, if appropriate, and the evaluator shall

[49] *Godinez v. Moran*, 509 U.S. 389, 396 (1993); *Dusky v. United States*, 362 U.S. 402 (1960); CRS § 16-8.5-101(11). The due process clause of the United States Constitution requires that a defendant be competent during the pendency of his/her criminal case. *Dusky*, *supra.*
[50]The criminal judge will determine whether the identified concerns warrant a forensic competency examination or the initiation of other proceedings as provided in CRS § 16-8.5-101 et. seq.
[51] *Jones v. District Court*, 617 P.2d 803, 807 (Colo. 1980).
[52] *See* C.R.S. §16-8.5-102(1) (2015).

address any questions. The evaluation shall explain the limits of confidentiality and the obligations regarding mandatory reporting of child abuse and elder abuse.

2.150 DD/ID

A. The information shall be provided in a manner that is easily understood, verbally and in writing, or through other modes of communication that may be necessary to enhance understanding.

Discussion: When the evaluator is working with a client with developmental disabilities, and determines that informed assent could not be acquired at the time of the evaluation, the evaluator shall obtain assistance from a third party who is not a practitioner from within the same agency. A third party may be an individual or group of individuals who understands the definition of informed assent and who has/had significant knowledge of the person's unique characteristics.

B. The evaluator shall obtain the assent of the legal guardian, if applicable, and the informed assent of the client with developmental disabilities for the evaluation and assessments. The legal guardian will be informed of the evaluation methods, how the information may be used and to whom it will be released. The evaluator shall also inform the client with developmental disabilities and the legal guardian about the nature of the evaluator's relationship with the client and with the court. The evaluator shall respect the client's right to be fully informed about the evaluation procedures. Results of the evaluation may be reviewed with the client and the legal guardian upon request.

If informed assent cannot be obtained after consulting with the third party, then the evaluator shall refer the case back to the community supervision team or the court.

2.160 The evaluator shall be sensitive to any cultural, ethnic, developmental, sexual orientation, gender, medical and/or educational issues, or disabilities that become known during the evaluation.

2.170 To ensure the most accurate prediction of risk for clients, the following evaluation modalities are all required in performing a sex offense-specific evaluation:[53]

A. Use of instruments that have specific relevance to evaluating clients

B. Use of instruments with demonstrated reliability and validity

C. Examination and integration of criminal justice data and other collateral information including:

1. The details of the current offense

2. Documents that describe victim trauma, when available

3. Scope of client's sexual behavior other than the current offense that may be of concern

[53] McGrath, R.J. (2016). Clinical strategies for evaluating sexual offenders. In Phenix, A. Hoberman, H.M. *Sexual Offending* (pp. 265-278). New York: Springer.

D. Structured clinical and sexual history interview

E. Psychological testing and offense-specific standardized assessments/instruments
F. Testing of deviant arousal or interest (i.e. Plethysmograph or Viewing Time [VT] instruments).

G. Use of at least one validated risk assessment instrument, when available, that was normed on a population most similar to the client being evaluated.

Discussion: Evaluation instruments and processes will be subject to change as more is learned in this area. For some populations, there may not be a validated risk assessment available, and therefore risk assessment should be based on clinical judgement and other relevant factors. When in doubt, the evaluator should err on the side of protecting community safety in drawing conclusions and making recommendations.

2.170 DD/ID

A. Due to the complex issues of evaluating clients with developmental disabilities, methodologies shall be applied individually, and their administration shall be guided by the following:

1. When possible, instruments should be used that have relevance and demonstrated reliability and validity, which are supported by research.

2. If a required procedure is not appropriate for a specific client, the evaluator shall document in the evaluation why the required procedure was not done.

B. Evaluators shall carefully consider the appropriateness and utility of using a plethysmograph assessment or viewing time assessment with clients who have developmental disabilities. For these assessments to be effective with this population, evaluators shall assess whether the client has a sufficient level of cognitive functioning to be able to adequately discriminate between stimulus cues. In addition, consideration shall be given to use of specialized assessment tools that have been developed for clients who have developmental disabilities.

2.200 ♦ Sex Offense-Specific Evaluation

Outlined in the following chart are the <u>required</u> areas of a sex offense-specific evaluation. The left hand column identifies the required areas to be evaluated. The right hand column identifies the evaluation procedures that are required and optional evaluation procedures that may be used. Assessment tools shall be utilized in the evaluation as appropriate to the specific client population being evaluated (e.g., female, developmentally disabled, or juvenile offense being evaluated for adult non-sex offense).

Discussion: The assessment tools identified below for each of the evaluation areas do not represent an exhaustive list of the available psychometric and behavioral measures. Some of these assessment tools have been validated, and as such should be applied following one's professional ethics and scope of practice based on the population for which it was intended and an individual client's treatment needs. The identified assessment tools are frequently used by evaluators while conducting sex offense-specific evaluations. Evaluators should follow updates related to improvements made to these tools, as they are periodically modified and improved upon. In addition, new tools may become available and may be utilized, as well. It is recognized that some methods of assessment may not be an option or the information to be reviewed may not be available.

Evaluation Areas – Required	**Required and Optional Evaluation Procedures** • Closed bullet indicates a required method o Open bullet indicates an optional method
COGNITIVE FUNCTIONING	
Intellectual Functioning *(e.g. Intellectual and Developmental Disability, Learning Disability, dementia, and traumatic brain injury)*	• Clinical Interview • History of Functioning and/or standardized tests • Clinical Mental Status Exam • Observational Assessment • Case File/Document Review • Collateral Information/Contact/Interview o Wechsler Adult Intelligence Scale (WAIS) o Test of Non-Verbal Intelligence (TONI) o Shipley Institute of Living Scale Revised o Stanford Binet o Slosson Intelligence Test – Revised o Slosson Full-Range Intelligence Test o Montreal Cognitive Assessment (MOCA) o Foldstein Mini-Mental Status Exam o Data from Care Providers o Data from Relatives or Support System Persons o Leiter International Performance Scale o Ravens Standard Progressive Matrices (for non-English speakers/readers) o BETA - Culture free test of intelligence
Neuropsychological Functioning *(fluid intelligence)*	• Clinical Interview • Clinical Mental Status Exam o Observational Assessment o Case File/Document Review o Collateral Information/Contact/Interview o Test of Memory and Learning o Cognistat – Neurobehavioral Cognitive Status Exam o Boston Naming Test o Luria-Nebraska Screening Test o Weschler Memory Scale Revised o Bilingual Verbal Abilities Test o Referral to Neuropsychologist if necessary o Wechsler Adult Intelligence Scale (WAIS) o Bender – Gestalt o Montreal Cognitive Assessment (MOCA) o CNS-VS o Kaplan-Baycrest Neurocognitive Battery o Interference Procedure Luria tests (not battery) o Halstead-Reitan Neuropsychological Battery o Repeatable Battery for the Assessment of Neuropsychological Status Update (R-BANS HRB) o Wisconsin Card Sorting Test

Academic Achievement *(Individualized Education Program including those ages 18-21, literacy, gifted and talented)*	• Clinical Interview • Clinical Mental Status Exam o Individualized Education Program o Observational Assessment o Case File/Document Review o Collateral Information/Contact/Interview o Woodcock-Johnson Psychoeducational Battery, Revised o Wide Range Achievement Test o Referral to Educational Diagnostic if necessary o Referral to Vocational Specialist if necessary o Kaufman Test of Educational Achievement (K-TEA) o Vineland Adaptive Behavior Scales (Vineland™)
MENTAL HEALTH	
Character/Personality Pathology	• Clinical Interview • Collateral Information/Contact/Interview • Clinical Mental Status Exam • Observational Assessment • Case File/Document Review o Hare Psychopathy Checklist Revised o Psychopathy Checklist – Screening Version o Millon Clinical Multiaxial Inventory (MCMI) o Minnesota Multiphasic Personality Inventory (MMPI) o Rorschach Test o Sentence Completion Series o State-Trait Anger Inventory o Social/Developmental History o Personality Assessment Inventory (PAI) o History: Criminal, Social, Relationship
Mental Illness/Psychiatric Health	• Clinical Interview • Collateral Information/Contact/Interview • Clinical Mental Status Exam • Observational Assessment • Case File/Document Review o Millon Clinical Multiaxial Inventory (MCMI) o Minnesota Multiphasic Personality Inventory (MMPI) o Rorschach Test o Sentence Completion Series o Symptom Checklist 90 Revised o Brief Symptom Inventory / Symptom Assessment-45 o Trauma Symptom Inventory o Beck Depression Inventory o Brief Psychiatric Rating Scale o Personality Assessment Inventory (PAI)
Self-Concept/Self-Esteem	• Clinical Interview • Clinical Mental Status Exam • Observational Assessment • Case File/Document Review • Collateral Information/Contact/Interview o CPI (California Personality Inventory) o Millon Clinical Multiaxial Inventory (MCMI) o Minnesota Multiphasic Personality Inventory (MMPI) o Personality Assessment Inventory (PAI)

MEDICAL	
▭ Pharmacological Needs ▭ Medical Condition ▭ History of Medication Use/Abuse	• Clinical Interview • Clinical Mental Status Exam • Observational Assessment • Case File/Document Review • Collateral Information/Contact/Interview ○ Referral to Physician, if indicated ○ Referral to Psychiatrist, if indicated ○ Referral for Medical Tests ○ Consultation with Psychiatrist (reference DSM-5)
DRUG/ALCOHOL USE	
Legal and Illegal Use/Abuse	• Clinical Interview • Collateral Information/Contact/Interview • Clinical Mental Status Exam • Observational Assessment • Case File/Document Review ○ Millon Clinical Multiaxial Inventory (MCMI) ○ Minnesota Multiphasic Personality Inventory (MMPI) ○ Clinical Analysis Questionnaire ○ Personal History Questionnaire ○ Substance Abuse Subtle Screening Inventory (SASSI) ○ Adult Substance Use Survey Revised ○ Substance Use History Matrix ○ Simple Screening Instrument for Alcohol and Other Drugs (SSI-AOD) ○ Alcohol Use Questionnaire Drug and Alcohol History ○ Alcohol Dependence Scale (ADS) ○ The Drug Abuse Screening Test (DAST) ○ Abel Substance Use Scale
STABILITY OF FUNCTIONING	
Family/Other Support System Stability *(e.g. past, current, familial boundaries, cultural and family norms, employment/education, and social support systems)*	• Clinical Interview • Interview Attitudes • Collateral Information/Contact/Interview • Clinical Mental Status Exam • Observational Assessment • Case File/Document Review • History of Functioning ○ Personal History Questionnaire ○ Dyadic Adjustment Scale ○ Marital Satisfaction Inventory
Current Contact with Children	• Clinical Interview • Parental Role • Extended family • Contact with minors via work/housing • Court orders related to contact with children • Collateral Information ○ Risk of Sexual Abuse of Children (ROSAC) ○ CCA (Child Contact Assessment) ○ Child Abuse Potential Inventory ○ Parental Stress Index ○ Parent Child Relationship Inventory
Financial/Housing/Employment/Education	• Clinical Interview

▭ Completion of Major Life Tasks ▭ History of Moves and Reasons ▭ Overall Employment and Housing Stability	• Collateral Information/Contact/Interview • History of Functioning • Case File/Document Review ○ Clinical Mental Status Exam ○ Observational Assessment ○ Personal History Questionnaire
Social Skills ▭ Ability to Form Relationships ▭ Ability to Maintain Relationships ▭ Courtship/Dating Skills ▭ Ability to Demonstrate Assertive Behavior	• Clinical Interview • Collateral Information/Contact/Interview • Clinical Mental Status Exam • Observational Assessment • Case File/Document Review ○ Interpersonal Behavior Survey
History or Risk of Violent Behaviors ▭ Suicidal/Homicidal Ideation ▭ Sadism ▭ Domestic Violence	• Clinical Interview • Collateral Information/Contact/Interview ○ Psychopathy Checklist—Revised (PCL-R) ○ Penile Plethysmography (PPG) ○ Domestic Violence Risk and Needs Assessment (DVRNA) ○ Spousal Assault Risk Assessment (SARA) ○ Marshal and Hucker Sexual Sadism Scale ○ Millon Clinical Multiaxial Inventory (MCMI) ○ HCR-20 ○ Domestic Violence Questionnaire ○ Suicide Probability Scale ○ Domestic Violence Risk Appraisal Guide (DVRAG) ○ Violence Risk Appraisal Guide (VRAG)
Community Connectedness (*e.g. spirituality, volunteer work, community organizations****)***	• Clinical Interview • Collateral Information/Contact/Interview ○ Millon Clinical Multiaxial Inventory (MCMI)
DEVELOPMENTAL HISTORY (Lifespan)	
▭ Disruptions in Parent/Child Relationship ▭ History of Behavior Problems History of Special Education Services, Learning Disabilities, School Achievement ▭ Indicators of Attachment Disorders ▭ History of Trauma ▭ Aging ▭ Recent Memory Functioning ▭ Adaptive Behavior ▭ Support Systems ▭ Executive Functioning	• Clinical Interview • History of Functioning • Collateral Information/Contact/Interview • Clinical Mental Status Exam • Observational Assessment • Case File/Document Review ○ Vineland Adaptive Behavioral Scale ○ Adaptive Behavioral Scale of the American Association for Mental Retardation ○ Current DD/ID system involvement ○ Current family involvement ○ Current social involvement ○ Wisconsin Card Sort Test ○ Boston Naming Test ○ Trail Making Test ○ Bender-Gestalt ○ Cognistat – Neurobehavioral Cognitive Status Exam ○ Montreal Cognitive Assessment (MOCA)
SEXUAL EVALUATION	
Sexual History *(Onset, Intensity, Duration, Arousal Pattern)* ▭ Witnessed or Experienced	• Clinical Interview • History of Functioning • Collateral Information/Contact/Interview

Victimization (Sexual or Physical) ▭ Source of Sexual Education ▭ Information and Extent of Sexual Knowledge ▭ Sexual dysfunction (medical, psychological, etc.) ▭ Sexual attitudes ▭ Pornography Use ▪ Age of Onset ▪ Frequency ▪ Duration ▪ Media (e.g. Telephone, Cable, Video, Internet, Social Media, Anime) ▪ Manner of use and experience ▭ History and Response to Sexual Experiences (Both Positive and Negative) ▭ Sexual Lifestyle, Environment and Culture (e.g. Sexting, Cults, Prostitution, Strip Clubs, etc.) ▭ History, Frequency and Method of Masturbation ▪ Objects ▪ Location	• Clinical Mental Status Exam • Observational Assessment • Case File/Document Review ○ Personal Sentence Completion Inventory – Miccio-Fonseca ○ Sex Offender Incomplete Sentence Blank ○ Wilson Sexual Fantasy Questionnaire ○ SONE Sexual History Background Form ○ Colorado Sex Offender Risk Scale (Actuarial scale normed on Colorado offenders from probation, parole and prison) ○ Multiphasic Sex Inventory ○ Penile Plethysmography (PPG) ○ Viewing Time (VT) ○ Wechsler Adult Intelligence Scale (WAIS) ○ Clarke Sex History Questionnaire for Males-Revised ○ Polygraph ○ Adverse Childhood Experiences Scale (ACES)
Arousal/Interest Pattern ▭ Sexual Arousal or Sexual Interest ▭ Preference ▭ Orientation ▭ Gender Identity	• Clinical Interview • Plethysmograph or Viewing Time (VT)
Specifics of Sexual Crime(s) *(Onset, Intensity, Duration, and Level of Arousal)* ▭ Detailed Description of Sexual Offense(s) ▭ Attitudes About Offense (i.e. Seriousness, Harm to Victim) ▭ Emotional state during the offense ▭ Drug and/or Alcohol Involvement in offense ▭ Level of denial	• Clinical Interview • History of Crimes • Collateral Information • Review of Criminal Records ○ Review of Victim Impact Statement ○ Contact with Victim Therapist ○ Polygraph Examination
RISK	
Risk of Re-offense	• Criminal History • Static Risk Assessment (see Section 2.400) • Dynamic Risk Assessment (see Section 2.400) ○ Violence Risk Assessment Guide (VRAG) ○ Vermont Assessment of Sex Offender Risk (VASOR) ○ Sex Offender Treatment Intervention and Progress Scale (SOTIPS) ○ MnSOST ○ CARAT ○ Static 99R or 2002R ○ Stable 2007 ○ Acute 2007 ○ Assessment of Risk and Manageability of Individuals

	with Developmental and Intellectual Limitations who Offend - Sexually (ARMIDILO-S) ○ Inventory of Offender Risk, Needs, and Strengths (IORNS) ○ VRS:SO ○ SVR ○ Child Pornography Offender Risk Tool (CPORT)
Risk of Failure in Treatment and Supervision	• Clinical Interview • Criminal History • Treatment Summaries or Notes (when available) • Collateral information related to prior failures (when available) ○ PCL-R ○ Stable 2007 ○ Acute 2007 ○ SORS ○ VRS:SO
READINESS FOR TREATMENT	
Amenability to Treatment ▭ Strengths and Barriers	• Clinical Interview ○ MSI ○ PCL-R ○ Millon Clinical Multiaxial Inventory (MCMI) ○ Static-99R ○ Stages of Change ○ Cooperation with bonds, current or potential housing, income, family stance/support, emotional stability ○ Collateral contact review of history case file/document review ○ Consideration of level of denial, DSM Dx, mental status, and various history items
Motivation Toward Sex Offender Treatment	• Clinical Interview ○ Clinical Mental Status Exam ○ Observational Assessment ○ Case File/Document Review ○ Review of Criminal Records ○ History of Compliance with Treatment and Supervision
VICTIM IMPACT	
▭ Client's perception of seriousness, harm to victim ▭ Physical, Mental and Emotional Harm to Victim, if Available ▭ Degree of victim empathy ▭ Access to victim	• Clinical Interview of Offender • Case File/Document Review • Review of Police Reports ○ Review Victim Impact Statement ○ Contact Victim Therapist/Advocates, when available ○ Interview Family Members
SECONDARY AND TERTIARY VICTIM IMPACT	
▭ Client's Perception of Impact on Secondary Victims ▭ Degree of general empathy	• Clinical Interview of Offender • Case File/Document Review • Review of Police Reports ○ Review Victim Impact Statement ○ Contact Victim Therapist/Advocates, when available ○ Interview Family Members

Discussion: No single test should be seen as absolute or predictive; rather, results should be seen as contributing to the overall evaluation of the client, and his or her risk to the community.

DD/ID Discussion: Many widely used risk assessment tools have not been created specifically for clients with developmental disabilities. Therefore, the evaluator shall use caution when choosing to use such instruments, and provide necessary accommodations to meet the needs of the client when interpreting the resulting data.

2.210 Formulations and Recommendation

The recommendations shall be based upon a formulation of all pertinent data collected in the evaluation process. Each recommendation shall include a clear and concise supporting explanation.

The evaluator shall make recommendations or findings regarding:

A. Level of risk, including an overall or cumulative assessment of the client's risk

B. Specific risk factors that require management and potential interventions

C. Specific protective factors that may enhance treatment amenability and overall rehabilitation

D. Current amenability to treatment

E. Appropriate placement options (e.g., community, outpatient, or residential)

F. Relevant diagnostic considerations regarding the treatment of co-existing conditions, the need for medical/pharmacological treatment (if indicated), and further assessments needed to address areas of concern

G. Other relevant considerations based on the individual client's risk and needs that could affect the safety of the client and/or community safety and/or treatment

The evaluator shall also provide information about a client's potential contact with his/her own children and suggested risk factors.

Discussion: This information should be clearly identified in the evaluation, with the purpose of providing information to assist a judge in decision formulation. Please note, evaluators are not required to make a recommendation either for or against such contact, although an evaluator may choose to include such a recommendation.

2.220 Any required evaluation areas that have not been addressed, or any required evaluation procedures that have not been performed, shall be specifically noted. In addition, the evaluator must state the limitations of the absence of any required evaluation areas or procedures on the evaluation results, conclusions or recommendations. When there is insufficient information to evaluate one of the required areas, then no conclusions shall be drawn nor recommendations made concerning that required area.

2.230 The polygraph examination may be used as an adjunct tool in the evaluation process. The polygraph should not be used to determine guilt or innocence or as the primary finder of facts for legal purposes (see Section 6.000 for Standards on the use of the polygraph).

2.240 Evaluators have an ethical responsibility to conduct evaluation procedures in a manner that ensures the integrity of testing data, the humane and ethical treatment of the client, and compliance with the mental health statutes. Evaluators should use testing instruments in accordance with their qualifications and experience.

2.250 Evaluators shall not represent or imply that an evaluation meets the criteria for a sex offense-specific evaluation if it does not comply with the SOMB *Standards and Guidelines*. Evaluators shall include a statement in each completed evaluation as to whether the evaluation is fully compliant with the SOMB *Standards and Guidelines* or not.

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 listed at the full operating level or the associate level under these Standards.

3.110 DD/ID
In a situation where a client's developmental disability interferes with the provider's ability to meet the requirements of any section of 3.000, the Community Supervision Team (CST) must come to consensus about any modification to the Standards that is implemented. The modification must be documented in writing and signed by each CST member.

3.120 A provider who treats sex offenders under the jurisdiction of the criminal justice system must use sex offense-specific treatment (see Definition Section). This does not preclude participation in adjunctive treatment as clinically indicated and approved by the Community Supervision Team.

Discussion: A provider who chooses to begin treating an offender during the pre-conviction stage should provide treatment in compliance with these Standards.

3.120 DD/ID
When providing treatment to individuals with developmental disabilities who may exhibit sexually inappropriate behaviors but who have not been convicted of a sex offense, it is recommended that the Standards be used as guidelines. The treatment of non-convicted individuals does not fall under the purview of the Sex Offender Management Board.

3.130 Upon an offender entering treatment, a provider shall develop a written treatment plan based on the needs and risks identified in current and past assessments/evaluations of the offender. Treatment plans should evolve over the course of treatment as new information is discovered.

The treatment plan shall:

A. Provide for the protection of victims and potential victims and not cause the victim(s) to have unsafe and unwanted contact with the offender.

B. Address the issue of ongoing victim input (will the victim be involved, in what manner, at what stage of treatment, etc.)

C. Be individualized to meet the unique needs and risks of the offender.

D. Identify the issues to be addressed, the planned intervention strategies, and the goals of treatment.

E. Define expectations of the offender, his/her family (when possible), and support systems.

3.140 Providers shall maintain client files in accordance with the professional standards of their individual disciplines and with Colorado state law and federal statutes 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 plans.

B. Record specific achievements, failed assignments, rule violations and consequences.

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

3.150 Approved providers shall participate in, and cooperate with, Board research projects related to evaluation or implementation of the Standards or sex offender management in Colorado in accordance with Section 16-11.7-103 (4) (d), C.R.S.

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

A. The provider shall employ treatment methods that give priority to the safety of an offender's victim(s), the safety of potential victims and the safety of the community.

B. 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 and Guidelines* for content of treatment [(see 3.160 (F)] and must contribute to the management of sex offenders. The sole use of individual therapy is not recommended with sex offenders, and should be avoided except when geographical—specifically rural—or disability limitations mandate its use.

Discussion: Group therapy may be supplemented by additional treatment modalities.

C. The use of male and female co-therapists in group therapy is highly recommended.

Discussion: Many sex offenders have polarized views of men and women. As a result, it is beneficial to have male and female co-therapists conduct therapy groups. Therapists can model equal non-sexual relationships, assertive communication, and the value of multiple perspectives. Based on the offender's preexisting stereotypes, he/she may tend to discount information from a therapist of a specific gender. The gender of the therapist that the offender is most willing to listen to varies from offender to offender. Therapeutic feedback generally becomes more powerful and less likely to be discounted when it is expressed by both a male and female therapist. Use of male and female co-therapists also provides a catalyst for a diversity of issues to emerge, which can then be addressed in treatment.

D. The ratio of therapists to sex offenders in a treatment group shall not exceed 1:8. Treatment group size shall not exceed 14 sex offenders.

D. DD/ID

It is likely that a group populated by sex offenders with developmental disabilities will require an even smaller client to therapist ratio. Ratios shall be determined based upon the needs of the group.

Discussion: It is understood that the occasional illness or absence of a co-therapist may occur, which may cause the treatment group to exceed this ratio. It is also understood that a particular treatment program may be structured in such a way that specific didactic modules of psycho-educational information are presented to larger groups of sex offenders at one time. Such psycho-educational information is a component of, but not a substitute for sex offense-specific treatment. These circumstances constitute occasional exceptions to the standard described in C. above. The test for compliance with this standard will be the regularity with which the ratio of therapists to sex offenders is congruent with 3.160 (c) above.

The Sex Offender Management Board believes that the treatment of sex offenders is sufficiently complex and the likelihood of re-offense sufficiently high that the client to therapist ratio and group size should be fairly small.

E. Genders shall not be mixed in a sex offense-specific treatment group.

Discussion: It is understood that psycho-educational groups, informed supervision sessions, victim clarifications sessions and other modalities that do not require the same level of therapeutic work as a treatment group, may successfully contain, and sometimes require, a mix of genders to participate together.

It is also understood that in the event a treatment group cannot be found for an individual because of their gender, individual therapy may be warranted. In this situation, case notes should carefully document why individual therapy was chosen for the specific offenders.

F. The provider shall employ treatment methods that are based on recognition of the need for long-term, comprehensive, offense-specific treatment for sex offenders. The provider shall use an evidence-based approach. Self-help or time-limited treatments shall be used only as adjuncts to long-term, comprehensive treatment.

F. DD/ID

Treatment planning and content shall take the needs of sex offenders who have developmental disabilities into consideration.

Discussion: Progress in treatment and the ability to integrate material is generally slower for sex offenders with developmental disabilities than for the non-disabled population. The presence of concrete thinking, difficulty with concepts and abstraction and the need for frequent repetition and simple, direct instruction is common. For example, sex offenders who have developmental disabilities may not be able to conceptualize the sequential cycle portion of the traditional relapse prevention plan. In this case, the ability to identify risk situations or behaviors and appropriate interventions is a reasonable alternative.

G. The provider, in consultation with the Community Supervision Team (CST), shall determine treatment intensity including frequency and duration of contact based on offender's needs and

risk. The treatment provider shall consult with the CST regarding the need for referral to a program of different intensity if not offered in his/her program.

Discussion: The intensity of treatment (number of hours of treatment per week) should be based on the offender's evaluated risk and treatment needs. The majority of sex offenders have significant long-standing problems that have contributed to their sexual offending behavior. Therefore, most sex offenders will need intensive treatment for a long period of time in order to decrease their risk of re-offense. Research has suggested that treatment intensity and duration are significant factors in the effectiveness of treatment for sex offenders and substance abusers. Programs that cannot provide the level of intensity necessary to manage the offender's risk should refer the offender to a treatment team that can provide the necessary level of intensity. At a minimum, offenders should participate in weekly group session; many offenders may benefit from more than one treatment session per week.

G. DD/ID

Managing the client's risk to the community remains the primary goal of treatment. The fact that clients with DD/ID may progress more slowly in treatment shall never be used as a reason for reducing monitoring and containment when risk continues to be present, or for accepting reduced compliance from the client.

H. A treatment provider shall employ treatment methods that integrate the results of a polygraph, plethysmographs, viewing time assessments or other physiological testing, as indicated.

Discussion: Providers who utilize this data shall be aware of the limitations of these technologies shall recognize that this data is only meaningful within the context of a comprehensive evaluation and treatment process.

H. DD/ID

The use of some of these assessments and testing instruments with sex offenders with developmental disabilities is relatively new; employing these results for the purposes of assessing risk and planning for treatment should be done cautiously. Please see Section 2.000 DD/ID for additional Standards pertaining to evaluations. Wherever possible, materials appropriate for use with sex offenders with developmental disabilities shall be utilized instead of materials developed for a non-developmentally disabled population.

I. Offense-specific treatment for sex offenders shall:

1. Hold offenders accountable for their behavior and assist them in maintaining their accountability;

2. Require offenders to disclose all current sex offending behaviors and complete a full sex history disclosure. If the offender refuses to answer incriminating sexual offense history questions, including sexual offense history polygraph questions, then the provider shall meet with the supervising officer and polygraph examiner to identify and implement alternative methods of assessing and managing risk and needs. The provider shall not unsuccessfully discharge an offender from treatment for solely refusing to answer incriminating sexual offense history questions, including sexual offense history polygraph questions;

Discussion: This provision has been included in the Standards and Guidelines to ensure compliance with an offender's privilege against self-incrimination and relevant case law.

In sex offender treatment and supervision, disclosure and accountability are encouraged. Disclosure of past sexual offending behaviors is considered important to understand the offender's index offense and offense patterns, to facilitate behavioral change and can be very beneficial to offenders in relieving guilt and shame regarding past offenses.

While treatment providers shall not unsuccessfully discharge an offender from treatment solely for refusing to answer incriminating questions, a treatment provider may opt to discharge a client from treatment or not accept a client into treatment if the provider determines a factor(s) exists that compromises the therapeutic process.

3. Reduce offenders' denial and defensiveness;

4. Decrease and/or manage offenders' deviant sexual urges and recurrent deviant fantasies;

5. Educate offenders and individuals who are identified as the offenders' support systems about the potential for re-offending and an offender's specific risk factors, in addition to requiring an offender to disclose critical issues and current risk factors;

6. Teach offenders self-management methods to avoid a sexual re-offense;

7. Identify and treat the offenders' thoughts, emotions, and behaviors that facilitate sexual re-offenses or other victimizing or assaultive behaviors;

8. Identify and treat offenders' cognitive distortions;

9. Educate offenders about non-abusive, adaptive, legal, and pro-social sexual functioning;

10. Educate offenders about the impact of sexual offending upon victims, their families, and the community;

11. Provide offenders with training in the development of skills needed to achieve sensitivity and empathy with victims;

12. Provide offenders with guidance to prepare, when applicable, written explanation or clarification for the victim(s) that meets the goals of: establishing full perpetrator responsibility, empowering the victim, and promoting emotional and financial restitution for the victim(s);

13. Identify and treat offenders' personality traits and deficits that are related to their potential for re-offending;

14. Identify and treat the effects of trauma and past victimization of offenders as factors in their potential for re-offending (It is essential that offenders be prevented from assuming a victim stance in order to diminish responsibility for their actions.);

15. Identify deficits and strengthen offenders' social and relationship skills, where applicable;

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

    Discussion: This plan shall be shared with the offender's identified support system.

17. Provide treatment or referrals for offenders with co-existing treatment needs such as medical, pharmacological, psychiatric needs, substance abuse, domestic violence issues, or disabilities;

18. Maintain communication with other significant persons in offenders' support systems to the extent possible to assist in meeting treatment goals;

19. Evaluate existing treatment needs based on developmental or physical disabilities, cultural, language, sexual orientation, and gender identity that may require different treatment arrangements;

20. If clinically indicated, every effort should be made to provide services in the client's primary language using professional interpretive and translation resources as needed;

    Discussion: Individuals who have an existing relationship with the offender, such as family members, shall not be used as interpreters in order to avoid dual relationships and conflict of interest.

21. Identify and address issues of gender role socialization; and

22. Identify and treat issues of anger, power, and control.

I. **DD/ID**
Achieving success in the above listed content areas for the sex offender with developmental disabilities may require modifications based on the needs of the individual such as using pictures instead of written assignments, or using a data collection system by the treatment provider to document skills learned by the client.

J. A treatment provider shall model empathy and respect to the offender.

Discussion: Disrespectful behavior includes, but is not limited to, labeling the person not the behavior, unnecessary volume when speaking to the offender, and name calling.

K. In cooperation with the supervising officer, the provider shall address the results of polygraph examinations. The treatment provider shall collaborate with the Community Supervision Team to schedule polygraph examinations and review the results and admissions in accordance with Section 6.000. Results and admissions of the polygraph shall be used to identify treatment and behavioral monitoring needs.

L. Recognizing the importance that the continuum of treatment intensity is dependent on offender progress, providers shall offer phases of reduced treatment intensity following an

offender successfully addressing all applicable issues and concepts contained in Standards 3.160 (I) 1 - 22. This phase of treatment shall include regular polygraph examinations. The main focus of this reduced intensity "maintenance treatment" shall be to:

1. Enhance application of the concepts learned in Standards 3.160 (I) 1. - 22. in the client's current lifestyle, including internalizing, integrating and consolidating these concepts;

2. Refine re-offense prevention skills. As offenders apply concepts it is possible that they will have lapses, which shall be addressed during the maintenance treatment; and

3. Return offenders to a more intensive phase of treatment if clinically indicated.

M. An offender can be moved to a maintenance phase of treatment when the community supervision team reaches consensus that the sex offender has:

1. Satisfactorily addressed all applicable issues listed in Standards 3.160 (I) 1. - 22;

2. Completed the non-deceptive sexual history disclosure polygraph process. For offenders who refuse to answer sexual offense history questions, including sexual offense history polygraph questions, providers shall refer to Standard 3.160 (I.) 2 to determine how to respond;

3. Yielded non-deceptive results on the two most recent and consecutive maintenance polygraphs and they are absent any information not previously disclosed to the containment team;

4. Produced an objective sexual arousal or interest measure demonstrating management of deviance;

5. Demonstrated consistent compliance with treatment and supervision conditions;

6. Modified his/her lifestyle to actively manage his/her risk and consistently applies the concepts learned in treatment. In addition, he/she discloses and addresses ongoing risk factors in treatment; and

7. Accepted s/he needs ongoing treatment and external support irrespective of required supervision conditions.

In assessing offender progress, teams shall look for external, objective and behaviorally measurable evidence.

M. DD/ID

In assessing progress of the offender with developmental disabilities, teams should remain mindful that not all sex offenders with developmental disabilities are appropriate for polygraph and/or for some sexual arousal or interest measurements. Please see Section 2.000 DD/ID for further discussion.

3.170 Shared Living Arrangements (SLAs)

SLAs are a modality of treatment and supervision designed to provide a higher level of accountability for sex offenders. Please see the Definitions section for details.

When a SLA is being used, the following shall occur:

A. The offender is subject to increased offender accountability/therapeutic supervision;

B. The SLA location is approved in advance by the CST;

C. The SLA location is within a jurisdiction that legally permits two unrelated sex offenders to reside in the same household;

D. The CST notifies the landlord/property management that the residence is a SLA;

E. The CST notifies local law enforcement of SLA location;

F. Visitors of the SLA are approved in advance by the CST;

G. Non-SLA members are prohibited from residing within the residence unless approved by the CST;

H. The provider matches offenders in the same residence based on individual risk/needs;

I. Offenders are expected to report violations regarding his/her roommate to provider and supervising officer;

J. When multiple treatment programs are involved in a SLA, communication among all involved providers occurs consistently; and

K. Treatment progress in a SLA is identified through the use of an individualized treatment plan which meets specific goals and objectives, and may incorporate specific time frames.

3.171 Providers utilizing a SLA modality of treatment should consider the following:

A. "Two-man accountability"[54] may be beneficial to the milieu;

B. Maintaining a specific vacancy and discharge policy/contract;

C. Monitoring of offender's/SLA member's whereabouts for accountability purposes; and

D. Providers are prohibited from renting to an offender due to ethical and dual relationship issues.

3.172 Placement of offenders in a SLA shall include consideration of the following:

A. Offender risk level

B. Offender amenability to treatment

C. Offender's level of personal accountability (e.g. denial issues)

[54] Two adult sex offenders approved by the CST to accompany one another to approved locations.

D. Offender's stage in the legal process (post-conviction vs. pre-plea)

E. Offender self-sufficiency (e.g., employment, mental health, disability, etc.)

F. Offender's prior history with treatment and supervision

G. Offender's victim preference

Discussion: According to the study conducted by the SOMB in 2004, SLAs are a viable treatment/supervision option for moderate to high risk sex offenders. In fact, the SLA provides a higher level of containment than the home environment of most sex offenders in this risk classification.[55] *However, the SLA should be used in a similar manner as any other treatment option and be matched using risk, need, and responsivity measures. With economic and housing concerns, an SLA can be an appealing solution. Research has yet to be conducted to confirm if SLAs are beneficial for offenders in other risk levels.*

3.200 ♦ Successful Completion of Legally Mandated Treatment

3.210 In certain cases it may be appropriate to end legally mandated, offense-specific treatment. However, most offenders will need ongoing treatment at some level. Completion of treatment is not the end of offenders' rehabilitative needs or the elimination of all risk to the community. Successful completion of legally mandated treatment prior to an offender's supervision termination date shall only be considered upon the unanimous agreement of the Community Supervision Team.

The decision to end treatment shall be based on:

A. A determination by the team that the offender would not pose an undue risk to victim and community safety without treatment;

B. A reexamination of the offender's progress over an extended period of time in the maintenance phase of treatment; and

C. A determination that the offender is low risk on criminogenic factors as defined by all information gained over the course of treatment and supervision.

DD/ID Discussion*: Because some sex offenders with developmental disabilities have difficulty learning to generalize behaviors and/or memorize information without subsequent behavioral change, the Community Supervision Team should, in these cases, also base its decision to end treatment on the client's actual demonstration of new skills.*

3.220 Prior to discontinuing offense-specific treatment, a provider shall, in cooperation with the Community Supervision Team, make recommendations for an aftercare plan that may include a variety of self-management skills/techniques and support systems.

3.300 ♦ Confidentiality

[55] Colorado Department of Public Safety, Division of Criminal Justice, SOMB. (2004). Report on Safety Issues Raised by Living Arrangements for and Location of Sex Offenders in the Community.

3.310 When enrolling an offender in treatment, a provider shall obtain signed waivers of confidentiality based on the informed assent of the offender. This waiver shall explain that written and verbal information will be shared between all team members. The waiver of confidentiality shall, if applicable, extend to the Department of Human Services, other individuals or agencies responsible for the supervision of the offender, and the SOMB for the purpose of research related to evaluation or implementation of the Standards or sex offender management in Colorado.

Discussion: Waivers of confidentiality should be required of the sex offender by the conditions of probation, parole, and community corrections and shall be part of the treatment provider-client contract.

3.310 DD/ID

The information shall be provided in a manner that is easily understood, verbally and in writing, in the native language of the person, or through other modes of communication as may be necessary to enhance understanding.

A. The provider shall obtain the informed assent of the legal guardian, if applicable, and the informed assent of the offender with developmental disabilities for treatment. The guardian will be informed of the treatment methods, how the information may be used and to whom it will be released. The provider shall also inform the offender with developmental disabilities and the guardian about the nature of the provider's relationship with the offender and with the court. The provider shall respect the offender's right to be fully informed about treatment procedures.

B. If informed assent cannot be obtained after consulting with the third party, then the provider shall refer the case back to the Community Supervision Team or the court.

3.320 Waivers of confidentiality shall extend to the victim, the victim advocate/therapist, the guardian ad litem of a child victim, the caseworker, the approved supervisor(s), the offender's current partner, the guardian, or other individuals involved in the case. This is especially important with regard to, but not limited to, offender non-compliance with treatment, information about risk, threats, and possible escalation of violence, and decisions regarding clarification or reunification of the family, and an offender's contact with past or potential child victims.

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

3.340 The provider shall ensure that an offender understands the scope and limits of confidentiality in the context of his/her particular situation, including the collection of collateral information, which may or may not be confidential.

3.350 The provider shall ensure that as a condition of residing in a SLA the offender is required to hold other offenders living in the SLA accountable. The offender is required to discuss and share information about other offenders in the SLA to the treatment provider and supervising officer for accountability purposes.

3.360 The provider shall obtain signed waivers from offenders living in a SLA for their roommate's CST members.

3.400 ♦ Treatment Provider-Client Contract

3.410 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 and the limits of confidentiality pursuant to the *Standards and Guidelines*, Section 3.300, which will be required for a provider to treat the client for his/her sexual offending behavior and describe the procedures necessary for the client to revoke the waiver;

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

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

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

6. Describe the expectations and requirements for a Shared Living Arrangement (SLA), when applicable.

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;

2. Comply with all requirements to pay for the cost of assessment and treatment for the victim(s) and their family(ies), including all medical and psychological tests, 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 relevant to the re-offense plan. Clinical judgment should be exercised in determining information provided to children;

4. Actively involve relevant family and support system;

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 and sexual arousal/interest testing as prescribed in the Standards and Guidelines [including DD/ID 3.160 (M)]; and

7. 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 in the contract between the provider and the client.

C. Failure to comply with the terms of the contract may result in termination from treatment.

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 stimulating, violent material and material related to deviant sexual interest;

3. Describe the responsibility of the client to protect community safety by avoiding risky, aggressive, or re-offending behavior, avoiding high risk situations, and 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.

3.500 Managing Sex Offenders in Denial

Denial is a psychological defense mechanism used to protect the ego from anxiety producing information. In addition to being a psychological defense mechanism, denial may also be a normal,[56] conscious action to avoid internal or external consequences associated with the offense behavior. For the purpose of this section, denial is defined as the failure of an offender to accept responsibility for his/her offense[57] on a continuum from moderate to high to severe. There is conflicting research regarding denial as a risk factor for sexual re-offense.[58] However, the literature also frames denial as an issue of responsivity to treatment.[59] Therefore, the intent of this section is to consider offender denial and treatment efficacy, not the risk factors associated with offender denial.

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[56] Yates, P. (2009). Is sexual offender denial related to sex offence risk and recidivism? A review and treatment implications. *Psychology, Crime & Law,* 183-199.

[57] Association for the Treatment of Sexual Abusers Practice Standards and Guidelines, 2001 (p. 63)

[58] Hanson & Bussiere (1998). Predicting relapse: A meta-analysis of sexual offender recidivism studies. *The Journal of Consulting and Clinical* Psychology, 348-362; Harkins L. Beech, AR, & Goodwill, AM, (2010). Examining the influence of denial, motivation, and risk on sexual recidivism, 78-94; Langton, C., Barbaree, H., Harkins, L., Arenovich, T., McNamee, J., Peacock, E., Dalton, A., Hansen, K. Luong, D. & Marcon, H. (2008) Denial and minimization among sexual offenders: Posttreatment presentation and association with sexual recidivism. *Criminal Justice and Behavior,* 69-98; Lund, C. (2000). Predictors or sexual recidivism: Did meta-analysis clarify the role and relevance of denial? *Sexual Abuse: A Journal of Research and Treatment,* 275-298; Mann, R., Hanson, K., & Thornton, D. Assessing risk for sexual recidivism: Some proposals on the nature of psychologically meaningful risk factors. *Sexual Abuse: A Journal of Research and Treatment,* 191-217; Nunes, K., Hanson, K., Firestone, P., Moulden, H., Greenbers, D. & Bradford, J. (2007). Denial predicts recidivism for some sexual offenders. *Sex Abuse,* 91-105. 2008; Lund, 2000; Mann et al., 2010; Nunes et al., 2007

[59] Responsivity to treatment is the third principle of the Risk, Needs, and Responsivity Model, which influences the extent to which an offender will benefit from treatment. It states that the styles and modes of treatment delivery should be individually matched to the learning style of the offender to the extent possible (see, for example,: Levenson, J., Prescott, D., & D'Amora, D. (2010). Sex offender treatment: Consumer satisfaction and engagement in therapy. *International Journal of Offender Therapy and Comparative Criminology,*307-326,; Looman, J., Abracen, J. & Serin, R. (2005). Psychopathy, treatment change and recidivism in high-risk, high-need sexual offenders, *Journal of Interpersonal Violence,* 549-568; Yates, O. (2009). Is sexual denial related to sex offence risk and recidivism? A review and treatment implications. *Psychology, Crime & Law,* 183-199).

Secrecy, denial, and defensiveness are behaviors frequently exhibited by sex offenders.[60] Research has shown cognitive distortions are significantly associated with greater denial/minimization.[61] Furthermore, attitudes supportive of sexual offending behavior have been documented to reliably predict sexual recidivism.[62] Almost all offenders fluctuate in their level of accountability or minimization of the offenses. Although most are able to admit responsibility for the sexual offense relatively soon after conviction, some offenders do not. Denial impedes treatment engagement, progress and efficacy.[63] Offender denial is also highly distressing and emotionally damaging to victims.[64]

When offenders take responsibility for their offense(s), they admit to the commission of the unlawful sexual behavior and the intent behind the behavior. Failure to take responsibility for the sexual offense by attributing it to external causes rather than the result of personal decisions and behavior has been identified as a risk factor for sexual re- offense. Acceptance of responsibility is unrelated to an admission of all sexual offending behaviors for which the offender was convicted.[65] Taking responsibility for the sexual offense also includes the recognition of the harmful impact the behavior has had on the victim, and exhibiting motivation to engage in treatment to address the sexually abusive behavior therapeutically. It is important to recognize that motivation can be either external (system imposed) or internal (real willingness to change). One of the goals of treatment is to inculcate genuine internal motivation for change.

It is very important to remember that denial can take many forms and may change or vary in intensity over the course of treatment. Denial is considered to be a critical treatment target.[66] The more common types of denial presented by sex offenders consist of the following: refutation of the offense, denial of intent, denial of extent, assertion of victim willingness, denial of planning and denial of relapse potential**.**[67]

3.510 Levels of Denial

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[60] Drapeau, M., Beretta, V., & de Roten, Y. (2008). Defense styles of pedophilic offenders. *International Journal of Offender Therapy and Comparative Criminology*, 185-195; Schneider, S., & Wright, R. (2004). Understanding denial in sexual offenders: A review of cognitive and motivational processes to avoid responsibility. *Trauma, Violence and Abuse*, 3-20.

[61] Nunes, K., & Jung, S. (2012). /are cognitive distortions associated with denial and minimization among sex offenders? *Sexual Abuse: A Journal of Research and Treatment*, 166-188; Schneider, S., & Wright, R. (2004). Understanding denial in sexual offenders: A review of cognitive and motivational processes to avoid responsibility. *Trauma, Violence and Abuse*, 3-20. 2013;

[62] Helmus, L., Hanson, K., Babchishin, K., & Mann, R. (2013). Attitudes supportive of sexual offending predict recidivism: A meta-analysis. *Trauma, Violence & Abuse*, 1-20.

[63] Beyko, M., & Wong, S. (2005). Predictors of treatment attrition as indicators for program improvement not offender short comings: A study of sex offender attrition. *Sexual Abuse: A Journal of Research and Treatment*, 375-389;; Blagden, N., Winder, B., Gregson, M., & Throne, K. (2013). Working with denial in convicted sexual offenders: A qualitative analysis of treatment professionals views and experiences and their implications for practice. *International Journal of Offender Therapy and Cognitive Criminology*, 332-356. ; Levenson J. (2011). But I didn't do it! Ethical treatment of sex offenders in denial. *Sexual Abuse: A Journal of Research and Treatment*, 346-364; Levenson, J., & Macgowan, M. (2004). Engagement, denial, and treatment progress among sex offenders in group therapy. *Sexual Abuse: A Journal of Research and Treatment*, 49-63.

[64] Levenson, J., & Prescott, D. (2009). Treatment experiences of civilly committed sex offenders: A consumer satisfaction survey. *Sexual Abuse: A Journal of Research and Treatment*, 6-20. ; Levenson, J., Prescott, D., & D'Amora, D. (2010). Sex offender treatment: Consumer satisfaction and engagement in therapy. *International Journal of Offender Therapy and Comparative Criminology*, 307-326; Levenson, J., Macgowan, M., Morin, J., & Cotter, L.(2009). Perceptions of sex offenders about treatment: Satisfaction and engagement in group therapy. *Sexual Abuse: A Journal of Research and Treatment*, 35-56.

[65] McGrath, R., Lasher, M., & Cumming, G. (2012). The sex offender treatment intervention and progress scale (SOTIPS): Psychometric properties and incremental predictive validity with static-99 R. *Sexual Abuse: A Journal of Research and Treatment*, 431-458.

[66] Blagden, N., Winder, B., Gregson, M., & Throne, K. (2013). Working with denial in convicted sexual offenders: A qualitative analysis of treatment professionals views and experiences and their implications for practice. *International Journal of Offender Therapy and Cognitive Criminology*, 332-356 ; Levenson J. (2011). But I didn't do it! Ethical treatment of sex offenders in denial. *Sexual Abuse: A Journal of Research and Treatment*, 346-364.

[67] See for example the Denial Minimization Checklist-III or the FoSOD, otherwise known as the Facets of Sex Offender Denial (Schneider, S., & Wright, R. (2004). Understanding denial in sexual offenders: A review of cognitive and motivational processes to avoid responsibility. *Trauma, Violence and Abuse*, 3-20.

The following is a description of different levels or intensity of denial.[68] These are intended to be used as a guide to help determine offender denial and a potential treatment intervention. They should be used in conjunction with the remainder of 3.500. Consensus should be reached amongst the CST when determining an offender's level of denial. It is imperative that the offense-specific evaluator/therapist has the final discretion due to clinical judgment and expertise in this specific area.

Level 1: *Moderate Denial*
This level consists of offenders who accept most of the responsibility for the unlawful sexual behavior involved in the offense, but may place some blame elsewhere. They may either justify their intent behind its occurrence and/or minimize its importance or harmful impact on the victim. These offenders demonstrate some motivation to change.

Level 2: *High Denial*
This level consists of offenders who accept some of the responsibility for the unlawful sexual behavior in the offense. However, they place most of the blame elsewhere. They may deny the intent behind their unlawful sexual behavior and/or may not recognize the harmful impact their behavior has had on the victim. They may admit engaging in other harmful sexual behavior. They exhibit some motivation to change, although it may only be externally motivated.

Level 3: *Severe Denial*
This level consists of offenders who do not accept **any** responsibility for **any** unlawful sexual behavior. They deny committing the current unlawful sexual behavior or even remotely similar behavior. They may not recognize the harmful impact sexual offending behavior has on victims (even if it is not their own behavior) and appear to have no motivation to change. Offenders presenting with this level of denial may blame the victim or the system, and/or present as excessively hostile or defensive.

Discussion: Offenders under appeal are not the same as offenders in 'denial'. The SOMB has a process to address treatment needs for such offenders under appeal via a Standards Variance Request, which can be filed through the Application Review Committee of the SOMB.

3.520 Polygraph examinations are a useful tool in reducing an offender's denial. Deniers shall be referred for an instant offense polygraph examination. Arousal assessment or physiological assessment instruments may be used to assist this process. This applies to offenders evaluated to be in any level of denial.

Discussion: In addition to requiring the offender to undergo an instant offense polygraph regarding the offense of conviction, the CST may also require the offender to undergo maintenance polygraph testing to monitor current behavior and enable the CST to respond to concerns quickly.

3.530 Sex offenders who are evaluated and found to be in Level 1, Moderate Denial or Level 2, High Denial are not prohibited from participation in sex offense-specific treatment solely based on these levels of denial.

[68] The utility of a multifaceted construct of denial and other forms of minimizations are emphasized as opposed to more simplified and dichotomous (yes or no) formats such as categorical denial. The importance of a continuous measure of denial has been supported by the literature in order to further distinguish an offender's criminogenic risks and amenability to engage in the therapeutic process (see for example, Langton, 2008; Levenson, J., & Macgowan, M. (2004). Engagement, denial, and treatment progress among sex offenders in group therapy. *Sexual Abuse: A Journal of Research and Treatment*, 49-63.

3.540 When making recommendations for offenders evaluated and found to be in Level 3, Severe Denial, the evaluator shall consider the offender's risk to re-offend sexually, his/her general criminogenic risk, victim impact and the offender's protective and aggravating factors. There should be a balance between the offender's need for treatment and mitigating and risk factors because untreated offenders are often not in the best interest of community or victim safety.

3.550 Sex offenders who are evaluated and found to be in Level 3, Severe Denial, are not appropriate to participate in offense-specific sex offender treatment; they shall participate in a Denier Intervention treatment to specifically address their denial and defensiveness. Denier Intervention should be performance based and establish clear expectations, target factors that may motivate the offender to remain in denial and apply performance based discharge criteria. Denier intervention for those evaluated to be in Level 3 denial occurs separately from regular offense-specific treatment. The goal of Denier Intervention is to foster a therapeutic alliance using a variety of treatment modalities[69] and assist the offender in taking at least some responsibility for his/her offense in order to enter full offense-specific treatment.

3.560 Denier intervention shall not exceed 90 days unless the CST achieves consensus and provides documentation that the offender has made some progress which would justify an extension of Denier Intervention for a prescribed period of time.[70] Offenders who are still in Level 3 denial and are strongly resistant after any phase of Denier Intervention is completed shall be terminated from treatment and revocation proceedings should be initiated.

*Discussion: Under these **rare** circumstances, the CST should consider the following factors before granting any extension:1)Level of risk to sexually re-offend 2)Level of risk to commit a new criminal offense 3)Protective factors 4)Engagement and progress made in the Denier Intervention process 5)Compliance with supervision conditions 6) Victim input, as it is important to support victim recovery 7)Criminogenic needs, including but not limited to, the following: Deviant sexual interests/arousal, sexual preoccupation, pro-offending attitudes and beliefs, intimacy deficits, emotional congruence with children, callousness and pervasive anger or hostility, self-regulation deficits, social deviance, impulsive criminal lifestyle, dysfunctional coping, and 8) Any other factor making treatment ineffective for the offender*

3.560 DD/ID

An exception may be made for sex offenders with developmental disabilities who are in Level 3 denial and are strongly resistant after this three (3) month phase. If termination from treatment and revocation are not clearly indicated for a specific offender, then a CST review shall occur at this 3 month mark to determine whether an extension of this pre-treatment phase followed by a second case review shall occur. Other options may be explored at this time and shall always

[69] A therapeutic alliance between the therapist and the client consists of three core elements: (1) an agreement on the treatment goals, (2) collaboration on the tasks that will be used to achieve the goals, and (3) an overall bond that facilitates an environment of progress and collaboration (see for example, Flinton, C. & Scholz, R. (2006). Engaging resistance: Creating partnerships for change in sexual offender treatment.. Brandon, VT: Safer Society Foundation; Levenson, J., Prescott, D., & D'Amora, D. (2010). Sex offender treatment: Consumer satisfaction and engagement in therapy. *International Journal of Offender Therapy and Comparative Criminology*, 307-326; Marshall, W., Serran, G., Moulden, H., Mulloy., R., Fernandez, Y., Mann, R. & Thornton, D. (2002). Therapist features in sexual offender treatment: Their reliable identification and influence on behavior change. Clinical Psychology and Psychotherapy, 395-405; Polaschek, D. & Ross, E. (2010). Do early therapeutic alliance, motivation, an stages of change predict therapy change for high risk, psychopathic violent prisoners? Criminal Behavior and Mental Health, 100-111; Schneider, S., & Wright, R. (2004). Understanding denial in sexual offenders: A review of cognitive and motivational processes to avoid responsibility. *Trauma, Violence and Abuse*, 3-20.

[70] Levenson, J. (2011). But I didn't do it! Ethical treatment of sex offenders in denial. *Sexual Abuse: A Journal of Research and Treatment*, 346-364; Yates, P. (2009). Is sexual denial related to sex offence risk and recidivism? A review and treatment implications. *Psychology, Crime & Law*, 183-199.

consider the above noted discussion point (3.560).

3.570 Denier Intervention shall only be provided by treatment providers who also meet the requirements to provide sex offense-specific treatment, as defined in Section 4.000 of these Standards.

3.580 Treatment providers and community supervision teams must establish specific and measurable goals and tasks for offenders in denial outlined in an individualized treatment plan. These measurable goals will establish whether offenders have reached the threshold of eligibility for referral to offense-specific treatment at the end of three months or earlier. It is especially important to document offenders' accountability for their offenses.

3.600 ♦ Treatment of Sex Offenders within the Department of Corrections

3.610 During incarceration and parole a continuum of treatment services shall be available to sex offenders.

3.620 Unless otherwise noted in this section, treatment for sex offenders in prison shall conform to these Standards for sex offense-specific treatment described in Section 3.000 and shall be provided by therapists who meet the qualifications for treatment providers described in Section 4.000.

The prison treatment provider shall employ treatment methods that are based on recognition of the need for long-term, comprehensive, sex offense-specific treatment. Self-help or time-limited treatments shall be used only as adjuncts to long-term, comprehensive treatment. Offenders who have been removed from the community are presumed to have a higher risk level and longer-term intensive treatment is warranted. The duration of treatment in prison will be based on the assessment by the clinical team. This shall be followed by community based sex offense-specific treatment upon the offender's release.

A sex offender who has been sentenced to the Department of Corrections (DOC), and who is participating in the treatment program, and who did not receive a sex offense-specific evaluation at the time of the pre-sentence investigation shall receive a sex offense-specific evaluation.

3.630 It is highly recommended that treatment in prison should be provided by male/female co-therapy teams.

3.640 Prison treatment providers shall utilize a modified team approach similar to that described in Section 5.000. Specifically, the polygraph examiner and treatment provider shall work closely together, and other professionals should be included in the team as indicated.

3.650 Treatment providers shall:

A. Prepare a summary of offenders' progress and participation in sex offender treatment and their institutional behavior. This summary shall be provided to the parole board prior to a hearing;

B. Prepare a summary for pre-parole investigation with recommendations regarding ongoing treatment needs, living arrangements and conditions of supervision related to the offender's rehabilitative needs; and

C. Forward pertinent documents including any pre-sentence investigation reports to outpatient treatment providers upon request and with a valid release.

4.000
QUALIFICATIONS OF TREATMENT PROVIDERS, EVALUATORS, AND POLYGRAPH EXAMINERS WORKING WITH SEX OFFENDERS

Pursuant to 16-11.7-106, C.R.S., the Department of Corrections, the Judicial Department, the Division of Criminal Justice of the Department of Public Safety, or the Department of Human Services shall not employ or contract with, and shall not allow sex offenders to employ or contract with any individual to provide sex offense-specific evaluation or treatment services unless the sex offense-specific evaluation or treatment services to be provided by such individual conform with these Standards.

4.100 TREATMENT PROVIDER: Adult Associate Level (First Application): Individuals who have not previously applied to the SOMB Approved Provider List, but who are working towards meeting provider qualifications for a treatment provider or evaluator, shall apply for Associate Level status using the required application. Initial listing at the Associate Level is good for one year to allow the provider time to develop competency in the required areas. The application shall be submitted and include a supervision agreement co-signed by their approved SOMB Clinical Supervisor, and fingerprint card (for purposes of a criminal history record check pursuant to Section 16-11.7-106 (2)(a) (I), C.R.S) prior to beginning work with sex offenders.

A. The applicant shall have a baccalaureate degree or above in a behavioral science with training or professional experience in counseling or therapy;

B. The applicant shall hold a professional mental health license or be approved by the Department of Regulatory Agencies as a Registered Psychotherapist, Licensed Professional Counselor Candidate, Licensed Marriage and Family Therapist Candidate, Psychologist Candidate, or Clinical Social Worker, and not be under current disciplinary action that the ARC determines would impede the applicants ability to practice as an SOMB listed provider;

C. The applicant shall demonstrate competency according to the individual's respective professional standards and ethics consistent with the accepted standards of practice of sex offense-specific treatment;

D. The applicant shall not have a conviction of, or a deferred judgment for, a municipal ordinance violation, misdemeanor, felony, or have accepted by a Court a plea of guilty or nolo contender to a municipal ordinance violation, misdemeanor, or felony if the municipal ordinance violation, misdemeanor, or felony is related to the ability of the approved applicant to practice under these Standards as reviewed and determined by the Application Review Committee. A certified copy of the judgment from a court of competent jurisdiction of such conviction or plea shall be conclusive evidence of such conviction or plea;

E. The applicant shall submit to a current background investigation (Section 16-11.7-106 (2)(a)(III), C.R.S.);

F. The applicant shall demonstrate compliance with the Standards; and

G. The provider shall comply with all other requirements outlined in the SOMB Administrative Policies.

H. **DD/ID**
Associate Level Treatment Providers who want to provide treatment services to adult sex offenders with developmental/intellectual disabilities shall demonstrate compliance with these Standards and submit an application demonstrating competency specific to working with this population.

I. The provider shall submit a signed supervision agreement outlining that:

1. The SOMB Clinical Supervisor shall review and co-sign all treatment plans, evaluations and reports by the applicant. The SOMB supervisor is responsible for all clinical work performed by the applicant.

2. The SOMB Clinical Supervisor shall employ supervision methods aimed at assessing and developing required competencies. It is incumbent upon the supervisor to determine the need for co-facilitated treatment and the appropriate time to move the applicant from any co-facilitated clinical contact to non-co-facilitated clinical contact based upon that individual's progress in attaining competency to perform such treatment.

3. The frequency of face-to-face supervision hours specific to sex offense-specific treatment and/or evaluation calculated as follows:

Direct Clinical Contact Hours per Month	Minimum Supervision Hours per Month
0-59	2
60-79	3
80 or more	4

Discussion: The initial supervision meeting must be in-person, face to face supervision at the beginning of the supervision relationship. After these initial meetings, alternate forms of supervision (phone or some type of video conferencing) may be utilized.

4.110 All Applicants Begin at the <u>Associate Level (First Application)</u>: With the possible exception of some out-of-state applicants, all applicants shall apply for, and be approved at, the Associate Level treatment provider, evaluator, or polygraph examiner status prior to applying for Full Operating Level.

A. **Out-of-State Applicants:** Individuals who hold professional licensure and reside outside Colorado may seek Full Operating Level or Associate Level status if they meet all the qualifications listed in these Standards. Required supervision hours must have been provided by an individual whose qualifications substantially match those of an SOMB Clinical Supervisor as defined in these Standards. Out-of-state applications will be reviewed on a case-by-case basis.

4.120 Professional Supervision of <u>Associate Level Treatment Providers and Evaluators</u>:

A. Supervision of Associate Level Treatment Providers shall be done by an approved SOMB Clinical Supervisor with treatment provider status in good standing.

B. Supervision of Associate Level Evaluators shall be done by an approved SOMB Clinical Supervisor with evaluator status in good standing.

C. Supervision of Associate Level Treatment Providers / Evaluators with the DD/ID specialty shall be done by an approved SOMB Clinical Supervisor with the DD/ID specialty.

D. The supervisor shall provide clinical supervision as stated in the Associate Level Section 4.100. Supervision hours for treatment and evaluation clinical work may be combined.

E. The supervisor shall review and co-sign all treatment plans, evaluations, and reports generated by Associate Level Treatment Providers and Associate Level Evaluators.

4.130 Required notifications to SOMB: Providers listed under Section 4.100 shall provide the following notifications to SOMB, as applicable:

A. Notify the SOMB in writing within two (2) weeks of changes to contact information. In such cases where a change in agency affiliation has occurred, individuals shall be required to provide updated information, where applicable on the treatment provider/client contract, description of program services, supervision agreement, and any other information pertinent to the change of employment Changes to contact information include any of the following:

1. Name
2. Treatment agency
3. Address
4. Phone number
5. Email address
6. Supervisor

B. Notify the SOMB in writing within 10 days of any changes in their status with the Department of Regulatory Agencies (DORA). This includes being subject to the filing of a complaint, having a founded complaint from DORA, or changing a DORA approval category (e.g. from licensed to unlicensed) The SOMB may periodically contact DORA regarding an individual's licensure or registration status for information.

C. Notify the SOMB in writing within 10 days of any arrest, conviction, nolo contender plea, or deferred judgment (other than a traffic violation of 7 points or less) for a municipal ordinance violation, misdemeanor, or felony, and sentence plea. The SOMB will be updated by the Colorado Bureau of Investigation of any of the above, and will consider such information, including proper notification of the SOMB, in its decision making related to whether an individual should continue to be listed with the SOMB.

4.200 TREATMENT PROVIDER: Adult -- Associate Level (Initial 3 years): An Associate Level Treatment Provider may treat sex offenders under the supervision of an approved SOMB Clinical Supervisor with treatment provider status under these Standards. Following initial listing at the Associate Level the provider may submit for continued placement on the provider list as an Associate Level Treatment Provider under Section 16-11.7-106 C.R.S. An applicant shall meet all the following criteria:

A. The applicant shall have a baccalaureate degree or above in a behavioral science with training or professional experience in counseling or therapy;

B. The applicant shall hold a professional mental health license or be approved by the Department of Regulatory Agencies as a Registered Psychotherapist, Licensed Professional Counselor Candidate, Licensed Marriage and Family Therapist Candidate, Psychologist

Candidate, or Clinical Social Worker, and not be under current disciplinary action that the ARC determines would impede the applicants ability to practice as an SOMB listed provider;

C. The applicant shall have completed face-to-face supervision hours specific to sex offense-specific treatment and/or evaluation calculated as follows:

Direct Clinical Contact Hours per Month	Minimum Supervision Hours per Month
0-59	2
60-79	3
80 or more	4

Discussion: The initial supervision meeting must be in-person, face to face supervision at the beginning of the supervision relationship. After these initial meetings, alternate forms of supervision (phone or some type of video conferencing) may be utilized.

D. Within the past five (5) years, the applicant shall have taken the SOMB provided introductory training to the *Standards and Guidelines*, and completed an additional forty (40) hours of training as determined by the SOMB Clinical Supervisor and applicant based upon individualized training needs. If the applicant is applying to be a provider for adults and juveniles, the training plan needs to reflect both populations. Please see the list of training categories at the end of this section.

E. The applicant shall submit documentation from their approved SOMB Clinical Supervisor outlining the supervisor's assessment of the applicant's competency in the required areas and support for the applicant's continued approval as an Associate Level Treatment Provider;

F. The applicant shall demonstrate competency according to the individual's respective professional standards and ethics consistent with the accepted standards of practice of sex offense-specific treatment;

G. The applicant shall submit to a current background investigation (Section 16-11.7-106 (2)(a)(III), C.R.S.) that includes satisfactory references as requested by the SOMB. The SOMB may also solicit such additional references as necessary to determine compliance with the *Standards and Guidelines*. The references shall relate to the work the applicant is currently providing;

H. The applicant shall not have a conviction of, or a deferred judgment for, a municipal ordinance violation, misdemeanor, felony, or have accepted by a Court a plea of guilty or nolo contender to a municipal ordinance violation, misdemeanor, or felony if the municipal ordinance violation, misdemeanor, or felony is related to the ability of the approved applicant to practice under these Standards as reviewed and determined by the Application Review Committee. A certified copy of the judgment from a court of competent jurisdiction of such conviction or plea shall be conclusive evidence of such conviction or plea;

I. The applicant shall demonstrate compliance with the *Standards and Guidelines*; and

J. The provider shall comply with all other requirements outlined in the SOMB Administrative Policies.

4.210 Continued Placement of <u>Associate Level Adult Treatment Providers</u> on the Provider List: Using a current re-application form**,** Associate Level Treatment Providers shall apply for continued placement on the list every 3 years by the date provided by the SOMB. Requirements are as follows:

A. The provider shall demonstrate continued competency related to sex offenders;

B. The applicant shall have completed face-to-face supervision hours specific to sex offense-specific treatment and/or evaluation calculated as follows:

Direct Clinical Contact Hours per Month	Minimum Supervision Hours per Month
0-59	2
60-79	3
80 or more	4

Discussion: *The initial supervision meeting must be in-person, face to face supervision at the beginning of the supervision relationship. After these initial meetings, alternate forms of supervision (phone or some type of video conferencing) may be utilized.*

C. Every three (3) years the provider shall complete an SOMB provided booster training to the *Standards and Guidelines*, and complete an additional forty (40) hours of training as determined by the SOMB Clinical Supervisor and applicant based upon individualized training needs.

These training hours may be utilized to meet the qualifications for both adult and juvenile treatment providers. The provider shall demonstrate a balanced training history. Please see the list of training categories at the end of this section.

D. The provider shall submit to a current background investigation (Section 16-11.7-106 (2)(a)(III), C.R.S.) that includes satisfactory references as requested by the SOMB. The SOMB may also solicit such additional references as necessary to determine compliance with the *Standards and Guidelines*. The references shall relate to the work the applicant is currently providing;

E. The applicant shall not have a conviction of, or a deferred judgment for, a municipal ordinance violation, misdemeanor, felony, or have accepted by a Court a plea of guilty or nolo contender to a municipal ordinance violation, misdemeanor, or felony if the municipal ordinance violation, misdemeanor, or felony is related to the ability of the approved applicant to practice under these Standards as reviewed and determined by the Application Review Committee. A certified copy of the judgment from a court of competent jurisdiction of such conviction or plea shall be conclusive evidence of such conviction or plea;

F. The provider shall report any practice that is in significant conflict with the *Standards and Guidelines*;

G. The provider shall demonstrate compliance with the *Standards and Guidelines*; and

H. The provider shall comply with all other requirements outlined in the SOMB Administrative Policies.

4.220 Required notifications to SOMB: Providers listed under Section 4.200 shall provide the following notifications to SOMB as applicable:

A. Notify the SOMB in writing within two (2) weeks of changes to contact information. In such cases where a change in agency affiliation has occurred, individuals shall be required to provide updated information, where applicable on the treatment provider/client contract, description of program services, supervision agreement, and any other information pertinent to the change of employment Changes to contact information include any of the following:

1. Name
2. Treatment agency
3. Address
4. Phone number
5. Email address
6. Supervisor

B. Notify the SOMB in writing within 10 days of any changes in their status with the Department of Regulatory Agencies (DORA). This includes being subject to the filing of a complaint, having a founded complaint from DORA, or changing a DORA approval category (e.g. from licensed to unlicensed) The SOMB may periodically contact DORA regarding an individual's licensure or registration status for information.

C. Notify the SOMB in writing within 10 days of any arrest, conviction, nolo contender plea, or deferred judgment (other than a traffic violation of 7 points or less) for a municipal ordinance violation, misdemeanor, or felony, and sentence plea. The SOMB will be updated by the Colorado Bureau of Investigation of any of the above, and will consider such information, including proper notification of the SOMB, in its decision making related to whether an individual should continue to be listed with the SOMB.

4.300 TREATMENT PROVIDER: <u>Adult - Full Operating Level</u>: Associate Level Treatment Providers wanting to move to Full Operating Level status (under Section 16-11.7-106 C.R.S.) shall submit an application and documentation of all of the requirements listed below, as well as a letter from the approved SOMB Clinical Supervisor indicating the provider's readiness and demonstration of required competencies to move to Full Operating Level provider. A Full Operating Level Treatment Provider may treat sex offenders independently and are not required per SOMB standards to have an SOMB approved Clinical Supervisor. Nothing within this section alleviates a provider from their duty to adhere to their ethical code of conduct pertaining to supervision and consultation.

A. The provider shall have been approved on the provider list in good standing at the Associate Level or shall have met the requirements at the Associate Level as outlined in 4.200;

B. The provider shall have attained the underlying credential of licensure or certification as a Psychiatrist, Licensed Psychologist, Licensed Clinical Social Worker, Licensed Professional Counselor, Licensed Marriage and Family Therapist, Clinical Psychiatric Nurse Specialist or Licensed Addiction Counselor, and not be under current disciplinary action that the ARC determines would impede the applicants ability to practice as an SOMB listed provider;

<u>OR</u>

The provider shall have maintained SOMB listing, in good standing, as an associate level treatment provider for at least 10 years (initial listing plus three renewal cycles) and be approved with the Department of Regulatory Agencies as a Registered Psychotherapist, Licensed Professional Counselor Candidate, Licensed Marriage and Family Therapist Candidate, Psychologist Candidate, or Clinical Social Worker, and not be under current disciplinary action that the ARC determines would impede the applicants ability to practice as an SOMB listed provider;

C. The provider shall have demonstrated the required competencies.

D. The provider shall have completed face-to-face supervision hours specific to sex offense-specific treatment and/or evaluation calculated as follows:

Direct Clinical Contact Hours per Month	Minimum Supervision Hours per Month
0-59	2
60-79	3
80 or more	4

Discussion: *The initial supervision meeting must be in-person, face to face supervision at the beginning of the supervision relationship. After these initial meetings, alternate forms of supervision (phone or some type of video conferencing) may be utilized.*

Providers should know the limits of their expertise and seek consultation and supervision as needed (i.e. clinical, medical, psychiatric). Adjunct resources should be arranged to meet these needs.

E. Within the past five (5) years, the applicant shall have taken the SOMB provided introductory or booster training to the *Standards and Guidelines*, and completed an additional forty (40) hours (these hours are in addition to the 40 hours required for Associate Level for a total of 80 hours) of training as determined by the SOMB Clinical Supervisor and applicant based upon individualized training needs.

If the applicant is applying to be a provider for adults and juveniles, training must reflect both populations. Please see the list of training categories at the end of this section.

F. The provider shall demonstrate competency according to the individual's respective professional standards and ethics consistent with the accepted standards of practice of sex offense-specific treatment;

G. The applicant shall not have a conviction of, or a deferred judgment for, a municipal ordinance violation, misdemeanor, felony, or have accepted by a Court a plea of guilty or nolo contender to a municipal ordinance violation, misdemeanor, or felony if the municipal ordinance violation, misdemeanor, or felony is related to the ability of the approved applicant to practice under these Standards as reviewed and determined by the Application Review Committee. A certified copy of the judgment from a court of competent jurisdiction of such conviction or plea shall be conclusive evidence of such conviction or plea;

H. The provider shall submit to a current background investigation (Section 16-11.7-106 (2)(a)(III), C.R.S.) that includes satisfactory references as requested by the SOMB. The SOMB may also solicit such additional references as necessary to determine compliance with

the *Standards and Guidelines*. The references shall relate to the work the applicant is currently providing;

I. The provider shall demonstrate compliance with the *Standards and Guidelines*; and

J. The provider shall comply with all other requirements outlined in the SOMB Administrative Policies.

K. **DD/ID**
Full Operating Level Treatment Providers who want to provide treatment services to adult sex offenders with developmental/intellectual disabilities shall demonstrate compliance with these Standards and submit an application demonstrating competency specific to working with this population.

4.310 Continued Placement of <u>Full Operating Level Adult Treatment Providers</u> on the Provider List: Using a current re-application form, treatment providers shall re-apply for continued placement on the list every 3 years by the date provided by the SOMB. Requirements are as follows:

A. The provider shall have attained the underlying credential of licensure or certification as a Psychiatrist, Licensed Psychologist, Licensed Clinical Social Worker, Licensed Professional Counselor, Licensed Marriage and Family Therapist, Clinical Psychiatric Nurse Specialist or Licensed Addiction Counselor, and not be under current disciplinary action that the ARC determines would impede the applicants ability to practice as an SOMB listed provider;

B. The provider shall demonstrate continued competency related to sex offenders based on; clinical experience, supervision, administration, research, training, teaching, consultation and/or policy development;

C. Every three (3) years the provider shall complete a SOMB provided booster training to the *Standards and Guidelines*, and completed an additional forty (40) hours of training in order to maintain proficiency in the field of sex offense-specific treatment and to remain current on any developments in the assessment, treatment, and monitoring of sex offenders;

If the applicant is reapplying to be a provider for adults and juveniles, training must reflect both populations. Please see the list of training categories at the end of this section.

D. The applicant shall not have a conviction of, or a deferred judgment for, a municipal ordinance violation, misdemeanor, felony, or have accepted by a Court a plea of guilty or nolo contender to a municipal ordinance violation, misdemeanor, or felony if the municipal ordinance violation, misdemeanor, or felony is related to the ability of the approved applicant to practice under these Standards as reviewed and determined by the Application Review Committee. A certified copy of the judgment from a court of competent jurisdiction of such conviction or plea shall be conclusive evidence of such conviction or plea;

E. The provider shall submit to a current background investigation (Section 16-11.7-106 (2) (a) (III), C.R.S.) that includes satisfactory references as requested by the SOMB. The SOMB may also solicit such additional references as necessary to determine compliance with the *Standards and Guidelines*. The references shall relate to the work the applicant is currently providing;

F. The provider shall report any practice that is in significant conflict with the *Standards and Guidelines*;

G. The provider shall demonstrate compliance with the *Standards and Guidelines;* and

H. The provider shall comply with all other requirements outlined in the SOMB Administrative Policies.

4.320 Required notifications to SOMB: Providers listed under section 4.300 shall provide the following notifications to SOMB as applicable:

A. Notify the SOMB in writing within two (2) weeks of changes to contact information. In such cases where a change in agency affiliation has occurred, individuals shall be required to provide updated information, where applicable on the treatment provider/client contract, description of program services, supervision agreement, and any other information pertinent to the change of employment Changes to contact information include any of the following:

1. Name
2. Treatment agency
3. Address
4. Phone number
5. Email address
6. Supervisor

B. Notify the SOMB in writing within 10 days of any changes in their status with the Department of Regulatory Agencies (DORA). This includes being subject to the filing of a complaint, having a founded complaint from DORA, or changing a DORA approval category (e.g. from licensed to unlicensed) The SOMB may periodically contact DORA regarding an individual's licensure or registration status for information.

C. Notify the SOMB in writing within 10 days of any arrest, conviction, nolo contender plea, or deferred judgment (other than a traffic violation of 7 points or less) for a municipal ordinance violation, misdemeanor, or felony, and sentence plea. The SOMB will be updated by the Colorado Bureau of Investigation of any of the above, and will consider such information, including proper notification of the SOMB, in its decision making related to whether an individual should continue to be listed with the SOMB.

4.400 EVALUATOR: Adult Associate Level (First Application): Individuals who have not previously applied to the SOMB Approved Provider List as an evaluator, but who are working towards meeting qualifications for an evaluator, shall apply for Associate Level status using the required application. Initial listing at the Associate Level is good for one year to allow the evaluator time to develop competency in the required areas. The application shall be submitted and include a supervision agreement co-signed by their approved SOMB Clinical Supervisor, and fingerprint card (for purposes of a criminal history record check pursuant to Section 16-11.7-106 (2)(a)(I), C.R.S) prior to beginning work with sex offenders.

A. The applicant shall be listed as an Associate Level or Full Operating Level Treatment Provider for adult sex offenders;

B. The applicant shall demonstrate competency according to the individual's respective professional standards and ethics consistent with the accepted standards of practice of sex offense-specific treatment;

C. The applicant shall not have a conviction of, or a deferred judgment for, a municipal ordinance violation, misdemeanor, felony, or have accepted by a Court a plea of guilty or nolo contender to a municipal ordinance violation, misdemeanor, or felony if the municipal ordinance violation, misdemeanor, or felony is related to the ability of the approved applicant to practice under these Standards as reviewed and determined by the Application Review Committee. A certified copy of the judgment from a court of competent jurisdiction of such conviction or plea shall be conclusive evidence of such conviction or plea;

D. The applicant shall submit to a current background investigation (Section 16-11.7-106 (2)(a)(III), C.R.S.);

E. The applicant shall demonstrate compliance with the *Standards and Guidelines*; and

F. The applicant shall comply with all other requirements outlined in the SOMB Administrative Policies.

G. **DD/ID**
Associate Level Evaluators who want to provide evaluation services to adult sex offenders shall demonstrate compliance with these Standards and submit an application demonstrating competency specific to working with this population.

H. The applicant shall submit a signed supervision agreement outlining that:

1. The SOMB Clinical Supervisor shall review and co-sign all evaluations and reports by the applicant. The SOMB supervisor is responsible for all clinical work performed by the applicant.

2. The SOMB Clinical Supervisor shall employ supervision methods aimed at assessing and developing required competencies. It is incumbent upon the supervisor to determine the need for co-facilitated evaluations and the appropriate time to move the applicant from any co-facilitated work to non-co-facilitated work based upon that individual's progress in attaining competency to perform such evaluations.

3. The frequency of face-to-face supervision hours specific to sex offense-specific treatment and/or evaluation calculated as follows:

Direct Clinical Contact Hours per Month	Minimum Supervision Hours per Month
0-59	2
60-79	3
80 or more	4

Discussion: The initial supervision meeting must be in-person, face to face supervision at the beginning of the supervision relationship. After these initial meetings, alternate forms of supervision (phone or some type of video conferencing) may be utilized.

4.410 Required notifications to SOMB: Providers listed under section 4.400 shall provide the following notifications to SOMB as applicable:

A. Notify the SOMB in writing within two (2) weeks of changes to contact information. In such cases where a change in agency affiliation has occurred, individuals shall be required to provide updated information, where applicable on the treatment provider/client contract, description of program services, supervision agreement, and any other information pertinent to the change of employment Changes to contact information include any of the following:

1. Name
2. Treatment agency
3. Address
4. Phone number
5. Email address
6. Supervisor

B. Notify the SOMB in writing within 10 days of any changes in their status with the Department of Regulatory Agencies (DORA). This includes being subject to the filing of a complaint, having a founded complaint from DORA, or changing a DORA approval category (e.g. from licensed to unlicensed) The SOMB may periodically contact DORA regarding an individual's licensure or registration status for information.

C. Notify the SOMB in writing within 10 days of any arrest, conviction, nolo contender plea, or deferred judgment (other than a traffic violation of 7 points or less) for a municipal ordinance violation, misdemeanor, or felony, and sentence plea. The SOMB will be updated by the Colorado Bureau of Investigation of any of the above, and will consider such information, including proper notification of the SOMB, in its decision making related to whether an individual should continue to be listed with the SOMB.

4.500 EVALUATOR: Associate Level (Initial 3 years): An Associate Level evaluator may evaluate sex offenders under the supervision of an evaluator approved at the SOMB Clinical Supervisor Level. To qualify to provide sex offender evaluation at the Associate Level under Section 16-11.7-106 C.R.S. an applicant shall meet all the following criteria:

A. The applicant shall be listed as an Associate Level or Full Operating Level Treatment Provider for adult sex offenders;

B. The applicant shall have completed face-to-face supervision hours specific to sex offense-specific treatment and/or evaluation calculated as follows:

Direct Clinical Contact Hours per Month	Minimum Supervision Hours per Month
0-59	2
60-79	3
80 or more	4

Discussion: *The initial supervision meeting must be in-person, face to face supervision at the beginning of the supervision relationship. After these initial meetings, alternate forms of supervision (phone or some type of video conferencing) may be utilized.*

C. Within the past five (5) years, the applicant shall have taken the SOMB provided introductory training to the *Standards and Guidelines*, and completed an additional forty (40) hours of training as determined by the SOMB Clinical Supervisor and applicant based upon individualized training needs. If the applicant is applying to be a treatment provider and evaluator the training needs to reflect both treatment and evaluation. If the applicant is applying to be an evaluator for adults and juveniles, training must reflect both populations. Please see the list of training categories at the end of this section;

D. The applicant shall demonstrate competency according to the individual's respective professional standards and ethics consistent with the accepted standards of practice of sex offense-specific evaluations;

E. The applicant shall not have a conviction of, or a deferred judgment for, a municipal ordinance violation, misdemeanor, felony, or have accepted by a Court a plea of guilty or nolo contender to a municipal ordinance violation, misdemeanor, or felony if the municipal ordinance violation, misdemeanor, or felony is related to the ability of the approved applicant to practice under these Standards as reviewed and determined by the Application Review Committee. A certified copy of the judgment from a court of competent jurisdiction of such conviction or plea shall be conclusive evidence of such conviction or plea;

F. The applicant shall submit to a current background investigation (Section 16-11.7-106 (2) (a) (III), C.R.S.) that includes satisfactory references as requested by the SOMB. The SOMB may also solicit such additional references as necessary to determine compliance with the *Standards and Guidelines*. The references shall relate to the work the applicant is currently providing

G. The applicant shall demonstrate continued compliance with the *Standards and Guidelines*, particularly 2.000; and

H. The provider shall comply with all other requirements outlined in the SOMB Administrative Policies.

I. **DD/ID**
Associate Level and Full Operating Level Evaluators who want to provide evaluations to adult sex offenders shall demonstrate compliance with these Standards and submit an application demonstrating competency specific to working with this population.

4.510 Continued Placement of <u>Associate Level Adult Evaluators</u> on the Provider List:
Associate Level evaluators shall apply for continued placement on the list every three (3) years by the date provided by the SOMB. Requirements are as follows:

A. The evaluator shall demonstrate continued competency related to sex offenders;

B. The applicant shall have completed face-to-face supervision hours specific to sex offense-specific treatment and/or evaluation calculated as follows:

Direct Clinical Contact Hours per Month	Minimum Supervision Hours per Month
0-59	2
60-79	3
80 or more	4

Discussion: *The initial supervision meeting must be in-person, face to face supervision at the beginning of the supervision relationship. After these initial meetings, alternate forms of supervision (phone or some type of video conferencing) may be utilized.*

C. Every three (3) years the evaluator shall complete a SOMB provided booster training related to the S*tandards and Guidelines*, and complete an additional forty (40) hours of training as determined by the SOMB Clinical Supervisor and applicant based upon individualized training needs. If the applicant is applying to be a treatment provider and evaluator the training needs to reflect both treatment and evaluation. If the applicant is applying to be an evaluator for adults and juveniles, training must reflect both populations. Please see the list of training categories at the end of this section;

D. The evaluator shall not have a conviction of or a deferred judgment for a municipal ordinance violation, misdemeanor, felony, or have accepted by a Court a plea of guilty or nolo contender to a municipal ordinance violation, misdemeanor, or felony if the municipal ordinance violation, misdemeanor, or felony is related to the ability of the approved applicant to practice under these Standards as reviewed and determined by the Application Review Committee. A certified copy of the judgment from a court of competent jurisdiction of such conviction or plea shall be conclusive evidence of such conviction or plea;

E. The evaluator shall submit to a current background investigation (Section 16-11.7-106 (2) (a) (III), C.R.S.) that includes satisfactory references as requested by the SOMB. The SOMB may also solicit such additional references as necessary to determine compliance with the *Standards and Guidelines*. The references shall relate to the work the applicant is currently providing;

F. The evaluator shall report any practice that is in significant conflict with the *Standards and Guidelines*;

G. The evaluator shall demonstrate continued compliance with the *Standards and Guidelines*, particularly 2.000; and

H. The evaluator shall comply with all other requirements outlined in the SOMB Administrative Policies.

I. **DD/ID**
Associate Level and Full Operating Level Evaluators who want to provide evaluation and/or treatment services to adult sex offenders with developmental/intellectual disabilities shall demonstrate compliance with these Standards and submit an application providing information related to experience and knowledge of working with this population.

4.520 Required notifications to SOMB: Providers listed under section 4.500 shall provide the following notifications to SOMB as applicable:

A. Notify the SOMB in writing within two (2) weeks of changes to contact information. In such cases where a change in agency affiliation has occurred, individuals shall be required to provide updated information, where applicable on the treatment provider/client contract, description of program services, supervision agreement, and any other information pertinent to the change of employment Changes to contact information include any of the following:

1. Name
2. Treatment agency
3. Address
4. Phone number
5. Email address
6. Supervisor

B. Notify the SOMB in writing within 10 days of any changes in their status with the Department of Regulatory Agencies (DORA). This includes being subject to the filing of a complaint, having a founded complaint from DORA, or changing a DORA approval category (e.g. from licensed to unlicensed) The SOMB may periodically contact DORA regarding an individual's licensure or registration status for information.

C. Notify the SOMB in writing within 10 days of any arrest, conviction, nolo contender plea, or deferred judgment (other than a traffic violation of 7 points or less) for a municipal ordinance violation, misdemeanor, or felony, and sentence plea. The SOMB will be updated by the Colorado Bureau of Investigation of any of the above, and will consider such information, including proper notification of the SOMB, in its decision making related to whether an individual should continue to be listed with the SOMB.

4.600 EVALUATOR: <u>Adult Full Operating Level</u>: Associate Level evaluators wanting to move to Full Operating Level status shall complete the application and submit documentation of all of the requirements listed below, as well as a letter from the approved SOMB Clinical Supervisor indicating the evaluator's readiness and demonstration of required competencies to move to Full Operating Level Evaluator. A Full Operating Level Evaluator may evaluate sex offenders independently and are not required per SOMB standards to have an SOMB approved Clinical Supervisor. Nothing within this section alleviates a provider from their duty to adhere to their ethical code of conduct pertaining to supervision and consultation.

A. The provider shall have attained the underlying credential of licensure or certification as a Psychiatrist, licensed Psychologist, Licensed Clinical Social Worker, Licensed Professional Counselor, Licensed Marriage and Family Therapist, Clinical Psychiatric Nurse Specialist or Licensed Addiction Counselor, and not be under current disciplinary action that the ARC determines would impede the applicants ability to practice as an SOMB listed provider;

<u>OR</u>

The provider shall have maintained SOMB listing, in good standing, as an associate level treatment provider for at least 10 years (initial listing plus three renewal cycles) and be approved with the Department of Regulatory Agencies as a Registered Psychotherapist, Licensed Professional Counselor Candidate, Licensed Marriage and Family Therapist Candidate, Psychologist Candidate, or Clinical Social Worker, and not be under current disciplinary action that the ARC determines would impede the applicants ability to practice as an SOMB listed provider;

B. The evaluator shall be simultaneously applying for, or currently listed as, a Full Operating Level Treatment Provider;

C. The evaluator shall have demonstrated the required competencies based on; clinical experience, supervision, administration, research, training, teaching, consultation, and/or policy development;

D. The evaluator shall have completed face-to-face supervision hours specific to sex offense-specific treatment and/or evaluation calculated as follows:

Direct Clinical Contact Hours per Month	Minimum Supervision Hours per Month
0-59	2
60-79	3
80 or more	4

Discussion: *The initial supervision meeting must be in-person, face to face supervision at the beginning of the supervision relationship. After these initial meetings, alternate forms of supervision (phone or some type of video conferencing) may be utilized.*

E. Within the past five (5) years, the applicant shall have taken the SOMB provided introductory or booster training to the *Standards and Guidelines*, and completed an additional forty (40) hours (these hours are in addition to the 40 hours required for Associate Level for a total of 80 hours) of training as determined by the SOMB Clinical Supervisor and applicant based upon individualized training needs. If the applicant is applying to be a treatment provider and evaluator, the training needs to reflect both treatment and evaluation. If the applicant is applying to be an evaluator for adults and juveniles, training must reflect both populations. Please see the list of training categories at the end of this section;

F. The evaluator shall demonstrate competency according to the individual's respective professional standards and ethics consistent with the accepted standards of practice of sex offense-specific evaluations;

G. The evaluator shall not have a conviction of, or a deferred judgment for a municipal ordinance violation, misdemeanor, felony, or have accepted by a Court a plea of guilty or nolo contender to a municipal ordinance violation, misdemeanor, or felony if the municipal ordinance violation, misdemeanor, or felony is related to the ability of the approved applicant to practice under these Standards as reviewed and determined by the Application Review Committee. A certified copy of the judgment from a court of competent jurisdiction of such conviction or plea shall be conclusive evidence of such conviction or plea;

H. The evaluator shall submit to a current background investigation (Section 16-11.7-106 (2) (a) (III), C.R.S.) that includes satisfactory references as requested by the SOMB. The SOMB may also solicit such additional references as necessary to determine compliance with the *Standards and Guidelines*. The references shall relate to the work the applicant is currently providing.);

I. The evaluator shall demonstrate compliance with the *Standards and Guidelines*, particularly 2.00; and

J. The evaluator shall comply with all other requirements outlined in the SOMB Administrative Policies.

K. **DD/ID**
Associate Level and Full Operating Level Evaluators who want to provide evaluations to adult sex offenders with developmental/intellectual disabilities shall demonstrate compliance

with these Standards and submit an application providing information related to experience and knowledge of working with this population.

4.610 Continued Placement of <u>Full Operating Level Adult Evaluators</u> on the Provider List: Using a current re-application form**,** evaluators shall apply for continued placement on the list every 3 years by the date provided by the SOMB. Requirements are as follows:

A. The evaluator shall have the underlying credential of licensure or certification as a Psychiatrist, Psychologist, Clinical Social Worker, Professional Counselor, Marriage and Family Therapist, Clinical Psychiatric Nurse Specialist or Licensed Addiction Counselor, and not be under current disciplinary action that the ARC determines would impede the applicants ability to practice as an SOMB listed provider;

B. The evaluator shall demonstrate continued competency related to sex offenders based on; clinical experience, supervision, administration, research, training, teaching, consultation, and/or policy development;

C. The evaluator may re-apply for listing as a Full Operating Level Adult Treatment Provider and Evaluator,

<u>OR</u>

The evaluator may discontinue their listing as a Full Operating Level Adult Treatment Provider and be placed on the Provider List as an evaluator only;

D. Every three (3) years the evaluator shall complete a SOMB provided booster training related to the *Standards and Guidelines*, and complete and additional forty (40) hours of training in order to maintain proficiency in the field of sex offense-specific treatment and evaluation and to remain current on any developments in the assessment, treatment, and monitoring of sex offenders;

If the applicant is reapplying to be an evaluator for adults and juveniles the training needs to reflect both populations. Please see the list of training categories at the end of this section.

E. The applicant shall not have a conviction of, or a deferred judgment for, a municipal ordinance violation, misdemeanor, felony, or have accepted by a Court a plea of guilty or nolo contender to a municipal ordinance violation, misdemeanor, or felony if the municipal ordinance violation, misdemeanor, or felony is related to the ability of the approved applicant to practice under these Standards as reviewed and determined by the Application Review Committee. A certified copy of the judgment from a court of competent jurisdiction of such conviction or plea shall be conclusive evidence of such conviction or plea;

F. The evaluator shall submit to a current background investigation (Section 16-11.7-106 (2)(a)(III), C.R.S.) that includes satisfactory references as requested by the SOMB. The SOMB may also solicit such additional references as necessary to determine compliance with the *Standards and Guidelines*. The references shall relate to the work the applicant is currently providing;

G. The evaluator shall report any practice that is in conflict with the *Standards and Guidelines*;

H. The evaluator shall demonstrate continued compliance with the *Standards and Guidelines*, particularly 2.000; and

I. The evaluator shall comply with all other requirements outlined in the SOMB Administrative Policies.

4.620 Required notifications to SOMB: Providers listed under section 4.600 shall provide the following notifications to SOMB as applicable:

A. Notify the SOMB in writing within two (2) weeks of changes to contact information. In such cases where a change in agency affiliation has occurred, individuals shall be required to provide updated information, where applicable on the treatment provider/client contract, description of program services, supervision agreement, and any other information pertinent to the change of employment Changes to contact information include any of the following:

1. Name
2. Treatment agency
3. Address
4. Phone number
5. Email address
6. Supervisor

B. Notify the SOMB in writing within 10 days of any changes in their status with the Department of Regulatory Agencies (DORA). This includes being subject to the filing of a complaint, having a founded complaint from DORA, or changing a DORA approval category (e.g. from licensed to unlicensed) The SOMB may periodically contact DORA regarding an individual's licensure or registration status for information.

C. Notify the SOMB in writing within 10 days of any arrest, conviction, nolo contender plea, or deferred judgment (other than a traffic violation of 7 points or less) for a municipal ordinance violation, misdemeanor, or felony, and sentence plea. The SOMB will be updated by the Colorado Bureau of Investigation of any of the above, and will consider such information, including proper notification of the SOMB, in its decision making related to whether an individual should continue to be listed with the SOMB.

4.700 CLINICAL SUPERVISOR: Full Operating Level Treatment Providers and/or Evaluators wanting to provide supervision to Associate Level Treatment Providers and/or Evaluators shall submit an application documentation and of all of the requirements listed below, as well as a letter from their current approved SOMB Clinical Supervisor indicating the provider's readiness and demonstration of required competencies to add the listing of Clinical Supervisor. Clinical Supervisors may only provide supervision in the areas they are currently approved (e.g. juvenile, adult, DD/ID, treatment, evaluation.)

A. The applicant shall be listed as a Full Operating Level Treatment Provider and/or Evaluator;

B. The applicant shall receive supervision from an approved SOMB Clinical Supervisor for assessment of his/her supervisory competence;

C. The applicant must be assessed as competent of SOMB Clinical Supervisor competency #1 prior to advancing to providing supervision under the oversight of their approved SOMB Clinical Supervisor;

D. Once the applicant is deemed competent in competency #1 he/she shall begin providing supervision under the oversight of his/her approved SOMB clinical supervisor;

E. Upon application the applicant shall submit competency ratings from his/her approved SOMB Clinical Supervisor using the "Competency Based Assessment for Approval as a Supervisor", including a letter of recommendation and narrative that addresses the following:

1. How the applicant has stayed current on the literature/research in the field (e.g. attend conferences, trainings, journals, books, etc.)

2. Research that can be cited to support the applicant's philosophy/framework.

3. How evolving research/literature has changed the applicants practice.

4. How supervision content/process has been impacted in response to emerging research/literature in the field.

F. The applicant must maintain listing in the areas he/she are providing supervision and must maintain compliance with the applicable Standards of his/her listing.

4.800 Period of Compliance: A listed treatment provider or evaluator, who is applying or reapplying, may receive a time period to come into compliance with any Standards. If they are unable to fully comply with the *Standards and Guidelines* at the time of application, it is incumbent upon the treatment provider or evaluator to submit in writing a plan to come into compliance with the *Standards and Guidelines* within a specified time period.

4.810 Denial of Placement on the Provider List

The SOMB reserves the right to deny placement on the Provider List to any applicant to be a treatment provider, evaluator, clinical supervisor or polygraph examiner under these Standards. Reasons for denial include but are not limited to:

A. The SOMB determines that the applicant does not demonstrate the qualifications required by these Standards;

B. The SOMB determines that the applicant is not in compliance with the *Standards and Guidelines* of practice outlined in these Standards;

C. The applicant fails to provide the necessary materials for application as outlined in the application materials and the administrative policies and procedures;

D. The SOMB determines that the applicant exhibits factors (boundaries, impairments, etc.) which renders the applicant unable to treat clients; and

E. The SOMB determines that the results of the background investigation, the references given or any other aspect of the application process are unsatisfactory.

4.820 Movement between Adult and Juvenile Listing Status: Providers who are Full Operating or Associate Level Treatment Providers, Evaluators, and/or Polygraph Examiners for juveniles who have committed sexual offenses may apply to be listed as an Associate Level Treatment Provider, Evaluator, and/or Polygraph Examiner for adult sex offenders.

The Full Operating or Associate Level Treatment Provider, Evaluator, and/or Polygraph Examiner for juveniles who have committed sexual offenses shall submit the required application outlining relevant competency with the application criteria as identified in these Standards, and identify any experience or training that may be considered for equivalency to these criteria. The Application Review Committee (ARC) shall determine if the submitted documentation substantially meets the application criteria or not, and will provide written notification of any additional needed experience or training.

4.830 Not Currently Practicing: When a listed provider is not currently providing any court ordered or voluntary sex offense-specific treatment, evaluation, or polygraph services, including not performing peer consultation or clinical supervision for this population but wishes to retain their listing status.

A. A listed provider who wishes to move to not currently practicing status needs to inform the SOMB in writing of this change in status. The listed provider will be identified on the approved provider list under not currently practicing status. No contact information (phone, address, etc.) will be listed.

B. The listed provider will be required to submit a reapplication of the not currently practicing status at the time of his/her regularly scheduled reapplication time. There will be no minimum qualifications for maintaining this status (e.g. clinical experience, supervision, training, etc.) outside of submission of a letter indicating the listed provider is not currently practicing and a $25 reapplication administrative fee.

C. The listed provider may not remain under not currently practicing status longer than 2 reapplication cycles (6 years). Following completion of the second reapplication submission timeframe, the listed provider must either relinquish listing status completely or submit reapplication to resume providing listed services.

D. Before a listed provider who is under not currently practicing status may resume providing sex offense-specific treatment, evaluation, or polygraph services, the provider shall notify the SOMB in writing of the intention to resume providing such services (including the name of a supervisor for those who were Associate Level providers, or a required peer consultant for those who were Full Operating Level Providers) and receive written verification from the SOMB of the submission.

E. Within one (1) year of resuming providing listed services, the listed provider who was formerly under not currently practicing status shall submit the applicable reapplication packet. The listed provider shall meet the minimum reapplication qualifications (e.g. training, clinical experience, competency, staying active in the field, etc.) to maintain prior listing level (Associate or Full Operating level).

4.900 POLYGRAPH EXAMINER - Intent to Apply: Individuals who have not applied to the SOMB Approved Provider List as a Polygraph Examiner, but are working towards meeting the qualifications for an Associate Level Polygraph Examiner, shall submit an Intent to Apply, including a supervision agreement co-signed by their Full Operating Level Polygraph Examiner, and fingerprint card (pursuant to Section 16-11.7-106 (2), C.R.S.) within 30 days from the time the supervision began.

The supervision agreement shall:

A. Specify supervision will occur at a minimum of four (4) hours of one-to-one direct supervision monthly, and that the supervisor is ultimately responsible for the test results.

B. State the supervisor of a polygraph applicant shall review samples of the audio/video recordings of polygraphs and/or otherwise observe the examiner; and provide supervision and consultation on question formulation for polygraph exams, report writing, and other issues related to the provision of polygraph testing of sex offenders. The supervisor shall review and co-sign all polygraph examination reports completed by a polygraph examiner under their supervision.

C. Outline the components of supervision to include, but not limited to:

1. Preparation for a polygraph examination

2. Review/live observation of an examination

3. Review of video and/or audio tapes of an examination

4. Review of other data collected during an examination

D. State supervision must continue for the entire time an examiner remains at the Intent to Apply or Associate Level.

E. State the applicant shall comply with the *Standards and Guidelines* as well as all other requirements outlined in the SOMB Administrative Policies.

4.910 Required notifications to SOMB: Providers listed under section 4.900 shall provide the following notifications to SOMB as applicable:

A. Notify the SOMB in writing within two (2) weeks of changes to contact information. In such cases where a change in agency affiliation has occurred, individuals shall be required to provide updated information, where applicable on the treatment provider/client contract, description of program services, supervision agreement, and any other information pertinent to the change of employment Changes to contact information include any of the following:

1. Name
2. Agency
3. Address
4. Phone number
5. Email address
6. Supervisor

B. Notify the SOMB in writing within 10 days of any arrest, conviction, nolo contender plea, or deferred judgment (other than a traffic violation of 7 points or less) for a municipal ordinance violation, misdemeanor, or felony, and sentence plea. The SOMB will be updated by the Colorado Bureau of Investigation of any of the above, and will consider such information, including proper notification of the SOMB, in its decision making related to whether an individual should continue to be listed with the SOMB.

4.1000 POLYGRAPH EXAMINER - Associate Level: An Associate Level polygraph examiner may administer post-conviction sex offender polygraph tests under the supervision of a Full Operating

Level Polygraph Examiner under the *Standards and Guidelines*. To qualify to administer post-conviction sex offender polygraph tests at the Associate Level, an applicant shall meet all of the following requirements:

A. The examiner shall have graduated from an accredited American Polygraph Association (APA) school and shall have a baccalaureate degree from a four (4) year college or university;

OR

The examiner shall have graduated from an accredited American Polygraph Association (APA) school, have a minimum of a high school diploma, and shall have maintained SOMB listing, in good standing, as an associate level Polygraph Examiner for at least 10 years (initial listing plus three renewal cycles);

B. The applicant shall complete a minimum of fifty (50) polygraph exams on post-conviction sex offenders while operating under the Intent to Apply status;

C. The applicant shall have completed all training as outlined in Standard 4.1020 of these Standards.

If an applicant wishes to substitute any training not listed here, it is incumbent on the applicant to write a justification demonstrating the relevance of the training to this standard.

D. The applicant shall demonstrate competency according to the individual's respective professional standards and conduct all examinations in a manner that is consistent with the reasonably accepted standard of practice in the polygraph examiner community;

E. The applicant shall submit to a current background investigation (Section 16-11.7-106(2)(a)(III), C.R.S.) that includes satisfactory references as requested by the SOMB. The SOMB may also solicit such additional references as necessary to determine compliance with the *Standards and Guidelines*. These references shall include, but not be limited to other members of the community supervision team;

F. The applicant shall submit quality assurance protocol forms from three (3) separate examinations submitted to three Full Operating Level Polygraph Examiners from outside the examiner's agency. Peer review must be conducted annually at a minimum;

G. The applicant shall not have a conviction of, or a deferred judgment for, a municipal ordinance violation, misdemeanor, felony, or have accepted by a court a plea of guilty or nolo contender to a municipal ordinance violation, misdemeanor, or felony if the municipal ordinance violation, misdemeanor, or felony is related to the ability of the approved applicant to practice under these Standards as reviewed and determined by the Application Review Committee. A certified copy of the judgment from a court of competent jurisdiction of such conviction or plea shall be conclusive evidence of such conviction or plea;

H. The applicant shall demonstrate compliance with the *Standards and Guidelines*; and

I. The applicant shall comply with all other requirements outlined in the SOMB Administrative Policies.

4.1010 Professional Supervision of <u>Associate Level Polygraph Examiners</u>: A supervision agreement shall be signed by both the polygraph examiner and his/her supervisor. The supervision agreement shall specify supervision occurring at a minimum of four (4) hours of one-to-one direct supervision monthly, and that the supervisor is ultimately responsible for the test results.

The applicant shall have an application on file with the SOMB that includes the supervision agreement. Supervision must continue for the entire time an examiner remains at the Associate Level. The supervision agreement must be in writing.

The supervisor of a polygraph applicant shall review samples of the audio/video recordings of polygraphs and/or otherwise observe the examiner; and provide supervision and consultation on question formulation for polygraph exams, report writing, and other issues related to the provision of polygraph testing of post-conviction sex offenders. The supervisor shall review and co-sign all polygraph examination reports completed by an Associate Level polygraph examiner under their supervision.

The components of supervision include, but are not limited to:

A. Preparation for a polygraph examination;

B. Review/live observation of an examination;

C. Review of video and/or audio tapes of an examination; and

D. Review of other data collected during an examination.

4.1010 DD/ID
Professional Supervision of Associate Level Polygraph Examiners with Developmental/Intellectual Disability Specialty

The applicant must have a Full Operating Level Polygraph Examiner with the Developmental/ Intellectual Disability Specialty providing supervision of these exams.

4.1020 Continued Placement of <u>Polygraph Examiner Associate Level</u> on the Provider List: Polygraph examiners at the Associate Level shall apply for continued placement on the list every three (3) years by the date provided by the SOMB. Requirements are as follows:

A. The examiner shall have graduated from an accredited American Polygraph Association (APA) school and shall have a baccalaureate degree from a four (4) year college or university;

<u>OR</u>

The examiner shall have graduated from an accredited American Polygraph Association (APA) school, have a minimum of a high school diploma, and shall have maintained SOMB listing, in good standing, as an associate level Polygraph Examiner for at least 10 years (initial listing plus three renewal cycles);

B. The examiner shall conduct a minimum of one hundred (100), with fifteen (15) juvenile post-conviction sex offense polygraph examinations in the three (3) year listing period on juveniles who have committed sexual offenses;

C. The examiner shall complete a minimum of forty (40) hours of continuing education every three (3) years in order to maintain proficiency in the field of polygraph testing and to remain current on any developments in the assessment, treatment, and monitoring of sex offenders. Up to ten (10) hours of this training may be indirectly related to sex offender assessment/ treatment/ management. It is incumbent on the trainee to demonstrate relevance to sex offender issues if the training is indirectly related to sex offender assessment/treatment/ management. The remaining thirty (30) hours shall be directly related to sex offender assessment/treatment/management and ten (10) of these hours shall be specific to sex offenders (please reference the List of Specialized Training Categories for further details). These training hours may be utilized to meet the qualifications for both adult and juvenile polygraph examiners;

D. The examiner shall submit to a current background investigation (Section 16-11.7-106(2)(a)(III), C.R.S.) that includes satisfactory references as requested by the SOMB. The SOMB may also solicit such additional references as necessary to determine compliance with the *Standards and Guidelines*. These references shall include, but not be limited to other members of the community supervision team;

E. The examiner shall submit quality assurance protocol forms from three (3) separate examinations submitted to three Full Operating Level Polygraph Examiners from outside the examiner's agency. Peer review must be conducted annually at a minimum;

F. The examiner shall not have a conviction of, or a deferred judgment for, a municipal ordinance violation, misdemeanor, felony, or have accepted by a court a plea of guilty or nolo contender to a municipal ordinance violation, misdemeanor, or felony if the municipal ordinance violation, misdemeanor, or felony is related to the ability of the approved applicant to practice under these Standards as reviewed and determined by the Application Review Committee. A certified copy of the judgment from a court of competent jurisdiction of such conviction or plea shall be conclusive evidence of such conviction or plea;

G. The examiner shall report any practice that is in significant conflict with the *Standards and Guidelines*;

H. The examiner shall demonstrate compliance with the *Standards and Guidelines*; and

I. The examiner shall comply with all other requirements outlined in the SOMB Administrative Policies.

J. **DD/ID**
Individuals wanting to provide polygraph services to sex offenders with developmental/ intellectual disabilities shall demonstrate compliance with and submit an application providing information related to experience and knowledge of working with this population.

4.1030 Movement to Full Operating Level: Associate Level Polygraph Examiners wanting to move to Full Operating Level status shall complete and submit documentation of:

A. The examiner shall have conducted at least two hundred (200) post-conviction sex offender polygraph tests on adult sex offenders, with twenty-five (25) post-conviction sex offender polygraph tests on juveniles who have committed sexual offenses, as indicated in Standard 4.800; and

B. The examiner shall submit a letter from his/her supervisor indicating the examiner's readiness to move to Full Operating Level status, including documentation of having completed the professional supervision components.

4.1040 Required notifications to SOMB: Providers listed under section 4.1020 shall provide the following notifications to SOMB as applicable:

A. Notify the SOMB in writing within two (2) weeks of changes to contact information. In such cases where a change in agency affiliation has occurred, individuals shall be required to provide updated information, where applicable on the treatment provider/client contract, description of program services, supervision agreement, and any other information pertinent to the change of employment Changes to contact information include any of the following:

1. Name
2. Agency
3. Address
4. Phone number
5. Email address
6. Supervisor

B. Notify the SOMB in writing within 10 days of any arrest, conviction, nolo contender plea, or deferred judgment (other than a traffic violation of 7 points or less) for a municipal ordinance violation, misdemeanor, or felony, and sentence plea. The SOMB will be updated by the Colorado Bureau of Investigation of any of the above, and will consider such information, including proper notification of the SOMB, in its decision making related to whether an individual should continue to be listed with the SOMB.

4.1100 POLYGRAPH EXAMINER - <u>Full Operating Level</u>: Polygraph examiners who administer post-conviction sex offender polygraph tests shall meet the minimum standards as indicated by the American Polygraph Association as well as the requirements throughout these Standards.

Polygraph examiners who conduct post-conviction sex offender polygraph tests on adult sex offenders shall adhere to best practices as recommended within the polygraph profession.

To qualify at the Full Operating Level to perform examinations of adult sex offenders, an examiner must meet **<u>all</u>** the following criteria:

A. The examiner shall have graduated from an accredited American Polygraph Association (APA) school and shall have a baccalaureate degree from a four (4) year college or university;

<u>OR</u>

The examiner shall have graduated from an accredited American Polygraph Association (APA) school, have a minimum of a high school diploma, and shall have maintained SOMB listing, in good standing, as an associate level Polygraph Examiner for at least 10 years (initial listing plus three renewal cycles);

B. The examiner shall have conducted at least two hundred (200) post-conviction sex offender polygraph exams, with twenty-five (25) juvenile post-conviction polygraph tests within five (5) years of application; and

Discussion: Post conviction sex offender polygraph tests completed for juvenile offenders and/or tests completed for approval as an Associate Level polygraph examiner status may be included for Full Operating Level polygraph examiner approval.

C. Following completion of the curriculum (APA school) cited in these Standards, the applicant shall have completed an APA approved forty (40) hours of training within five (5) years of application specific to post-conviction sexual offending which focuses on the areas of evaluation, assessment, treatment and behavioral monitoring and includes, but is not limited to the following:

1. Pre-test interview procedures and formats.
2. Valid and reliable examination formats.
3. Post-test interview procedures and formats.
4. Reporting format (i.e. to whom, disclosure content, and forms).
5. Recognized and standardized polygraph procedures.
6. Administration of examinations in a manner consistent with these Standards.
7. Participation in sex offender multidisciplinary teams.
8. Use of polygraph results in the treatment and supervision process.
9. Professional standards and conduct.
10. Expert witness qualifications and courtroom testimony.
11. Interrogation techniques.
12. Maintenance/monitoring examinations.
13. Periodic/compliance examinations.

The successful completion of an APA approved forty (40) hour training specific to post-conviction sexual offending (PSOT) as referenced above will meet the qualifications for both adult and juvenile polygraph examiners.

Ten (10) of the forty (40) hours shall be specific to the treatment of adult sex offenders. These training hours may be utilized to meet the qualifications for both adult and juvenile polygraph examiners.

If an examiner wishes to substitute any training not listed here, it is incumbent on the examiner to write a justification demonstrating the relevance of the training to this standard;

D. **DD/ID**
Of these forty (40) hours of training, the examiner shall have completed ten (10) hours specific to adults sex offenders with developmental/intellectual disabilities who have committed sexual offenses.

E. The examiner shall demonstrate competency according to the individual's respective professional standards and conduct all examinations in a manner that is consistent with the reasonably accepted standard of practice in the clinical polygraph examiner community;

F. The examiner shall submit to a current background investigation (Section 16-11.7-106(2)(a)(III), C.R.S.) that includes satisfactory references as requested by the SOMB. The SOMB may also solicit such additional references as necessary to determine compliance with the *Standards and Guidelines*. These references shall include, but not be limited to other members of the community supervision team;

G. The examiner shall not have a conviction of, or a deferred judgment for, a municipal ordinance violation, misdemeanor, felony, or have accepted by a court a plea of guilty or nolo contender to a municipal ordinance violation, misdemeanor, or felony if the municipal ordinance violation, misdemeanor, or felony is related to the ability of the approved applicant to practice under these Standards as reviewed and determined by the Application Review Committee. A certified copy of the judgment from a court of competent jurisdiction of such conviction or plea shall be conclusive evidence of such conviction or plea;

H. The examiner shall demonstrate compliance with the *Standards and Guidelines*;

I. The examiner shall comply with all other requirements outlined in the SOMB Administrative Policies.

4.1110 Continued Placement of a <u>Full Operating Level Polygraph Examiner</u> on the Provider List: Polygraph examiners at the Full Operating Level shall apply for continued placement on the list every three (3) years by the date provided by the SOMB. Requirements are as follows:

A. The examiner shall have graduated from an accredited American Polygraph Association (APA) school and shall have a baccalaureate degree from a four (4) year college or university;

<u>OR</u>

The examiner shall have graduated from an accredited American Polygraph Association (APA) school, have a minimum of a high school diploma, and shall have maintained SOMB listing, in good standing, as an associate level Polygraph Examiner for at least 10 years (initial listing plus three renewal cycles);

B. Full Operating Level Polygraph Examiners shall complete a minimum of forty (40) hours of continuing education every three (3) years in order to maintain proficiency in the field of polygraph testing and to remain current on any developments in the assessment, treatment, and monitoring of adult sex offenders. Up to ten (10) hours of this training may be indirectly related to sex offender assessment/treatment/management. It is incumbent on the trainee to demonstrate relevance to sex offender issues if the training is indirectly related to sex offender assessment/treatment/management. The remaining thirty (30) hours shall be directly related to sex offender assessment/ treatment/management and ten (10) of these hours shall be specific to sex offenders (please reference the List of Specialized Training Categories for

further details). These training hours may be utilized to meet the qualifications for both adult and juvenile polygraph examiners;

C. The examiner shall conduct a minimum of one hundred (100) post-conviction polygraph examinations in the three (3) year listing period on adult sex offenders;

D. The examiner shall submit to a current background investigation (Section 16-11.7-106(2)(a)(III), C.R.S.) that includes satisfactory references as requested by the SOMB. The SOMB may also solicit such additional references as necessary to determine compliance with the *Standards and Guidelines*. These references shall include, but not be limited to other members of the community supervision team;

E. The examiner shall submit quality assurance protocol forms from three (3) separate examinations submitted to three Full Operating Level Polygraph Examiners from outside the examiner's agency each year. Three different types of reports should be reviewed;

F. The examiner shall not have a conviction of, or a deferred judgment for, a municipal ordinance violation, misdemeanor, felony, or have accepted by a court a plea of guilty or nolo contender to a municipal ordinance violation, misdemeanor, or felony if the municipal ordinance violation, misdemeanor, or felony is related to the ability of the approved applicant to practice under these Standards as reviewed and determined by the Application Review Committee. A certified copy of the judgment from a court of competent jurisdiction of such conviction or plea shall be conclusive evidence of such conviction or plea;

G. The examiner shall report any practice that is in significant conflict with the *Standards and Guidelines*;

H. The examiner shall demonstrate compliance with the *Standards and Guidelines*; and

I. The examiner shall comply with all other requirements outlined in the SOMB Administrative Policies.

J. DD/ID

Individuals wanting to provide polygraph services to adult sex offenders with developmental/ intellectual disabilities shall demonstrate compliance with these Standards and submit an application providing information related to experience and knowledge of working with this population.

Of these forty (40) hours of continuing education, the examiners shall have completed ten (10) hours specifically related to adult sex offenders with developmental/intellectual disabilities.

4.1120 Period of Compliance: A listed polygraph examiner, who is applying, may receive a period of time to come into compliance with any Standards. If they are unable to fully comply with the *Standards and Guidelines* at the time of application, it is incumbent upon the polygraph examiner to submit in writing a plan to come into compliance with the *Standards and Guidelines* within a specified time period.

4.1130 Denial of Placement on the Provider List

The SOMB reserves the right to deny placement on the Provider List to any applicant to be a treatment provider, evaluator, clinical supervisor or polygraph examiner under these Standards. Reasons for denial include but are not limited to:

A. The SOMB determines that the applicant does not demonstrate the qualifications required by these Standards;

B. The SOMB determines that the applicant is not in compliance with the *Standards and Guidelines* of practice outlined in these Standards;

C. The applicant fails to provide the necessary materials for application as outlined in the application materials and the administrative policies and procedures;

D. The SOMB determines that the applicant exhibits factors (boundaries, impairments, etc.) which renders the applicant unable to treat clients; and

E. The SOMB determines that the results of the background investigation, the references given or any other aspect of the application process are unsatisfactory.

4.1140 Required notifications to SOMB: Providers listed under section 4.1000 shall provide the following notifications to SOMB as applicable:

A. Notify the SOMB in writing within two (2) weeks of changes to contact information. In such cases where a change in agency affiliation has occurred, individuals shall be required to provide updated information, where applicable on the treatment provider/client contract, description of program services, supervision agreement, and any other information pertinent to the change of employment Changes to contact information include any of the following:

1. Name
2. Agency
3. Address
4. Phone number
5. Email address
6. Supervisor

B. Notify the SOMB in writing within 10 days of any arrest, conviction, nolo contender plea, or deferred judgment (other than a traffic violation of 7 points or less) for a municipal ordinance violation, misdemeanor, or felony, and sentence plea. The SOMB will be updated by the Colorado Bureau of Investigation of any of the above, and will consider such information, including proper notification of the SOMB, in its decision making related to whether an individual should continue to be listed with the SOMB.

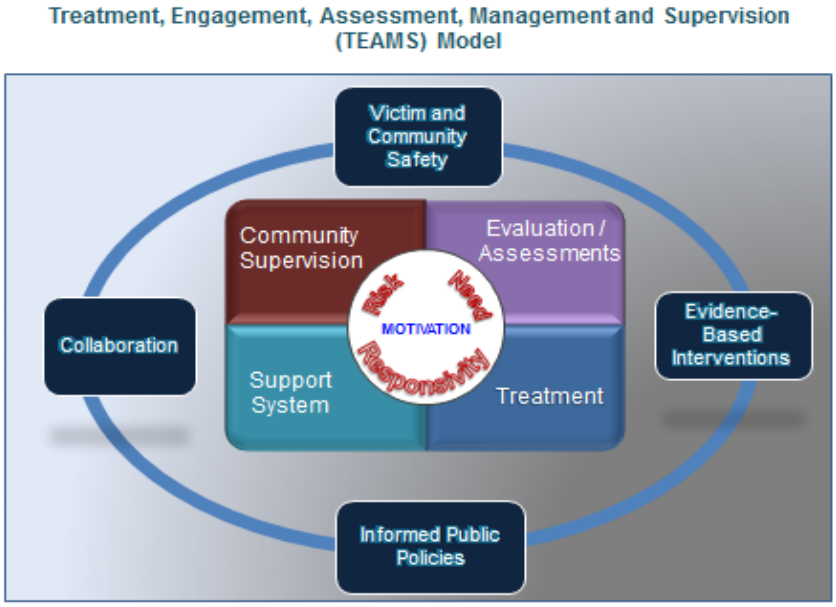
LIST OF SPECIALIZED TRAINING CATEGORIES

Sex offense-specific training may include but is not limited to training from these areas:	**Victim specific training** may include but are not limited to training from these areas:	**Adult specific training** may include but are not limited to training from these areas:	**Juvenile specific training** may include but are not limited to trainings from these areas:	**Developmental/ Intellectual Disabilities specific training** may include but are not limited to trainings from these areas:
▪ Sex offender evaluation and assessment ▪ Sex offender treatment planning and assessing treatment outcomes ▪ Community supervision techniques including approved supervisor training ▪ Treatment modalities: o Group o Individual o Family o Psycho-education o Self-help ▪ Sex offender treatment techniques including: o Evaluating and reducing denial o Behavioral treatment techniques o Cognitive behavioral techniques o Relapse prevention o Offense cycle o Empathy training o Confrontation techniques o Safety and containment planning ▪ Sex offender risk assessment ▪ Parental Risk Assessment ▪ Crossover ▪ Objective measures including: o Polygraph o Plethysmograph o Viewing Time (VT) ▪ Psychological testing ▪ Special sex offender populations including:	▪ Victim impact ▪ Victim treatment and recovery ▪ Victim experience in the criminal justice system ▪ Contact, Clarification and reunification with victims ▪ Secondary victims ▪ Victim Rights Act (VRA) ▪ Prevalence of sexual assault ▪ Human trafficking ▪ Victim Centered approach to treatment and supervision	▪ Prevalence of sexual offending by adults ▪ Victimization rates ▪ Typologies of adult sex offenders ▪ Continuing research in the field of adult sexual offending ▪ Anger management ▪ Healthy sexuality and sex education ▪ Learning theory ▪ Multicultural sensitivity ▪ Understanding transference and counter-transference ▪ Family dynamics and dysfunction ▪ Co-morbid conditions, differential diagnosis ▪ Investigations ▪ Addictions and substance abuse ▪ Domestic Violence ▪ Knowledge of criminal justice and/or district court systems, legal parameters and the	▪ Prevalence of sexual offending by juveniles/ ▪ Victimization rates ▪ Typologies of juveniles who commit sexual offenses ▪ Continuing research in the field of sexual offending by juveniles ▪ Difference between juveniles and adults ▪ Philosophy of treatment adult vs. juvenile ▪ Clarification and contact with victims ▪ Reunification with families impacted by sexual abuse ▪ Healthy sexuality and sex education ▪ Multicultural sensitivity ▪ Developmental stages ▪ Understanding transference and counter-transference ▪ Family dynamics and dysfunction	▪ Treatment, evaluation and monitoring considerations for the sex offender with developmental/ intellectual disabilities ▪ Impact of disability on the individual ▪ Healthy sexuality and sex education for the sex offender with developmental/ intellectual disabilities ▪ Statutes, rules and regulations pertaining to individuals with developmental/ intellectual disabilities ▪ Co-occurring mental health issues

Sex offense-specific training may include but is not limited to training from these areas:	**Victim specific training** may include but are not limited to training from these areas:	**Adult specific training** may include but are not limited to training from these areas:	**Juvenile specific training** may include but are not limited to trainings from these areas:	**Developmental/ Intellectual Disabilities specific training** may include but are not limited to trainings from these areas:
○ Sadists ○ Psychopaths ○ Developmentally/ Intellectually disabled ○ Compulsives ○ Juveniles ○ Females ▪ Family clarification/ visitation/reunification ▪ Pharmacotherapy with sex offenders ▪ Impact of sex offenses ▪ Assessing treatment progress ▪ Supervision techniques with sex offenders ▪ Offender's family stability, support systems and parenting skills ▪ Sex offender attachment styles ▪ Knowledge of laws, policies and ethical concerns relating to confidentiality, mandatory reporting, risk management and offender participation in treatment ▪ Ethics ▪ Philosophy and Principles of the SOMB ▪ Trauma and vicarious Trauma		relationship between the provider and the courts ▪ Any of the topics in the above sex offense-specific category that is also specific to adult sex offenders ▪ Philosophy of treatment adult vs. juvenile	▪ Co-morbid conditions, differential diagnosis ▪ Investigations ▪ Addictions and substance abuse ▪ Partner Violence ▪ Any of the topics in the above sex offense-specific category that is also specific to juveniles who sexually offend	

5.000 REVISED SEPTEMBER 2017 STANDARDS AND GUIDELINES FOR COMMUNITY SUPERVISION TEAMS WORKING WITH ADULT SEX OFFENDERS

5.000 ♦ The SOMB TEAMS Model and the Community Supervision Team (CST)



5.005 TEAMS is an acronym for Treatment, Engagement, Assessment, Management and Supervision.[71] This model guides the CST members to work collaboratively with each other to assist the client/offender in becoming a prosocial, productive member of society, and in order to enhance community safety. The foundations of the model are Victim and Community Safety, the use of Evidence Based and Research Informed Practices, Informed Public Policies and Collaboration.

Community safety is enhanced when treatment providers and community supervision professionals practice in their area of specialization and work together. This collaboration should include frequent and substantive communication about information that will assist in reducing an offender's risk to the community. When the CST members respect individual roles and mutually agree upon their goals and the treatment and supervision interventions that will be pursued, the offender can be treated and managed more effectively.
The components of the TEAMS Model are:

A. **Community Supervision** - Community supervision is made up of Probation, Parole, Community Corrections or a modified CST in the Department of Corrections.

B. **Evaluation and Assessments** – Evaluations include empirically validated instruments that determine risk. For the purpose of the TEAMS Model, assessments may include, but are not limited to, a polygraph report, viewing time instruments and/or a PPG. (See Section 2.000.)

[71] The TEAMS model was originally approved by consensus of the SOMB on February 19, 2016.

C. **Treatment** - SOMB approved sex offense-specific treatment. Treatment may also include adjunct treatment for underlying mental health or drug and alcohol treatment. (See Section 3.000.)

D. **Support System** – The support system can be an individual(s), a family member(s) or an organization(s) that provide pro-social support to enhance offender motivation for positive behavioral change.

The goal of the CST's collaborative efforts is to engage offenders in treatment and supervision in order to decrease risk, enhance protective factors, and increase their intrinsic motivation for positive behavioral change.

5.010 As soon as possible after the conviction and referral of a sex offender to probation, parole, or community corrections, the supervising officer should convene the initial meeting of the CST.[72] When offenders are placed in institutions, "community" refers to the institutional setting and there is a modified CST.

Institutional treatment programs utilize a modified Community Supervision Team (CST) approach similar to that described in Section 5.000. Specifically, the polygraph examiner and SOMB approved treatment provider should work closely together, and other institutional professionals should be included in the CST as indicated. The SOMB approved clinical supervisor shall function as the head of the CST for purposes of convening the team.

5.015 CST members should participate in regular staffings to share information and address pertinent issues. CSTs should communicate frequently enough to manage and treat sexual offenders effectively with community safety as the highest priority. When the CST members respect individual roles and mutually agree upon their goals and the treatment and supervision interventions that will be pursued, the offender can be treated and managed more effectively.

5.020 Some offenders may have multiple supervising officers (e.g. a probation officer and parole officer, or a probation officer and community corrections case manager). In such cases, the supervising officers should determine the role each will serve in supervising the offender. As issues arise, agency representatives are encouraged to staff the matters and develop a coordinated response.

The following Guidelines will help ensure a coordinated response in dual supervision cases:

A. The agency that has the longest jurisdiction over the offender should be the lead agency;

B. If the offender is required to participate in offense-specific treatment, the lead agency should

[72] Petersilia, J., & Turner, S. (1993). Intensive Probation and Parole. In M.H. Tonry, ed., *Crime and Justice: A Review of Research.*Chicago: University of Chicago Press.; Gendreau, P., Goggin, C., & Fulton, B. (2000). Intensive probation in probation and parole settings. In C. R. Hollin (Ed.), *Handbook of Offender Assessment and Treatment.* 195-204. Chichester, UK: John Wiley & Sons Ltd.; Cumming, G., &Buell, M. (1997). *Supevision of the Sex Offender*. Brandon, VT: Safer Society Press.; Kercher, G., & Long, L. (1991). *Supervision and Treatment of Sex Offenders*. Huntsville, TX.: Sam Houston Press.; O'Connell, M., Leberg, E., & Donaldson, C. (1990). *Working with Sex Offenders: Guidelines for Therapist Selection*. Thousand Oaks, CA: Sage Publications, Inc.; English, K., Pullen S., and Jones, L. (eds.). (1996). *Managing Adult Sex Offenders: A Containment Approach.* American Probation and Parole Association.; Center for Sex Offender Management (CSOM). (January 2000). *Community Supervision of the Sex Offender: An Overview of Current and Promising Practices*. Retrieved from: http://www.csom.org/pubs/supervision2.pdf; CSOM. (October 2000). *The Collaborative Approach to Sex Offender Management*. Retrieved from: http://www.csom.org/pubs/collaboration.pdf; Baker, D.K., Skolnick, J., Doucette, G., Levitt, G., & O'Connor, C. (2005). Intensive Parole Supervision of the Sex Offender—Putting the Containment Approach Into Practice. In B. Schwartz, ed. *The Sex Offender: Issues in Assessment, Treatment, & Supervision of Adult and Juvenile Populations, Volume V*. Kingston, NJ: Civic Research Institute.

refer the offender to an SOMB approved provider who is utilized and approved by both agencies;

C. Housing assistance and other re-entry services should be provided and coordinated in a cooperative manner by both agencies to the extent they are able to assist;

D. Staffing and communication between the supervising officers of each agency is encouraged to take place according to a set schedule and may be conducted over the phone and by email;

E. If there is a significant disagreement or discrepancy in case management decisions, both officers should consider the offender's risk, protective factors, and treatment needs, and apply the most appropriate plan;

F. Safety plans should be approved by both officers. Where there is a significant disagreement on whether to approve a safety plan, both officers should consider the offender's protective factors, risk, and treatment needs, and approve the most appropriate plan;

G. As issues arise during dual supervision cases, agency representatives are encouraged to consistently communicate and obtain feedback to develop and ensure a coordinated team response as it pertains to issues which include, but are not limited to incentives, sanctions, technical violations, home visits and arrests;

H. Expectations should be clearly communicated to the defendant from both agencies and as they change overtime; and

I. Each supervising officer must clearly communicate to the client his/her expectations with respect to each officer's duties/domains so that the client understands who is managing various issues in supervision, especially if the identity or role of the supervising officer changes over time.

5.025 Each Community Supervision Team (CST) is established for a particular offender and is flexible enough to include any individuals necessary to ensure the best approach to management and treatment. CST membership may therefore change over time.[73]

At a minimum, each CST shall consist of the following as deemed appropriate and applicable:

A. The supervising officer (except in the case of institutional settings, see Standards 5.005 and 5.010);

B. The offender's treatment provider;

[73] Lowden, K., Hetz, N., Patrick, D., Pasini-Hill, D., English, K., & Harrison, L. (2003). *Evaluation of Colorado's prison therapeutic community for sex offenders: A report of findings*. Office of Research and Statistics, Colorado Division of Criminal Justice, Denver, CO.; Stalans, L. (2004). Adult Sex Offenders on community supervision: A review of recent assessment strategies and treatment. *Criminal Justice and Behavior 31 (5)*, 564-608.; Boone, D.L., O'Boyle, E., Stone, A., & Schnabel, D. (2006, March). *Preliminary evaluation of Virginian's sex offender containment programs.* Richmond, VA: Research, Evaluation and Forecasting Unit, Virginia Department of Corrections.; Hepburn, J., & Griffin, M. (2002). *An analysis of risk factors contributing to the recidivism of sex offenders on probation.* Report submitted to the Maricopa Adult Probation Department and the National Institute of Justice.; England, K. A., Olsen, S., Zakrajsek, T. Murray, P. & Ireson, R. (2001). Cognitive/behavioral treatment for sexual offenders: An examination of recidivism. *Sexual Abuse: A Journal of Treatment and Practice, Vol. 13, No. 4*, 223-231.; Walsh, M. (2005). *Overview of the IPSO program intensive parole for sex offenders in Framingham, Massachusetts. Presentation by the Parole Board Chair to the National Governor's Association policy meeting on sexual offenders.* November 15, 2005. San Francisco, CA.; English, K., Pullen, S., & Jones, L. (Eds.) (1996). *Managing adult sex offenders: A containment approach*. Lexington, KY: American Probation and Parole Association.

C. Evaluators (as applicable);

D. The polygraph examiner (as applicable); and

E. The Victim Representative.

The team may include extended family members, other clinical professionals, law enforcement, spiritual leaders, peers, victim representatives, victims, coaches, employers and other individuals as deemed appropriate by the CST.

Discussion: It is important to note that each CST member (e.g., polygraph examiner and victim representative) may not be present at each CST meeting/staffing. However, CST members should maintain communication on a regular basis as a crucial part of the process. Victim representatives should be consulted to provide input for all CSTs, and will be more active in the cases when the actual victim is involved in the supervision and treatment of the offender. Victim representatives should always be included for consultation on safety concerns and victim contact, clarification and reunification.

5.025 DD/ID

When the CST is formed around an offender with DD/ID issues it is important that the CST consult with and or add as an adjunct member individuals who may assist the offender transition and who understand the unique needs presented by the offender.

Therefore, in addition to the core members of the CST, any of the following, when involved, should be added to teams supervising sex offenders who have developmental or intellectual disabilities:

- Community Centered Board Case Manager
- Residential Providers
- Supported Living Coordinator
- Day Program Provider
- Vocational or Educational Provider
- Guardians
- Social Services
- Family Members
- Authorized Representatives
- Other Applicable Providers

5.030 DD/ID

Responsibilities of Additional CST Members for Sex Offenders Who Have Developmental Disabilities

When the CST is formed around an offender with DD/ID issues and additional team members are added to the CST it is important that they meet the criteria below:

A. Team members shall have specialized training or knowledge regarding sexual offending behavior, the management and supervision of sex offenders and the impact of sex offenses on victims;

B. Team members shall be familiar with the conditions of the offender's supervision and the

treatment contract; and

C. Team members shall immediately report to the supervising officer and the treatment provider any failure to comply with the conditions of supervision or the treatment contract or any perceived high-risk behavior.

5.050 Promoting and Monitoring Behavioral Change

The Teams Model promotes engagement of offenders by the CST in the treatment and supervision process to enhance protective factors, decrease risk and increase the offender's motivation for positive behavioral change. The SOMB enabling statute declares that "some sex offenders respond well to treatment and can function as safe, responsible and contributing members of society, provided that they receive treatment and supervision." [74] Supervision and treatment engagement is a critical component to measuring successful outcomes.[75] While it is the CST's duty to promote behavioral change, the responsibility of ultimate success or failure lies within the client.

5.055 Managing and monitoring behavioral change is the responsibility of each member of the CST (Roles). When working with offenders, positive reinforcement has been proven to be more effective in promoting behavioral change. Positive reinforcements should be applied more frequently than negative reinforcements when trying to change behavior.[76] Responses to negative behaviors should be applied commensurate to the severity of the violation or negative behavior.[77]

Each member of the CST has a role in managing and monitoring behavioral change. Some of these roles may overlap between the community supervision officer and treatment provider. It is essential that the supervising officer and treatment provider work collaboratively to coordinate supervision and treatment to enhance behavior change progression. The team should work closely together to identify the progress of supervision and treatment goals while recognizing and respecting the expertise of each team member. It is critical for the supervising officer and treatment provider to work collaboratively when an offender's risk is at an increased level. Each member of the CST will defer to the expertise of the other in coordinating a response during times of increased risk. The response should take into consideration the offender's assessed risk, progress in treatment, and protective factors, and victim and community safety. Final decisions concerning matters of the court, court ordered terms and conditions or parole board directives will be made by the supervising officer in consultation with the treatment provider. Final decisions concerning matters of the treatment contract, components of treatment, or treatment issues in general will be made by the treatment provider or evaluator in consultation with the supervising officer. Rare exceptions to this Standard would be if the offender poses a documented public safety risk and the

[74] *Managing adult sex offenders: A containment approach*. Lexington, KY: American Probation and Parole Association.
[75] Beggs, S. (2010). Within-treatment outcome among sexual offenders: A review. *Aggression and Violent Behavior, 15(5),* 369-379.; Levenson, J. S., & Macgowan, M. J. (2004). Engagement, denial, and treatment progress among sex offenders in group therapy. *Sexual Abuse: A Journal of Research and Treatment, 16(1),* 49-63.
Payne, S. T., & Dozier, C. L. (2013). Positive reinforcement as treatment for problem behavior maintained by negative reinforcement. *Journal of Applied Behavior Analysis, 46(3),* 699-703.; Robinson, C., Lowenkamp, M. S., Lowenkamp, C. T., & Lowenkamp, M. N. (2015). Towards and empirical and theoretical understanding of offender reinforcement and punishment. *Federal Probation, 79(1),* 3-10.; Wood, P. B., Wilson, J. A., & Throne, D. P. (2015). Offending patterns, control balance, and affective rewards among convicted sex offenders. *Deviant Behavior, 36(5),* 368-387.
[77] *Managing adult sex offenders: A containment approach*. Lexington, KY: American Probation and Parole Association.

supervising officer must act quickly to address the risk to the community. Promoting and monitoring behavior change begins with assessing risk and identifying target behaviors that are directly related to specific criminogenic needs areas. Assessing need areas may focus on the following areas but are not limited to:[78]

- Cooperation with Supervision and Treatment
- Sexual Offense Responsibility
- Sexual Risk Management
- Sexual Behavior/Attitudes/Interest
- Antisocial Behavior/Attitudes/Thoughts/Beliefs/Personality Pattern
- Criminal Rule Breaking Attitudes or Behaviors
- Social Influences
- Problem Solving
- Impulsivity
- Treatment and Supervision Cooperation
- Intimacy deficits as seen in Family and Marital
- Victim impact/empathy

The CST should consider these factors while individualizing each case. The team should collaboratively consider whether the best response is to continue working with the offender in the community, modify the terms and conditions of supervision or treatment contract or to request the offender be regressed or revoked from community supervision.[79]

5.100 ♦ Responsibilities of the Supervising Officer Within the Team

5.105 The supervising officer shall refer sex offenders for evaluation and treatment only to providers who are approved by the SOMB[80]. When making referrals, the supervising officer should consider the provider who will best maximize the offender's ability to learn by matching interventions to an offender's learning style, and who will motivate the offender to change by enhancing their strengths and abilities.[81] The supervising officer should ensure that sex offenders sign applicable Authorizations for Release of Information to allow for information sharing (see Section 9.000).

Some factors to consider when referring for sex offense-specific treatment include, but are not limited to:[82]

A. Recommendations of the Sex Offense-Specific Evaluation (SOSE);

B. Recommendations of the Presentence Investigation Report (PSIR);

[78] McGrath, R. J., Cumming, G. F., & Lasher, M. P. (2013). SOTIPS: Sex Offender Treatment Intervention and Progress Scale Manual.
[79] Revised 2010 Center for Effective Public Policy – *Shaping Offender Behavior*, Mark Carey, The Carey Group
[80] Section See Section 16-11.7-106, C.R.S.
[81] Andrews, D. A., Bonta, J., & Wormith, J. S. (2011). The Expanded Risk-Need-Responsivity (RNR) Model [Table 1]. The risk-need-responsivity (RNR) model: Does adding the good lives model contribute to effective crime prevention. *Criminal Justice and Behavior, 38(7),* 735-755.
[81] See Section 16-117-105(2), C.R.S.
[82] If an offender has already begun treatment prior to supervision, the supervising officer may nonetheless require a change of provider if, in consideration of the factors, a change is warranted.

C. Community safety;

D. Assessed risk factors (static and dynamic);

E. Assessed criminogenic factors (e.g. employment, family circumstances, etc.);

F. Level of supervision;

G. Offender's specialized needs such as mental illness, physical or developmental disability, and cultural differences;

H. Availability and proximity of services;

I. Continuity of care;[83]

J. Offender stability factors (i.e. work, family situation); and

K. Other factors based on the offender's individualized strengths and needs.

5.110 For offenders who begin community supervision on or after August 10, 2016, the supervising agency shall provide the offender with a choice of two appropriate treatment providers agencies staffed by SOMB approved providers unless the supervising agency documents in the file that, based upon the nature of the program offered, the needs of the offender, or the proximity of the appropriate treatment provider agency, fewer than two such agencies can meet the specific needs of the offender, ensure the safety of the public , and provide the supervising agency with reasonable access to the treatment provider agency and the offender during the course of treatment (Section 16-11.7-105(2), C.R.S).

Discussion: A treatment provider has the right not to accept a referral based on the provider's determination that he/she cannot meet the needs of the client. For more information, refer to Section 3.000.

5.115 The supervising officer should require sex offenders who are transferred from other states through an Interstate Compact Agreement to participate in offense-specific treatment and specialized conditions of supervision contained in these Standards. For additional information regarding Interstate Compact Agreement rules, refer to the following: http://www.interstatecompact.org/Legal/RulesStepbyStep.aspx

5.120 For offenders who present denial or minimization per 3.500, the supervision officer should use an individualized approach that employs an array of behavioral change and compliance monitoring strategies supported by research. These efforts to monitor compliance should focus on targeting non-sexual criminogenic risk factors and enhancing treatment responsivity. Consideration of sexual risk factors and progression in offense-specific treatment should be appropriately be addressed in consultation with the treatment provider.

[83] The supervising officer should consider the therapeutic alliance and existing protective factors that potentially could be disrupted as a result of moving the offender.

5.125 The supervising officer should report the following to the treatment Provider in a timely manner:

A. Violations of supervision conditions;

B. Change in supervision conditions;

C. Notable achievements, successes and incentives; and

D. Any other significant occurrence(s) in the offender's circumstances (e.g. arrest, health issues, employment status).

5.130 The supervising officer should employ principles designed to encourage and reinforce pro-social and positive behaviors and that minimize anti-social behavior. The supervising officer should respond to violations commensurate with the seriousness of the behavior, especially if the risk that the offender may commit another crime has increased. Where appropriate, the supervising officer should consult with the CST using risk to re-offend as a key factor in determining the appropriate level of response. Responses should be tailored to address the individual's unique risk, needs and responsivity factors in a coordinated manner whenever possible. The CST should also consider the following when responding to violation behaviors:

A. Victim and Community safety;

B. Using risk assessments that produce consistent results to inform decision making;

C. Responding to behaviors as quickly as possible;

D. Addressing every violation;

E. Informing offenders how responses to violations are determined; and

F. Avoiding overly restrictive sanctions that unnecessarily interfere with healthy behaviors and protective factors.

5.135 The supervising officer should review the treatment provider's monthly written updates on the sex offender's status and progress in treatment.

5.140 The supervising officer should be aware of the offender's treatment progress, and periodically discuss and review with the offender any treatment issues that may arise.

5.145 The supervising officer should assess and periodically review the level of supervision.

5.150 The decision to recommend early discharge from supervision should be unanimous recommendation by all members of the CST. Sex offenders serving an indeterminate probation or parole sentence must serve the minimum of their sentence in accordance with §18-1.3-1004 C.R.S, and meet the criteria for reduction in supervision, found in the *Lifetime Criteria for Reduction in Level of Supervision while on Probation and Discharge from Probation* in the these *Standards and Guidelines.*

5.155 After consultation with the CST, the supervising officer may request an extension of supervision to allow an offender to successfully complete treatment if the treatment provider agrees it would be necessary and if it is statutorily permissible.

5.160 The CST should consider the offender's risk factors and protective factors as well as risk to the community before progressing or regressing an offender. The supervising officer in consultation with The CST should individualize incentives and sanctions to deliver consistent and tailored responses to each person's behavior with the goal of impacting short and long term behavior change. To maximize effectiveness, responses should be swift, certain, proportional, consistent and linked to specific risk, needs and significance of the behavior.

Discussion: Responses to violations by Community Supervision Teams should be swift, certain, proportional, consistent and tailored to the offender's risk, needs, and the significance of the behavior.[84] *These responses should be individualized to encourage behavior change with a unified approach and focus on victim protection and community safety.*

5.165 The supervising officer, in consultation with the CST, should not allow a sex offender who has been unsuccessfully terminated from treatment to re-enter a treatment program unless the treatment plan addresses the specific risk, need, and responsivity factors that led to the unsuccessful discharge from treatment.

5.170 If an offender successfully completes treatment and subsequently begins to demonstrate a partial or poor understanding of sexual offense risk factors and risk management strategies or consistently uses ineffective risk management strategies with several lapses; the supervising officer may refer the offender for an updated assessment. The assessment may include a sex offense-specific evaluation, to determine whether there is a need to return the offender to treatment.

Discussion: Because risk is dynamic, the CST should collaborate as to the level and duration of any change in the phase or level of supervision and treatment. The CST should defer to the expertise of individuals within their professional roles. The CST may utilize an updated sex offense-specific evaluation and should rely on current risk assessment to inform decision making.

Discussion: Just as an offender can progress through the modules and phases of treatment and supervision, an offender may be regressed through proper legal procedures, to a previous phase of supervision, treatment module or treatment program as determined by negative behavior or high risk behavior. Such negative or high risk behavior may include, but is not limited to, drug or alcohol use, failure to comply with treatment requirements, a significant negative change in residence or living situation, not maintaining a steady job or lack of stable employment, initiating contact with the victim, evidence of arousal to inappropriate stimuli or violating any of the terms and conditions of supervision.

5.175 Supervising officers who are assigned to supervise sex offenders should successfully complete training programs prior to assuming their caseload when possible. Officers should attend annual continuing education specific to sex offender supervision and treatment issues. The amount of appropriate training should be determined to by each agency. The training topics should include specific components of the TEAMS model such as evaluation and assessment, treatment,

[84] Wodahl, E. J., Ogle, R., Kadleck, C., & Gerow, K. (2013). Offender perceptions of graduated sanctions. *Crime & Delinquency, 59(8),* 1185-1210.

community supervision, risk, need, responsivity issues, victim impact and safety, and the role of offender support systems. It is also desirable for agency supervisors of officers managing sex offenders to be specifically trained in these areas.

Discussion: Supervising Officers are encouraged to periodically attend group or individual treatment sessions as determined appropriate, in coordination with the treatment provider. The visiting supervising officer shall be bound by the same confidentiality rules as the treatment provider and should sign a statement to that effect. It is understood that the treatment team may set reasonable limits on the number and timing of visits in order to minimize any disruption to the group process. The successful completion of the above training is necessary prior to the supervising officer attending any individual or group treatment sessions of sex offenders under his/her supervision.

5.200 ♦ Responsibilities of the Treatment Provider within the Team

5.205 A treatment provider shall:

A. Work collaboratively with the supervising officer of each offender, the polygraph examiner, and with other relevant professionals.

B. Immediately report to the supervising officer any significant occurrence(s) in the offender's circumstances and all violations of the provider/client contract, including those related to specific conditions of probation, parole, or community corrections.

C. A provider shall immediately report to the supervising officer evidence or likelihood of an offender's increased risk of re-offending.

D. A provider shall report to the supervising officer any reduction in frequency 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 CST.

E. Provide to the supervising officer on a monthly basis progress reports documenting an offender's attendance, financial status in treatment, participation in treatment, change in risk factors, changes in the treatment plan, and treatment progress.

F. Provide the following information regarding the offender's treatment progress pursuant to Colorado State Statute if a revocation of probation or parole, or regression of community corrections is filed by the supervising officer:

- Changes in the treatment plan
- Attendance record
- Treatment activities
- The offender's compliance in treatment
- Treatment recommendations including level
- Offenders' threat to the community
- Any other material relevant to the court at the hearing

G. Be prepared to testify in court if necessary.

H. Coordinate with the (CST) all recommendations regarding child and victim contact in compliance with all pertinent aspects of Section 5.700 of the Standards. When contact with the offender's own child has not been prohibited or restricted, the CST should review whether there are, or should be, options to place parameters or restrictions around the contact when necessary to ensure safety. There may also be instances when new information indicates that such contact is contraindicated due to increased risk of the offender to the child. To restrict or preclude contact, a subsequent Court/Parole Board Order is needed. Therefore, the treatment provider shall communicate such information to the supervising officer. If the CST is in agreement, then such information should be presented to the Court/Parole Board pursuant to local procedures.

I. Require the offender to complete comprehensive safety plans for a variety of activities in the community.

J. The safety plan shall include the following information:

- Activity
- Who is participating in the activity
- Date and time of activity
- Location of activity
- Pertinent risk factors
- Coping skills
- Signatures and date of approval by CST members

5.300 ♦ Responsibilities of the Polygraph Examiner within the Team

A. The examiner shall make the final determination of questions used, and determine whether to administer a broader or more narrowly focused examination within the scope of the requested polygraph exam.

B. The polygraph examiner shall work collaboratively and participate as a member of the CST.

C. The polygraph examiner shall submit written reports to each member of the (CST) for each polygraph exam as required in section 6.160.

D. Participation in CST meetings shall be on an as needed basis.

E. Polygraph examiners should address any questions regarding the technical aspects of the polygraph to the CST if needed.

5.400 ♦ Responsibilities of the Victim Representative within the Team

As a member of the CST, the primary responsibility of the victim representative is to provide an avenue for victims and their families to be informed and heard. Involving a victim representative on the CST has many benefits, including improving supervision of the offender, increasing offender accountability, building empathy for the victim, decreasing offender secrecy, preventing an unbalanced alignment with the offender, and contribute to a safer community. The exchange of information between the victim or the victim representative and CST is crucial for the rehabilitation of the offender and is often beneficial for the healing of the victim.

The victim may choose not to provide or receive information. In that circumstance, the victim representative will contribute general input regarding the perspective of victim(s) to the CST. The victim representative should also provide general victim input in cases such as internet crimes when the intended victim is a law enforcement officer posing as a child or in cases where victims are unidentified in child sexual abuse images. Bringing the victim perspective is important in protecting potential victims and the community.

Upon convening, the CST should identify the best person to be the victim representative for each individual case, such as the victim therapist, a victim advocate, or other (refer to Resources for Victim Representation). Due to the importance of victim contribution to the CST for the reasons stated above, the victim representative should make reasonable attempts to contact the victim(s) in order to determine the victim's desired level of involvement and provide the victim(s) with accurate information regarding offender treatment and management. The CST shall orient the victim representative to the function of the team and the representative's role as a CST member.

5.405 Victim Representative shall:

A. Assure that the CST is operating with a victim centered approach (see Section 8.000: Victim Impact and a Victim Centered Approach);

B. Assure that the CST is emphasizing victim safety, both physically and psychologically, throughout the treatment, supervision and management of the offender;

C. Share information received from the victim and concerns of the victim with the CST when available. Such information could include safety concerns, grooming behaviors, specifics of the offense, and offending behaviors;

D. Convey information to the victim as agreed upon by the CST such as, but not limited to, terms and conditions of probation, general treatment contract, treatment and supervision timelines, offender location, progress in treatment and on supervision, victim clarification and family reunification planning, and any other pertinent information as determined by the CST;

Discussion: Teams should discuss what information can and should be shared, taking into account what information is valuable for the victim, for the victim to feel safe, and for the victim to feel that the community as a whole is protected. Teams have legal and ethical considerations when determining what information is appropriate for sharing with victims and should exercise good professional judgment. Victims are assisted by understanding why decisions are made in the interest of public safety. Even with support systems in place, the criminal justice system is still difficult for victims. Teams can honor and contribute to justice for victims by operating with a victim centered approach.

E. Provide input on how CST decisions may affect victims, secondary victims or potential victims;

F. Assist the CST in ensuring that victim needs and perspectives are considered and responded to by the CST to the best of their ability;

G. Offer support, referrals, and resource information to the victim and victim's family;

H. Participate in CST meetings;

I. Contribute to the treatment content by providing the following types of information to the CST:

1. Impact of sexual offending on victims, secondary victims, and the community;

2. Recognition of harm done to victims;

3. Restitution and reparation to victims and others impacted by the offense including the community;

4. Impact of offender denial on victims; and

5. Input regarding victim contact, clarification and family reunification when appropriate.

J. Submit questions from the victim to the CST for review and share the responses to these questions with the victim or explain why a question may not be answered. The representative can also explain to the victim why certain types of information cannot be shared;

K. Function as a liaison between the victim, or victim therapist, and CST as needed;

L. Advocate on behalf of the victim for the non-offending parent and family members to support the victim, prioritize the victim's safety, physical and emotional well-being and address the needs of the victim. This parental and family support is critical for the healing of the victim;

M. Assist with planning for victim clarification sessions or family reunification, if appropriate to the case; and

N. Assist with issues related to newly identified victims, when necessary.

5.500 ♦ Role of Family Members and Natural Supports within the Team

The TEAMS Model recognizes that an individual's support system is an important factor in a person's motivation for change. Those who have offended are more likely to achieve success when they receive caring support from families[85] and other natural support systems (e.g. – friends, Circles of Support and Accountability, spiritual advisors, etc.) and the community. Such support encourages an individual's engagement in treatment, efforts to live a healthy and productive life, and success in meeting supervision requirements.[86]

CSTs should recognize that family members may possess important history, and should welcome information that can be valuable in the treatment and supervision of a person who has offended. Engaging an individual's family and friends supports behavioral change and enhances the safety of those who have been victimized and the community. When support system members understand and are supportive of

[85] The term "family" is used in a broad sense and should be defined by the person who has offended.

[86] de Vries Robbé, M., Mann, R. E., Maruna, S., & Thornton, D. (2015). An exploration of protective factors supporting desistance from sexual offending. *Sexual abuse: a journal of research and treatment*, *27*(1), 16-33.; Willis, G. M., & Grace, R. C. (2008). The quality of community reintegration planning for child molester's effects on sexual recidivism. *Sexual Abuse: A Journal of Research and Treatment*, *20*(2), 218-240.; Willis, G. M., & Grace, R. C. (2009). Assessment of Community Reintegration Planning for Sex Offenders Poor Planning Predicts Recidivism. *Criminal Justice and Behavior*, *36*(5), 494-512.

treatment and supervision requirements, there can be a positive impact on the person who has been victimized, the community, and the person who has offended.

In situations where family members are providing support both to family members who have been victimized and to those who have offended against them, considerable challenges may arise. Family members should ensure that the support they are providing to the person who has committed the offense does not compromise or negatively impact the safety, physical or emotional well-being, and needs of the person who has been victimized. (For additional information, see Section 8.000: Victim Impact and A Victim Centered Approach).

If members of the support system are not prepared to fulfill this important role, the CST should help educate and guide them about the treatment process. Individuals under the supervision of the CST should be encouraged to include members of their support system in the change process. In some instances, it may be necessary for the CST to help the person who has offended to recognize that until potential support members address their own needs, they may not be capable or appropriate, at that point in time, to provide positive support.

In the event the CST has exhausted their efforts in providing education or guidance to the support system, and certain members of the support system have demonstrated over time that they are unable to provide positive support, the CST can temporarily choose to discontinue or limit the support system's involvement. The CST should continue to assess/work with the support system so that it can provide positive prosocial support in the future.

The CST should involve families and friends who support behavioral change which will enhance the safety of those who have been victimized and the community, as well as help the person who has offended to live a safe and prosocial life. As CST's accept and engage natural support systems within the treatment and supervision process, it is important to recognize that support offered by family members and friends falls along a continuum of involvement. This involvement can range from provision of basic needs and expression of care and concern to direct engagement in treatment and supervision processes. All types of healthy support should be welcomed by CSTs. Examples of such support include but are not limited to:

A. Assisting with basic needs such as housing, transportation and finances;

B. Providing positive social support, healthy social interaction, encouragement, and role modeling;

C. Participating in individual or family therapy sessions as agreed upon by the offender and treatment provider;

D. Participating in supervision meetings as agreed upon by the offender and supervising officer

E. Providing peer support or mentoring to the offender;

F. Becoming an Approved Supervisor (see Section 5.770 – 5.776);

G. Becoming an Approved Community Support Person (see Definitions Section); and

H. Becoming a CDOC Approved Support Person (see CDOC Administrative Regulation 700-19).

5.600 ♦ The Use of Polygraph within the Team

5.605 The polygraph shall be used (see Section 6.xxx on suitability for testing) to gather information to assist the CST in individualizing their approach to the offender's risk and need, and to gauge how the offender will respond to supervision and treatment interventions. The polygraph shall be used in conjunction with other information to inform adjustments to supervision and treatment. The goal is to promote offender honesty and accountability. The polygraph results (see Section 6.000) shall not be used in isolation without considering information gathered from other behavioral monitoring tools. The polygraph shall not be used in isolation to remove protective factors. The CST response to behaviors utilizing the polygraph shall be based on offender risk and needs.

5.610 In instances when the CST has concerns related to an offender's suitability for testing, they shall consult with the polygraph examiner. The determination regarding an offender's suitability for polygraph testing rests with the polygraph examiner.[87] (See Section 6.210 for additional information regarding suitability for polygraph testing.)

5.615 If pursuant to Standard 6.210, the polygraph examiner determines the offender is currently unsuitable for polygraph examination, the requirement for polygraph examination may be waived. This waiver is for the current polygraph only, and is not a permanent waiver. However, if the offender has a condition that is not likely to improve, the CST shall consider granting a waiver for future testing as well. If the CST determines that a waiver is appropriate, this decision, and the reason for the decision, shall be documented by the supervising officer and treatment provider.

5.620 If the CST determines that the polygraph shall be waived, they shall determine what information is being sought and if there are alternate methods which can be utilized to obtain this information. (See Section 6.210). Alternate methods may include the use of GPS or Electronic Monitoring, drug/alcohol testing, plethysmograph testing, viewing time (VT) assessment, and other case management practices such as collateral contacts, office and home visits, employment visits, computer and phone monitoring, and increased supervision and treatment requirements.

5.625 Either the supervising officer or the treatment provider may collaborate with the polygraph examiner to determine content areas for question formulation. However, they shall defer to the polygraph examiner to make the final determination of question formulation, and to determine whether to administer a broader or more narrowly focused examination. (See Section 6.030.)

5.630 The CST shall continually assess the ongoing use of maintenance/monitoring polygraphs, and may adjust the use of maintenance/monitoring polygraphs based on all clinical indicators, including prior polygraph results, of an offender's risk and needs. The polygraph frequency may be increased when risk is elevated and decreased when the offender demonstrates engagement with supervision and treatment, and protective factors are enhanced. This change in risk should be measured by an objective dynamic risk assessment tool. (For additional information on maintenance and monitoring polygraph testing frequency, see Section 6.013.)

Discussion: The following guidelines may be considered by the CST when determining maintenance/monitoring exam frequency: What information is being sought by the polygraph and how will this information inform treatment and supervision? Are there alternate methods which can be utilized to obtain the information being sought? What risk factor(s) is the CST concerned

[87]Polygraph examiners have experience and training specific to suitability of potential examinees. Therefore, the supervising officer and treatment provider should defer to the polygraph examiner's expertise regarding this subject matter.

with and how are these factors connected to the frequency of examinations? In addition, the CST should defer to the polygraph examiner to ensure appropriate testing parameters (e.g., timeframe, subject matter, etc.) suggested by the CST will result in an exam with a high degree of validity and accuracy. (For example, the CST may decrease the frequency of the maintenance exams to 9 months and monitoring exams to 1 year.) Question formulation is a key factor impacting test validity and therefore, should only be completed by the polygraph examiner (see Section 6.022).

5.635 CST decisions and responses shall not be based solely on the results of a polygraph examination. The polygraph results alone (e.g., no deception indicated, deception indicated, and inconclusive/no opinion results), and considered in isolation without additional information or disclosures, are not necessarily supportive of increased risk to re-offend.[88] (See Sections 6.000 and 6.013.)

5.640 Adjustments to treatment/supervision shall be based on risk and need as determined by all forms of clinical indicators including information from pre- and post-test interviews, offender behavior and accountability, transparency and engagement in treatment, dynamic risk assessment, information gained during clinical sessions, information provided by offender family and support systems, information received from victim sources, offender compliance to supervision terms and conditions and treatment contract, and information gained through interaction with the supervising officer.

5.645 The CST shall not make conditional for the offender any increase or decrease in supervision level, or any other consequence, based upon the finding of non-deceptive, inconclusive, or deceptive polygraph results.

5.650 The CST shall discuss information learned from the polygraph examination (including pre- and post-test interviews/admissions) and determine the best course of response. (See 5.630 above).

Discussion point: The CST should reinforce and support offender disclosure prior to a polygraph exam. Openness and honesty can be a new behavior for some offenders and should be identified as a strength in terms of treatment engagement and supervision compliance. The expectation for an offender is to disclose prior to the polygraph exam, and the CST should communicate this to the offender prior to the exam so the offender understands this expectation. Conversely, the CST must also respond to the disclosed supervision and treatment violation behavior with an emphasis on addressing criminogenic needs and target behaviors. The goal is to increase the probability of behavior change through responding to all behaviors. (See Section 5.050 – Promoting and Monitoring Behavioral Change.)

5.655 After consultation with the polygraph examiner, the CST may determine it not to be suitable that a follow-up polygraph examination be based solely on a deceptive or inconclusive polygraph exam. The CST shall determine if they can identify a specific area of concern related to follow-up testing. The CST shall consider if there are alternate methods to obtain the information being sought. When alternate methods exist to obtain the needed information, the CST shall use those methods when available. If it is determined that a follow-up test is required, the CST has discretion to refer the offender to a different polygraph examiner for follow-up testing. When a different polygraph examiner is used for follow-up testing, the new examiner shall be given a copy of the prior examination. In addition, the new examiner

[88] Grubin, D. (2008). The case for polygraph testing of sex offenders. *Legal and Criminological Psychology, 13,* 117-189.

may speak with the original examiner, if necessary. (See Section 9.000 for requirements related to information sharing.)

Discussion: *Providing copies of the prior polygraph exam report and speaking with the prior polygraph examiner, if needed, will allow any necessary information to be supplied to the new examiner by the original examiner in order to complete an accurate and thorough re-examination.*

5.660 If the supervising officer receives information that an offender is not in compliance with supervision following completion of treatment or while the offender is in aftercare, the supervising officer should determine the appropriate methods of discovering the information. The supervising officer should also consider the individual risk and protective factors of the offender, and the nature of the information being sought. If it is determined that a polygraph exam is the most appropriate way to verify compliance, the supervising officer should consult with the polygraph examiner prior to the polygraph exam. The polygraph examiner will then determine which type of test should be conducted to assist in obtaining the information sought.

Discussion: When it is determined that a polygraph is required in these circumstances, the frequency of testing must follow the guidelines and timeframes specified in Section 6.013 (i.e., questions asked on maintenance exams should cover the previous nine (9) months and monitoring exams the previous year).

5.665 Once an offender has successfully completed treatment, the supervising officer will have the discretion to determine the frequency of polygraph examinations. If the offender remains compliant with supervision conditions, the supervising officer may remove any requirement for polygraph testing.

Discussion: Discretion to determine the frequency of testing does not imply that frequency of polygraph testing can be increased beyond the recommendations in Section 6.013. The ability to no longer require polygraph examination is for offenders who have successfully completed treatment and are compliant with supervision. If there is evidence of non-compliance or the offender has demonstrated an increased risk to re-offend, then the supervising officer may determine that a polygraph is needed. The supervising officer should consult with the polygraph examiner to determine the appropriate timeframes for testing with the intention of maintaining consistent fidelity for polygraph testing (See Section 6.000).

5.700
CONTACT WITH VICTIMS, CHILDREN AND AT RISK ADULTS

5.700 ♦ Sex Offenders' Contact with Victims, Minor Children, and At Risk Adults

Contact is restricted until more is known about an offender's risk for recidivism. Even when an offense-specific evaluation and Child Contact Assessment (CCA) have been completed, accurate risk prediction is limited. The offense for which the offender was charged and convicted is not the only indicator of risk to offend against minor children.[89] Additional information may be discovered at any time and should be incorporated into assessments and team decisions regarding offender management. An important aspect of ongoing risk assessment is measuring an offender's ability to comply with the requirements of treatment and supervision.[90]

A growing body of research indicates most sex offenders supervised by the criminal justice system have more extensive sex offending histories, including multiple victim and offense types, than is generally identified in their criminal justice records.[91] Some of this research has been conducted with convicted sex offenders in Colorado.[92] Minor children are particularly vulnerable and unlikely to report abuse. Research suggests that adult and minor child victims are also unlikely to report or re-report abuse.[93]

Research indicates that sex offenders often engage in physical and sexual abuse of their intimate partners.[94] It is critical that the CST investigate and assess a sex offender's history of physical and sexual abuse and stalking behaviors of partners and/or family members. It is also critical to assess for the potential of violence in the offender's current relationship. Domestic violence is difficult to detect and it is incumbent upon the CST to rule out its occurrence prior to allowing any contact with minors or approving of an Approved Supervisor as it is unlikely a victim of domestic violence would report issues of concern to the CST.

This section addresses the restrictions and methods to approve supervised contact with minor children, victims, and at risk adults (pursuant to 5.740 – 5.757). Before an offender can have contact with any minor child(ren), he/she must meet the criteria stated in 5.740. This criteria is not applicable when a Court/Parole Board Order does not prohibit or restrict such contact between an offender and his/her own child(ren). In the absence of a Court/Parole Board Order not prohibiting such contact, an offender must meet the criteria in 5.740 or submit to a CCA to determine if the contact is appropriate. An offender who has ever victimized any of his/her own

[89] Knopp, F.H. (1984); Freeman-Longo, R., Blanchard, G. (1998); Ahlmeyer, S., Heil, P., McKee, B., and English, K. (2000); English, K. (1998); Heil, P., Ahlmeyer, S., Simons, D. (2003); Ahlmeyer, S. (1999); Becker, J., and Coleman, E. (1987); Abel, G., Rouleau, J. (1990); Office of Research and Statistics, Division of Criminal Justice, Colorado Department of Public Safety (2000); Tanner, J. (1999); Hanson, R., Harris, A. (1998); Hindman, J. (1989).

[90] Hanson, R.K., Harris, A. (1998).

[91] Knopp, F.H. (1984); Freeman-Longo, R., Blanchard, G. (1998); Ahlmeyer, S., Heil, P., McKee, B., and English, K. (2000); English, K. (1998); Heil, P., Ahlmeyer, S., Simons, D. (2003); Ahlmeyer, S. (1999); Becker, J., and Coleman, E. (1987); Abel, G., Rouleau, J. (1990); Office of Research and Statistics, Division of Criminal Justice, Colorado Department of Public Safety (2000); Weinrott, M. & Saylor, M. (1991).

[92] Heil, P. & Simons, D. (2008). Multiple paraphilias: Prevalence, etiology, assessment and treatment. In R. Laws & Donohue, W. (Eds). *Sexual deviance* (2nd ed.). New York,: Guilford Publications, Inc.; Heil, P., Simons, D., & Burton, D. (2010). Using the polygraph with female sexual offenders. In T. Gannon & F. Cortoni (Eds), *Female sexual offenders: Theory, assessment, and treatment*. Chichester, UK: John Wiley & Sons, Ltd.

[93] Marshall, W. (1998) ; Hanson, R.F., et al. (1999); (1992). *Rape in America: A Report to the Nation*; Underwood, R., Patch, P., Cappelletty, G., Wolfe, R. (1999); Hindman, J. (1989); Colorado Coalition Against Sexual Assault (1998); Cardarelli, A. (1998).

[94] Simons, D. A., & Davies, A. M. (2009, October). Intimate partner rape: Prevalence and characteristics among domestic violence and sexual offenders. Paper presented at the 28th Annual Association for the Treatment of Sexual Abusers Research and Treatment Conference in Dallas, TX.

minor children, regardless of the victim's age, is ineligible for the CCA. The CCA will result in a recommendation regarding the level and type of contact, if any, with the offender's own child(ren). The CST shall utilize the CCA to inform decisions regarding contact with an offender's own child(ren). Standards 5.750 and 5.756 address criteria for contact with victims and at risk adults.

There may be instances when a Court/Parole Board has not prohibited or restricted contact between an offender and his/her own child(ren), prior to meeting criteria for contact pursuant to these Standards. When contact with the offender's own child has not been prohibited or restricted, the CST should review whether there are, or should be, options to place parameters or restrictions around the contact when necessary to ensure safety. There may also be instances when new information indicates that such contact is contraindicated due to increased risk of the offender to the child. To restrict or preclude contact, a Court/Parole Board Order is needed. Therefore, the treatment provider shall communicate such information to the supervising officer. If the CST is in agreement, then such information should be presented to the Court/Parole Board pursuant to local procedures.

Offenders residing in a SLA shall not have contact with their child(ren) at the SLA location or with their SLA roommate present.

5.710 Definitions

- **Own Minor Child** is a minor child with whom the offender has a parental role, including but not limited to, biological, adoptive, and step-child(ren).

- **Approved Supervisor** is a person who can supervise the offender's contact with a specified minor child or children per 5.770. This person is an individual who has met the criteria described in 5.771-5.775, has been approved by the CST, and has signed the contract.

- **Approved Community Support Person** provides positive support for change efforts and may accompany the offender in approved activities that do not involve minor children. Someone significant to the offender and/or a roommate who attends treatment with the offender, has a positive relationship with the supervising officer and treatment provider, and is well versed in and supportive of the offender's supervision and treatment requirements.[95]

- **At Risk Adult** is an individual who is less able to protect him/her self-based on diminished capacity or position of trust pursuant to Section 18-6.5-102, C.R.S.

5.720 No Contact with Minor Children

Sex offenders shall have no contact with any minor child under the age of 18 or any victim until the CST unanimously agrees that the offender has either met:

A. The corresponding criteria listed in Standard 5.740; or

B. A Court/Parole Board has not prohibited or restricted contact between an offender and his/her own child(ren); or

[95] Colorado Department of Public Safety, Division of Criminal Justice, (2004). *Report on safety issues raised by living arrangements for and location of sex offenders in the community*.

C. The CST agrees based on the recommendation from a CCA, if eligible (see Standard 5.730).

Additionally, in order for contact to occur, the CST shall ensure the offender does not meet any of the Exclusionary Criteria listed in Standard 5.725 or Disqualifiers for CCA in Standard 5.732.

Discussion: There may be situations where the CST deems it appropriate for young adult offenders, ages 18 to 20, per 5.110 (E), to have contact with teenage siblings or peers that are close in age when there is not a significant power differential or when it does not pose an undue risk.

Discussion: The SOMB recognizes the significance of the relationship between a parent and his/her minor child and the risk that a sex offender can pose to his/her own minor children. When contact is prohibited with the offender's immediate family members that are under the age of 18, treatment providers should consider the impact on the minor children and facilitate resolution of the separation per Appendix B as appropriate.

5.721 Contact is intended to refer to any form of interaction including:

A. Physical contact, face to face, or any verbal or non-verbal contact;

B. Being in a residence with a minor child or victim;

C. Being in a vehicle with a minor child or victim;

D. Visitation of any kind;

E. Correspondence including written, electronic, telephone contact, messages left on a voice mail or answering machine, text messaging, computer communication, Twitter, Facebook and other social networking sites, gifts, or communication through third parties;

F. Entering the premises, traveling past or loitering near any of the offender's victims' residences, schools, day cares, or places of employment;

G. Going to or loitering near places used primarily by minor children, as defined by the CST; and

H. Giving birth or attending the birth of a child.

5.722 When contact is being considered based on the CCA or the offender's achievement of the criteria in 5.740, the treatment provider, in conjunction with the CST, shall:

A. Ensure that contact does not conflict with any existing court order or parole board directives;

B. Consider the child's best interest;

C. Ensure consultation with, and, consider the views of the custodial parent or guardians of the minor child prior to authorizing contact. If the minor child has a therapist, he/she shall be consulted;

D. Arrange contact in a manner that places the child's safety first. When assessing safety, both psychological and physical well-being shall be considered;

E. Ensure all contact occurs in the presence of an Approved Supervisor, (see Standard 5.770) or professional member of the CST;

F. Specify what is approved for the offender with each child. Contact possibilities occur on a continuum including written, telephone, and in-person and from non-physical to physical;

G. Closely supervise or monitor the contact process, including requiring that any concerns or rule violations be reported to the CST; and

H. Ensure the ongoing assessment of the child's emotional and physical safety and immediate termination of contact if any aspect of safety is in jeopardy.

Discussion: In the event of a pregnancy the CST may consider parent-minor child attachment and bonding when making a decision about minor child contact.

5.723 In **rare** instances, the supervising agency may be required to request treatment while allowing minor child contact based on a court order in conflict with the Standards. It is important to recognize that treatment under unsafe conditions is not beneficial to the offender or others in the treatment program and undermines treatment program integrity.[96] While the Court has authority and discretion in sentencing matters, the treatment provider is an independent entity who is responsible to maintain best clinical practices in compliance with the Standards.

5.724 Treatment providers shall refuse to accept or continue to treat offenders who do not agree to comply with the requirements in the *Standards and Guidelines* regarding restricted contact with minor children or victims. The supervising agency should be informed in writing of the reasons for the refusal and of the possible risk to the involved minor children or victims. This Standard does not apply to an offender's contact with his/her own child(ren) based on a Court/Parole Board Order not prohibiting or restricting such contact.

5.725 Exclusionary Criteria for Any Form of Minor Child Contact

Due to extreme risk, when any of the following exclusionary criteria are present, the offender is not eligible for a CCA and the CST shall ensure that the offender is **NEVER** considered for any type of contact with minor children. There may be instances when a Court/Parole Board has not prohibited or restricted contact between an offender and his own child and new information indicates that such contact is contraindicated due to increased risk of the offender to the child. In addition, concerns may also exist related to the effective treatment of the offender within the context of a Court/Parole Board Order allowing contact when one or more of the exclusionary criteria are diagnosed. In such cases, a Court/Parole Board Order is needed to preclude such contact. Therefore, the treatment provider shall communicate such information to the supervising officer. If the CST is in agreement, then such information should be presented to the Court/Parole Board pursuant to local procedures.

A clinical diagnosis by an approved evaluator or treatment provider of:

A. Pedophilia – Exclusive type per the most current version of the Diagnostic and Statistical Manual of Mental Disorders (DSM); **OR**

[96] Quinsey, V.L., Harris, G.T., Rice, M.E., Cormier, C.A. (1998).

B. Psychopathy **or** Mental Abnormality per the Psychopathy Check List Revised (PCL-R) or per the (Millon Clinical Multi-phasic Inventory) MCMI III (85 or more on each of the following scales: Narcissistic, Antisocial and Paranoid); **OR**

C. Sexual sadism, a defined in the most current version of the DSM and/or via any standardized sadism assessment instrument.

Discussion: When there is a diagnosis of pedophilia or a diagnosis of a history of pedophilia, the evaluator should refer to the current version of the DSM to ensure that the diagnosis is accurate prior to excluding the offender from a CCA.

5.726 Contact with minor children shall be in the presence of a trained, Approved Supervisor unless contact is not prohibited or restricted based on a Court/Parole Board Order regarding an offender's own child. Additional exceptions include offenders who have met the criteria for unsupervised contact with their own minor child(ren) (Refer to Standards 5.760 and 5.761) or via decisions by the CST following a CCA.

Discussion: CST members should not abdicate any part of their authority or responsibility regarding an offender to an Approved Supervisor. CSTs should evaluate and assess the performance of the Approved Supervisor on an ongoing basis and revoke Approved Supervisor status if necessary.

5.730 Child Contact Assessment (CCA with own minor child)

When the following circumstances exist, a CCA may be initiated to assess the appropriateness of an offender's contact with his/her own minor child (see definition in 5.710):

A. The offender does not meet any of the exclusionary criteria in 5.725 or disqualifiers in 5.732;

B. The offender does not have two or more pre-screen factors in 5.753;

C. The offender wants contact with his/her own minor child as defined in 5.710, under the age of eighteen (18); and

D. The offender does not have a history of victimizing any of his own minor child(ren), regardless of the victim's age, as substantiated by criminal or civil court history or by self-report.

When a CCA is being conducted it may occur after a plea has been entered, after conviction, during incarceration, or upon acceptance of an Interstate Compact case, and shall be completed by an SOMB approved evaluator who has been approved to conduct CCAs. Contact with an offender's minor child(ren) shall be prohibited prior to, and during, the offense-specific evaluation unless such contact is not prohibited or restricted by the Court/Parole Board. In the instance when a pre-plea CCA is conducted, the CST should determine if it is adequate and current to inform the CST's decision regarding minor child contact, and meets the requirements of the Standards. A recommendation regarding an offender's appropriateness for contact with his/her own minor children cannot be made until a CCA has been completed and a CST has been convened. If the offender qualifies for a CCA after the pre-screen is completed, the evaluator shall complete all components of the CCA as indicated in 5.734. The completed CCA shall contain recommendations for the level and type of contact, if any. Contact is ultimately determined by the CST, unless contact is currently not prohibited or restricted by the Court/Parole

Board. It is important to acknowledge that risk levels can change and that the plan must be continually assessed and revised as necessary throughout the period of criminal justice supervision.

If the CCA does not occur during the offense-specific evaluation, it may be completed at a later time; however, the offender should not have contact with his/her own minor children, unless a Court/Parole Board Order does not prohibit or restrict such contact, until the CCA has been completed **or** the offender has met the criteria in 5.740.

Discussion: Though offenders often desire to undergo a CCA as soon as possible, the SOMB recognizes that the accuracy of assessing an offender's appropriateness for contact with his/her minor child(ren) increases with the duration that an offender is involved in treatment and supervision.

Discussion: The SOMB recognizes that in cases involving DHS, where a criminal case has not been filed, it may be useful to conduct an evaluation similar to a CCA in conjunction with an offense-specific evaluation in order to make informed decisions regarding minor child contact. This standard is not intended to preclude that from occurring.

Discussion: Ideally, the sex offender should not have contact with his/her own minor children until a CCA is completed and finds contact is appropriate. However, if a Court/Parole Board has allowed contact absent the completion of a CCA, it should not preclude a CCA from being completed.

5.731 Evaluators conducting CCAs shall:

A. Be a current SOMB approved evaluator (see Section 4.500, 4.600);

B. Have CCA specific training;

C. Submit sample reports for review to the ARC (Application Review Committee) as required on the SOMB application;

D. Ensure that subjects sign appropriate release of information forms to allow the mandatory scoring protocol to be sent to the Division of Criminal Justice DCJ/SOMB for validation and research purposes; and

E. Send all CCA scoring forms conducted on completed CCAs to DCJ/SOMB.

5.732 Disqualifiers for CCA:

A. Pedophilia – Non-Exclusive Type (per current version of the DSM); or

B. SVP – Per finding in Colorado court, parole board, or via equivalency pursuant to C.R.S.

If an offender is disqualified from undergoing the CCA evaluation, he/she **must** meet 5.740 criteria to be approved for minor child contact, unless such contact is not prohibited or restricted by the Court/Parole Board regarding an offender's own child.

5.733 CCA Pre-Screen

CCA Pre-Screen Chart (If no Exclusionary criteria)	
PRE-SCREEN FACTORS If *2 or more factors* indicated, ineligible for CCA and must meet criteria in 5.740 to have minor child contact	**PRE-SCREEN DATA SOURCES** Evaluation Procedures or Documentation
Adult[97] history of illegal sexual behavior with child(ren) age 12 or younger[98]	Self-report[99] Criminal history Substantiated civil court history
Three or more unlawful sexual behaviors	Self-report Collateral Criminal history (conviction, factual basis, or plea agreement) Substantiated civil court history
Sexual interest or arousal to prepubescent children	Valid baseline or initial PPG or VT[100] Self-report Criminal history of child pornography[101]
Unresolved CCA polygraph*	CCA polygraph
Level III denial	SOMB Standards, section 3.510[102]

* For offenders who refuse to answer incriminating sexual offense history questions, including incriminating sexual offense history polygraph questions, providers shall refer to Standard 3.160 I. 2 to determine how to respond.

5.734 – CCA Instrument

CHILD CONTACT ASSESSMENT		
Required Areas of Evaluation	**Risk Factors**	**Evaluation Procedures Key:** • **Required** ○ **Optional**
Interpersonal Relatedness		
Offender's Attachment Style	Insecure Attachment, specifically Disorganized	• History of Relationship Attachment • Clinical Interviews

[97] Adult is defined as 18 years old or older

[98] The age of 12 or younger is based on the distinction between pubescent and pre-pubescent development stages. There is disagreement in the current research regarding the onset of puberty, and the SOMB recognizes the limitations of defining the criteria based on a specific age.

[99] Admission made during polygraph assessments are considered self-report

[100] Tests that are inconclusive or show no response (flat line) are not valid and must be repeated or tested with the other procedures

[101] Conviction or documentation of history of seeking child pornography

[102] If one other factor is present, a complete CCA polygraph must be completed. A CCA polygraph is not necessary if 2 or more prescreen factors are present. If no other factors are present, the CCA polygraph can be delayed until the full CCA assessment.

CHILD CONTACT ASSESSMENT

Required Areas of Evaluation	Risk Factors	Evaluation Procedures Key: • **Required** o **Optional**
	or Unclassified and Anxious	• Collateral Sources o Instruments: o The Attachment Style Questionnaire (ASQ: Feeney, Nollar & Hanrahan, 1994) o Batholomew Attachment Inventory o Adult Attachment Interview(George, C., Kaplan, N., & Main) o The Adult Attachment Projective (AAP: George) o Hazan & Shaver Adult Adult Attachment Scale
Offender's Empathy	Lack of empathy for minor children in abusive situations	• History of Empathy with Minor Children • Clinical Interviews • Collateral Sources o Instruments: o Hansons' Empathy for Children Test o Empat (McGrath, Cann, & Konopasky, 1998)
Offender's Ability for Family Stability	History of relationship -instability and prior absences from the home Childhood history of: -witnessing sexual abuse -witnessing domestic violence -sexual abuse victimization Any history of domestic violence (DV): -use and/or threatened use of weapons in current or past offense or access to firearms[103] - Obsession with the victim (i.e. stalking or monitoring, obsessive	• Relationship History • Clinical Interviews including adult relationships and family of origin (parental models, family environment, stability, abuse, adult relationships) • Collateral Sources • Substantiated civil court history • DV restraining orders • DV arrests/criminal history If history of arrests or restraining orders, **<u>minimum of one of the following</u>** instruments specific to DV[110]: o VRAG o DVRAG o SARA o DVRNA

[103] Kropp, R.P. & Hart, S.D. (2008). *Manual for the spousal assault risk assessment guide* (2nd ed.). Vancouver, BC: ProActive Resolutions, Inc.

CHILD CONTACT ASSESSMENT		
Required Areas of Evaluation	**Risk Factors**	**Evaluation Procedures Key:** • **Required** ○ **Optional**
	jealousy)[104] - Victim safety concerns (i.e. offender controls most of victim's daily activities) - Offender tried to strangle - victim - Physical violence increasing in severity - Victim forced to have sex - Victim pregnant at time of offense and offender aware - Victim is pregnant and offender previously abused her during pregnancy[105] - Violence and/or threatened violence toward family members, including child abuse[106] - attitude support/condone DV[107] - Victim initiated separation within past 6 months related to DV[108] - Prior attempted or Completed DV - treated[109]	○ ODARA ○ Or any other instrument(s) standardized for the assessment of violence potential
Offender's Parenting Involvement/Skills	- History of non-payment of child support - No prior access to minor child(ren) in a home	• Parenting history • Clinical Interview • Collateral Sources (e.g., Social Services Records)

[110] Instruments should be used pursuant to relevance to normative population.
[104] Campbell, J.C., Kozial-McLain, J., Webster, D., Block, C.R., Campbell, D., Curry, M.A., Gary, F., McFarlane, J., Sachs, C., Sharps, P., Ulrich, Y., Wilt, S., & Manganello, J. (2004). *Research results from a national study of intimate partner homicide: The Danger Assessment Instrument* (NCJ 199710). Washington, DC: U.S. Department of Justice, National Institute of Justice.
[105] Gazmararian, J.A., Lazorick, S., Spitz, A.M., Ballard, T.J., Saltzman, L.E., & Marks, J.S. (1996). Prevalence of violence against pregnant women. *JAMA*, 275(24), 1915-1920.
[106] Kropp, R.P. & Hart, S.D. (2008). *Manual for the spousal assault risk assessment guide* (2nd ed.). Vancouver, BC: ProActive Resolutions, Inc.
[107] Kropp, R.P. & Hart, S.D. (2008). *Manual for the spousal assault risk assessment guide* (2nd ed.). Vancouver, BC: ProActive Resolutions, Inc.
[108] Campbell, J.C., Kozial-McLain, J., Webster, D., Block, C.R., Campbell, D., Curry, M.A., Gary, F., McFarlane, J., Sachs, C., Sharps, P., Ulrich, Y., Wilt, S., & Manganello, J. (2004). *Research results from a national study of intimate partner homicide: The Danger Assessment Instrument* (NCJ 199710). Washington, DC: U.S. Department of Justice, National Institute of Justice.
[109] Stalans, L.J. et al. (2004). Identifying three types of violent offenders and predicting violent recidivism while on probation: A classification tree analysis. *Law and Human Behavior*, 28(3), 253-271.

CHILD CONTACT ASSESSMENT

Required Areas of Evaluation	Risk Factors	Evaluation Procedures Key: • **Required** ○ **Optional**
	environment[111] - Poor parenting ability and disciplinary practices - Minimal knowledge of child(ren)'s life - Minimal knowledge of parenting Skills - Any history of social services involvement - Minimal knowledge of child(ren)'s developmental stages & needs - Poor parental boundaries - History and risk of child abuse & neglect	If history of abuse, **MUST** conduct one of the following: ○ Child Abuse Potential Inventory (Milner, 1986) ○ SIPA (Stress Index for Parents of Adolescents) ○ ASPECT (Ackerman-Schoendorf Scales for Parent Evaluation of Custody)
Offender Stability		
Offender's General Stability	- History of poor compliance with supervision & treatment - History of supervision & treatment[112] - History of unstable employment - History of frequent moves[113] - History of financial instability[114] - Substance abuse history[115] - Poor spousal conflict resolution skills	• History of General Stability • Clinical Interview • Collateral Sources • Criminal History Instruments: ○ LSI-R (Level of Service Inventory-Revised) ○ PSI Report ○ DVRAG
Offender's Non-Sexual Criminal Risk Risk for Future Criminal	Past behavior from criminal record	• History of Criminal Behavior • Clinical Interview • Collateral Sources

[111] If the offender has not lived with children, an absence of problematic parenting should be considered unknown risk rather than lack of risk.

[112] If the offender has no prior history of supervision and treatment, an absence of noncompliance should be considered unknown risk rather than lack of risk.

[113] Division of Criminal Justice Office of Research and Statistics, Colorado Department of Public Safety. (2010). Handbook: Sexually Violent Predator Assessment Screening Instrument. Retrieved from: http://dcj.state.co.us/ors/pdf/docs/Risk%20Assessment/merged%20SVP%20handbook.pdf

[114] Contact Probation Collections Investigator to obtain bankruptcy or low credit score information

[115] Within the last 6 months

CHILD CONTACT ASSESSMENT

Required Areas of Evaluation	**Risk Factors**	**Evaluation Procedures Key:** • **Required** ○ **Optional**
Behavior		○ Instruments: ○ LSI-R (Level of Service Inventory-Revised)
Offender's Mental/Emotional Health	- History of mental health - diagnosis - Personality disorder - Poor compliance with - medication - recommendations - Other mental health - concerns	• History of Mental/Emotional Health • Clinical Interview • Collateral Sources • Instrument/Assessment/Source (**Minimum of one below must be conducted**): ○ MMPI 2 ○ MCMI III ○ PAI ○ DSM IV TR Diagnosis from Clinical Interview
Sexual Risk		
Offender's Arousal to/Sexual Interest in Minor Child(ren)	- Arousal to or interest in minor child(ren) or animals or sadism	• History of Deviant Arousal or Interest ○ Clinical Interview ○ Collateral Sources • Instruments (**Minimum of one below must be conducted**): ○ VT ○ Plethysmograph
Offender's Historical Sexual Behaviors	Review of index offense - Assess, sexual compulsivity, particularly: - Affairs - Extent of pornography use - Early onset of sex with peers Paraphilias, particularly: - Coprophilia - Indecent Exposure - Voyeurism - Transvestism - Frottage Any history of sexual contact with animals Any history of sadistic behavior/fantasy	• History of Sexual Offense Risk Behaviors • Clinical Interview including Offense-specific Evaluation • Collateral Sources/ official records • Self-report • Instruments: • CCA Polygraph • Risk Assessment, pursuant to Standard 2.060

CHILD CONTACT ASSESSMENT		
Required Areas of Evaluation	**Risk Factors**	**Evaluation Procedures Key:** • **Required** ○ **Optional**
	Any history of intimate partner sexual assault	
Offender's Cognitive Distortions	Boundary distortions Distortions regarding: -Sexuality with minor children -Gender roles -Age, sex, and consent -Hostile masculinity	• Beliefs related to age, sex and consent • Clinical Interview • Collateral Sources ○ Instruments: ○ Multiphasic Sexual Inventory ○ Abel Assessment Cognitive Distortion Scale ○ Bumby Cognitive Distortion Scale
Offender's Responsibility and Level of Denial	Significant Denial	• Presence of Denial • Clinical Interview • Collateral Sources • SOMB Managing Sex Offenders in Denial (3.510 of Standards)

5.740 Criteria for Contact with Secondary/Non-Victim Minor Children

These criteria shall be applied in the following circumstances:

A. Contact with any child(ren) under the age of 18, including an offender's own child(ren).

B. When the CST has determined that contact is not allowed based on the results of the CCA.

C. When the CST has determined that contact with an offender's own minor child(ren) is allowed based on the results of the CCA and the offender requests contact with a minor child who is not an offender's own.

Unless a Court/Parole Board Order regarding an offender's own child prohibits this restriction, treatment providers, in conjunction with the CST, shall ensure the offender achieves the following criteria specific to the minor child with whom the offender wants contact:

A. The offender accepts responsibility for the offense related behavior and any significant differences between the offender's statements, the victim's statements and corroborating information about the abuse have been resolved;

B. The offender has yielded non-deceptive results in all required areas of the sexual history disclosure polygraph exam(s). For offenders who refuse to answer incriminating sexual offense history questions, including incriminating sexual offense history polygraph questions, providers shall refer to Standard 3.160 I. 2 to determine how to respond;

C. The offender has yielded non-deceptive results with no new disclosures on the most recent maintenance polygraph. The content of the maintenance polygraph shall have addressed behavior that puts victims/minor children at risk;

D. The offender is not exhibiting any significant risk related behavior(s);

E. The offender consistently demonstrates the use of cognitive and behavioral interventions to interrupt deviant fantasies and behaviors as evidenced by the offender's Plethysmograph or viewing time (VT) results;

F. The offender has disclosed information related to risk and other relevant factors as prescribed by the CST. The CST will make a determination of who should receive this information;

G. The offender consistently demonstrates and has documented an understanding of the factors that led to his/her offending and accepts the possibility of re-offense. The offender has developed a written plan for preventing re-offense to the satisfaction of the CST;

H. The offender consistently demonstrates an understanding of the impact of the abuse on the victim(s) and the victim's family, the offender's family, and the community, as evidenced by behavioral accountability and self-regulation;

I. The offender consistently demonstrates an understanding of and is willing to respect the minor child's verbal, non-verbal, and physical boundaries and need for privacy.

J. The offender consistently demonstrates an understanding of how to safely participate in having contact with minor child(ren);

K. The offender is willing to accept limits or prohibitions on contact as established by the CST with input from the minor child(ren), minor child(ren)'s other parent or guardian, or minor child's therapist and will put the minor child(ren)'s needs first;

L. The offender demonstrates he/she is willing to plan for contact, to develop and utilize an approved safety plan for all contact, to accept supervision during contacts, and to terminate contact when directed by the CST, the Approved Supervisor, or the minor child(ren). The safety plan shall be approved in advance and in writing by the CST and signed by the offender;

M. The offender consistently demonstrates compliance with supervision conditions, accepts the interventions of the CST, and does not demonstrate ongoing hostility toward the criminal justice system;

N. The offender consistently demonstrates satisfactory progress in treatment, including consistent compliance with treatment conditions; and

O. The offender has satisfactorily participated in clarification in order to re-establish a parental relationship when the contact involves a non-victim own minor child (see 5.750 – 5.752).

Discussion: Some offenders have a history of persistent arousal to minors. Although they may be able to meet 5.750 criteria, because of the likelihood that proximity to minor children will trigger or increase this arousal, the CST shall frequently reassess offender's ability to maintain a

reduced level of arousal.[116] *The CST shall reject, deny, or terminate an offender's approval for contact with minors if there is behavior or other evidence to indicate arousal to minors cannot be managed unless a current Court/Parole Board Order does not prohibit such contact regarding an offender's own child. A subsequent Court/Parole Board Order is needed to preclude such contact (see Section 5.725).*

Discussion: Best practice indicates that clarification with the primary victim should occur prior to any contact occurring with the secondary victim(s). However, in situations where the primary victim does not desire clarification/contact, the wishes and best interest of the secondary victim(s) should be considered by the CST with regard to decision making on a case by case basis.

Discussion: When an offender wants to give an item to his/her minor child(ren) or a minor such as a gift, card, picture, etc. it shall be reviewed and approved in advance by the CST.

5.750 Contact, Clarification, or Reunification with Victims

It is crucial for the CST to ensure the greatest caution is used before allowing an offender contact with a known victim. A Child Contact Assessment is prohibited as an avenue for contact with known victims, (see Section 5.732 re: disqualifiers for CCA). The rationale for using the utmost caution in these matters is based on the knowledge that while minor children are among the most vulnerable potential victims, those previously victimized by the offender remain at high risk for re-victimization in a variety of ways. This is due to the fact that the offender has already demonstrated a willingness and ability to engage in offending behavior against them and it is highly unlikely that minor children will re- report abuse. CST members should be aware that research indicates younger minor children and those who know the perpetrator are least likely to report abuse in the first place,[117] and that almost 100% of victims whose offenders were family members indicate they would not report abuse if it recurred due to the devastating consequences they experienced upon their first report.[118] Further, even minor children known to be victims of sexual abuse, based on diagnoses of sexually transmitted diseases, were reluctant to report when questioned by trained investigators.[119] For these reasons, while some victims may express a desire for contact it may not actually be in their best interest. The CST must balance victim wishes with the paramount concern for victim safety. It is also important for the CST to resist pressure from an offender or victim's family regarding decision-making. The decision to allow victim contact shall be based on consideration over a protracted period of time regarding the best interests of the victim with significant input from the victim's therapist, or prior therapist, the offender's achievement of all criteria listed in 5.740; the presence of an Approved Supervisor (see 5.770), and unanimous approval by the CST unless such contact is not prohibited or restricted by the Court/Parole Board regarding an offender's own child.

Refer to Appendix B for best practice/guideline regarding victim or other family member criteria for contact, clarification, and reunification.

5.751 Clarification with the Victim

The victim clarification process is designed to primarily benefit the victim. Through the process the offender acknowledges that the victim has no responsibility for the offender's behavior. The

[116] Davis, G., Williams, L., and Yokley, J. (1996, 1999) *Sex offender treatment and monitoring program at the Colorado Department of Corrections.*
[117] Smith, Letourneau, Saunders, Kilpatrick, Resnick & Best. (2000).
[118] Marshall via ATSA. (1992).
[119] Lawson & Chaffin. (1992).

questions posed to the offender and topics to be addressed must be victim-directed, defined and the goals and purpose of such communication must be clear to all involved. Issues to be addressed include the damage done to the victim, family and/or secondary victim(s).

Clarification is a lengthy process that occurs over time usually beginning with the offender's ability to accurately self-disclose about the offending behavior. Following written work, clarification may then progress to verbal or face-to-face contact. Although victim participation is never required and is sometimes contraindicated, should the process proceed to an actual clarification meeting with the victim, all contact is victim- centered and based on victim needs.

The CST shall incorporate all assessments including polygraph results into their decision-making process regarding victim clarification.

Secondary victims and significant persons in the victim's life may be impacted by sexual offenses. Clarification with others, (i.e. victim's parents, siblings, neighbors) who have been impacted by the offense may be warranted in some cases.

5.752 Victim clarification procedures shall be approved by the CST and specifically include the victim representative. The CST shall use the following criteria:

A. The victim requests clarification and the victim representative/therapist concur that the victim would benefit from clarification.

B. Parents of a minor victim are informed of, and give approval for, the clarification process.

C. The offender evidences empathic regard through consistent behavioral accountability including an improved understanding of: the victim's perspective; the victim's feelings; and the impact of the offender's behavior.

D. The offender shall be required to undergo an event specific polygraph yielding results indicative of truthfulness if his/her description of the offense differs in any significant way from the victim's and any remaining differences between the offender's and the victim's description of the offense behavior are resolved to the satisfaction of the CST. The offender acknowledges the victim's statements without minimizing, blaming, or justifying.

E. The offender is prepared to answer questions and is able to make a clear statement of accountability and give reasons for victim selection to remove guilt and perceived responsibility from the victim.

G. The offender is able to demonstrate the ability to manage abusive or deviant sexual interest/arousal specific to the victim.

H. The offender displays decreased risk by demonstrating progress in all the areas identified in section 3.160 (I), which are supported by polygraph testing. For offenders who refuse to answer incriminating sexual offense history questions, including incriminating sexual offense history polygraph questions, providers shall refer to Standard 3.160 I. 2 to determine how to respond.

I. Sexual impulses are at a manageable level and the offender can utilize cognitive and behavioral interventions to interrupt deviant fantasies as determined by continued assessment.

*Discussion: There may be **rare** occasions when, due to victim de-compensation, limited contact in writing or in a supervised, therapeutic setting in order to reduce victim trauma or symptomatology may be beneficial and appropriate prior to all of the above criteria being met. Extreme caution should be employed to ensure the offender will not cause further harm if this course of action is pursued. It may be that while the victim would benefit from such a session the offender may not be at a point where he/she could safely participate. Additionally, therapeutic sessions under these circumstances must be very limited, (e.g. 1-2 sessions) as this is not meant to circumvent the standard procedure for clarification described above.*

5.753 Contact with victims under age 18

Contact **with a victim** is first initiated through the clarification process, unless such contact is not currently prohibited or restricted by Court/Parole Board Order regarding an offender's own child. In such cases, when clarification is approved by the victim, and it is clinically indicated, the clarification process continues to apply pursuant to these Standards. If contact is prohibited, offenders must meet all criteria listed in section 5.740 prior to being allowed victim contact. Once that criterion has been met, and upon agreement of the CST, the offender may progress to contact outside of a therapeutic setting.

If a Court/Parole Board Order has not prohibited or restricted an offender from having contact with his own child, and that child is a victim of the index offense, the CST should seek input from the victim's therapist or a victim representative regarding such contact. If such contact is contraindicated for the victim or offender, a subsequent Court/Parole Board Order is needed to preclude such contact. If the CST is in agreement, then such information should be presented to the Court/Parole Board pursuant to local procedures.

The CST shall:

A. Ensure all contact occurs in the presence of an Approved Supervisor (see 5.770), or professional member of the CST.

B. Ensure that the wishes of the victim as well as the recommendations of the victim representative support all the contact that occurs. An offender's therapist shall not initiate offender contact with a victim absent professional victim representative support.

C. Support the victim's wishes regarding contact with the offender to the extent that it is consistent with the victim's safety and well-being.

   Discussion: A common dynamic that may occur in families is direct or indirect influence or pressure on the victim to have contact with the offender. A third party professional assessment regarding victim needs may be warranted prior to contact with the offender.

D. Arrange contact in a manner that places victim safety first. When assessing safety, psychological and physical well-being shall be considered.

E. Determine what types of contact are permissible based on offender and victim factors, known risk factors and other considerations. The CST shall consider placing more boundaries and limitations on types of contact with known victims than may be required of the same offender with non-victim minor children. Contact possibilities occur on a continuum including written, telephone, and in-person and from non-physical to physical. The CST shall specify what is approved for the offender with each victim.

F. Closely supervise or monitor the contact process, including requiring that any concerns or rule violations be reported to the CST.

G. Ensure the ongoing assessment of the victim's emotional and physical safety and immediate termination of contact if any aspect of safety is in jeopardy.

5.754 Contact with adults victimized as minors (victim(s) named in present offense)

While the CST cannot control what an adult victim does, the Standards still apply to offender behavior regardless of the victim's age. The offender must meet all relevant criteria listed in section 5.740 prior to contact being approved. When making a determination about offender contact the CST shall ensure that the adult victim's desires, best interests and need for self-determination are adequately represented throughout the decision-making process and as long as contact continues. Factors specific to the offender and his/her relationship to the victim shall also be considered.

When contact is allowed the CST shall also determine what types of contact are permissible based on offender and victim factors, known risk factors and other considerations. Contact possibilities occur on a continuum including written, telephone, and in-person, (therapeutic or otherwise), and from non-physical to physical. The CST shall specify what is approved for the offender with each victim.

Discussion: During the course of supervision and treatment offenders will often disclose additional victims who are now adults with whom they may have an ongoing relationship. The CST should be mindful of allowing offenders to continue or re-establish relationships with known victims. Contact should be considered individually taking into account offender risk, progress in treatment, and victim characteristics.

5.755 Contact with adult victims (victim(s) named in present offense)

The CST must be attentive to the possibility of ongoing enmeshment and abuse of power between an offender and someone whom he/she victimized as an adult as risk is more proximate in these situations. While it is important for the CST to recognize an adult victim's need for self-determination the CST may prohibit the offender from having contact based on concerns for the victim's safety.

While the CST cannot control what an adult victim does, the Standards still apply to offender behavior regardless of the victim's age. The offender must meet all applicable criteria listed in section 5.752 prior to contact being approved. When making a determination about offender contact the CST shall ensure that the adult victim's desires and best interests are adequately represented throughout the decision-making process and as long as contact continues. Factors specific to the offender and his/her relationship to the victim shall also be considered. The CST shall take into account whether the adult in question has been victimized in non-sexual ways by the offender such as domestic violence or stalking.

When contact is allowed the CST shall determine what types of contact are permissible based on offender and victim factors, known risk factors and other considerations. Contact possibilities occur on a continuum including written, telephone, and in-person, (therapeutic or otherwise), and from non-physical to physical. The CST shall specify what type of contact is approved regarding each victim.

5.756 Potential Adult Victims

The SOMB recognizes that it is not possible to limit a sex offender's contact with all adults in the community. However, care should be taken to limit the offender's access to places and groups where he or she has a history of accessing victims (e.g.: bars, clubs, singles groups, senior centers, medical care facilities, campuses, etc.) or where he or she may present a current risk.

It is also imperative that consideration be given to protecting at-risk adults. Treatment providers and other members of CSTs shall not allow sex offenders to have unsupervised contact with adults who are at particular risk for victimization due to mental status, disability, incapacity, domestic violence, sexual offense, or position of trust. Decisions to allow any contact with at-risk adults should be made using the same criteria as for minor child contact (see Standard 5.740).

5.757 Family Reunification

Family Reunification is defined as the offender living in the same residence with his/her minor children.

Family reunification shall not occur for offenders who meet the exclusionary criteria (see Section 5.725) unless a Court/Parole Board Order does not prohibit or restrict contact by the offender with his/her own child(ren). When contact with the offender's own child has not been prohibited or restricted, the CST should review whether there are, or should be, options to place parameters or restrictions around the contact when necessary to ensure safety. There may also be instances when new information indicates that such contact is contraindicated due to increased risk of the offender to the child. To restrict or preclude contact, a subsequent Court/Parole Board Order is needed. Therefore, the treatment provider shall communicate such information to the supervising officer. If the CST is in agreement, then such information should be presented to the Court/Parole Board pursuant to local procedures.

Prior to considering family reunification the offender shall have met the criteria listed in 5.740 and the CST shall unanimously agree that family reunification is appropriate.

For those offenders for whom the 5.740 criteria are waived pursuant to the results of the Child Contact Assessment which includes the polygraph exams, this criteria does not apply unless new information of concern has arisen.

Due to ongoing risk of re-offense, family reunification in cases when the offender has a history of incestuous behavior is rarely indicated.

The CST shall coordinate all efforts toward family reunification with any active child protective agency.

Family reunification shall <u>never</u> take precedence over the safety (physical, sexual, and psychological) of any victim or the offender's own minor children. If reunification is indicated, after careful consideration of the potential risks over an extended period of time, supervising officers and treatment providers shall carefully monitor the process through termination of supervision.

The CST shall ensure that the spouse/partner or primary caregiver is willing and able to fully support all conditions imposed by the CST, which includes active involvement in the offender's

treatment process and any treatment in which the minor child(ren) are involved. The CST shall consider any history of domestic violence when determining whether the spouse/partner or primary caregiver support the conditions necessary for family reunification.

5.760 Unsupervised Contact with Offender's Minor Child(ren) Under Age 18

Offenders being considered for unsupervised contact with their minor child(ren) shall:

A. Not meet any of the Exclusionary Criteria as referenced earlier in Standard 5.725; and

B. Have met and demonstrated compliance with all criteria in Standard 5.740 without evidence of increased arousal or sexual acting out, as verified by the two most recent maintenance/monitoring polygraph tests. Not show any deviant arousal to, or interest in, minor children as confirmed through current clinical and physiological measures; and

C. Have demonstrated that supervised visits have been sufficient in quality, frequency, and duration as determined by the CST; and

D. Have demonstrated satisfactory progress in treatment and consistent compliance with supervision and treatment conditions; and

E. Not have committed any offenses against any of the minor children in question; **OR**

F. Have a Court/Parole Board Order allowing such unsupervised contact.

5.761 The criteria listed below shall be used by the CST when considering granting an offender unsupervised contact with his/her own minor children. Offenders shall not be allowed to have unsupervised contact with minor children who are not their own.

A. For those offenders for whom the 5.740 criteria are waived pursuant to the results of the CCA which includes the polygraph exams, these criteria do not apply, unless new information of concern has arisen.

B. Unsupervised contact shall never be allowed for a sex offender diagnosed with any type of pedophilia (per current version of DSM) or with an established and ongoing pattern of deviant sexual interest/arousal to minors. When contact with the offender's own child has not been prohibited or restricted, the CST should review whether there are, or should be, options to place parameters or restrictions around the contact when necessary to ensure safety. There may also be instances when new information indicates that such contact is contraindicated due to increased risk of the offender to the child. To restrict or preclude contact, a subsequent Court/Parole Board Order is needed. Therefore, the treatment provider shall communicate such information to the supervising officer. If the CST is in agreement, then such information should be presented to the Court/Parole Board pursuant to local procedures.

Discussion: An established pattern is determined to exist when an offender has shown deviant sexual interest/arousal to minors via pattern of offending, self-report by the offender, or assessment of sexual interest/arousal over a period of time.

C. The CST shall support the minor child's wishes when he/she does not want to have unsupervised contact with the offender. In cases when the minor child wants unsupervised

contact the CST shall prioritize the best interest of the minor child including physical and emotional safety.

D. When there is a therapist working with the minor child the therapist shall be consulted in the decision to grant unsupervised visitation. When the minor child is not currently seeing a therapist, the CST should consult a therapist who has worked with the minor child to discuss general issues surrounding unsupervised contact.

E. The CST shall ensure that the offender has an approved safety plan regarding the minor child involved.

F. The CST shall consider input from the custodial parent/guardian when making any decision regarding any unsupervised contact with the offender's own minor child(ren). When contact with the offender's own child has not been prohibited or restricted, the CST should review whether there are, or should be, options to place parameters or restrictions around the contact when necessary to ensure safety. In such instances, the CST shall seek ongoing input from the custodial parent/guardian to ensure that contact is not posing undue risk to the child(ren). If such risk is identified, a subsequent Court/Parole Board Order is needed to preclude such contact. If the CST is in agreement, then such information should be presented to the Court/Parole Board pursuant to local procedures.

G. The CST can rescind or suspend unsupervised contact if conditions change that warrant such action unless ordered by the Court/Parole Board. A new Court/Parole Board Order would be required to rescind or suspend such contact.

H. The CST shall thoroughly document reasons for all decisions made regarding an offender's unsupervised contact with his/her minor children.

I. There may be some offenders who are the sole caregivers of their minor child(ren) and can meet all the preceding criteria, however, due to an unforeseen event, there is a sudden loss of an Approved Supervisor (e.g. spousal death, etc.). In such cases, the CST shall make a referral and consult with the Department of Social Services to develop an alternative plan for the care and parenting of the minor child(ren), which may or may not include maintaining the minor child(ren) in the offender's custody.

5.762 Modifying Contact

CSTs should plan for changes in risk level and recognize that offenders present with some level of risk for sexual re-offending. Progress in treatment may not be consistent over time. The CST should also consider that changes in child development characteristics or adult victim characteristics may affect offenders' risk level. CST approval of situations that involve contact with minor children under the age of eighteen shall be continually reviewed and may be changed, suspended, or rescinded by the CST based on current risk, non-compliance, or other concerns. It should be noted that continual or repetitive separation and reunification can be detrimental to family dynamics.

5.770 Approved Supervisor

Approved Supervisors are adults who have been approved by the CST to supervise contact between an offender and specified minors.

The following Standards sections regarding the responsibilities and duties of an Approved Supervisor apply in situations in which an offender is allowed to have supervised contact with minors. They are not intended to address situations where the CST is requiring accompaniment for general movement in the community or involving activities unrelated to contact with minors. The CST should consult with the minor children and children's custodial parents/guardians regarding any concerns regarding the Approved Supervisor.

5.771 Qualifications of an Approved Supervisor

Prior to allowing a person to be an Approved Supervisor, the CST shall ensure that he or she meets the following qualifications:

A. Agrees to undergo and pay for a complete criminal history background check.

B. **DD/ID**
Understands the nature of the disability and that sexual offending behavior exists independently of the disability of the offender.

C. Has adequately addressed any issues regarding personal history of victimization.

D. Supports intervention efforts of the CST without antagonism.

E. Willing to maintain open communication with the CST and report relevant offender behavior.

F. Willing to maintain protection of minor children as the highest priority and believes this outweighs any offender or family interests.

G. Demonstrates empathy for the offender's victims.

H. Does not deny or minimize the offender's responsibility or the seriousness of sexual offending.

5.772 Disqualifications for an Approved Supervisor

Prior to allowing a person to be an Approved Supervisor, the CST shall ensure that none of the following apply:

A. Currently under the jurisdiction of any court or criminal justice agency for a matter that the CST determines could impact his/her capacity to safely serve as an Approved Supervisor.

B. Prior convictions for child abuse or neglect, or for unlawful sexual behavior as defined by SOMB Statute. If ever investigated for unlawful sexual behavior, child abuse, or neglect presents information requested by the CST so that the CST may consider the current impact on his/her capacity to serve as Approved Supervisor.

Discussion: In very rare circumstances, the CST may choose to make an exception to the prohibition about a misdemeanor child abuse conviction. The reasons for this exception should be made by the unanimous agreement of the CST and documented in writing.

C. Significant cognitive or intellectual impairment as determined by the CST.

D. Significant mental health or substance abuse problems as determined by the CST.

E. Significant health or physical limitation that interferes with the performance of his/her duty as determined by the CST.

F. Relationships where a significant power differential exists that may inhibit the proposed Approved Supervisor from fulfilling the required responsibilities (e.g. adult child of the offender - see Section 5.775).

G. Past or present victimization by the offender with domestic violence or any other form of abuse. If there is any indication that this may have occurred, the CST shall investigate by privately interviewing the potential Approved Supervisor using questions derived to identify perpetration behaviors[120] or by requiring the offender to participate in a single issue polygraph regarding physical and sexual violence. Confidentiality for a victim in this situation must be upheld due to the possibility of offender retaliation.

Discussion: The CST shall periodically re-assess the Approved Supervisor to ensure ongoing compliance with qualifications and ensure that the Approved Supervisor is not subsequently excluded given that situations may change.

5.773 All sex offender treatment providers shall offer an Approved Supervisor training program of sufficient duration for the potential Approved Supervisor to learn, process, and internalize information about offender characteristics, risk, and behaviors. Additionally, providers shall require Approved Supervisors to attend ongoing support groups where concerns shall be discussed and addressed and clarification regarding expectations is available.

5.774 The CST shall ensure that the Approved Supervisor demonstrates understanding of the following information:

A. The underlying factual basis of the present offense(s);

B. The offender's thorough disclosure of the offense and acceptance of all responsibility;

C. The offender's complete and verifiable sexual history disclosure;

D. What constitutes sexual offending and other abusive behavior and the ongoing risk the offender presents to minors;

E. The offender's risk factors, deviant sexual arousal patterns, offense cycle, pathways, and grooming behaviors;

F. Offender treatment progress and offender risk are variable over time;

G. Any offender mental health issues without making excuses for his/her behavior;

H. The offender's community supervision conditions, including Standard 5.710, treatment contract expectations, and rules regarding the approved contact;

[120] e.g. Danger Assessment by Jacquelyn Campbell

I. The offender's requirement to provide the CST with a written safety plan for supervised contact;

J. Any offender history of domestic violence and risk to his/her partner or to other family members; and

K. The offender's potential ability to manipulate the Approved Supervisor.

5.775 Approved Supervisor Duties and Responsibilities

The treatment provider shall develop a written contract that is signed by the CST and the Approved Supervisor. The contract shall require that the Approved Supervisor:

A. Maintain qualifications and stay current on the knowledge and responsibilities as referenced in Standards 5.771 through 5.774, including annually providing the CST with a certified copy of his/her criminal history through the Colorado Bureau of Investigation that incorporates CCIC/NCIC information;

B. Shall not consume alcohol or mind-altering substances while functioning as an Approved Supervisor;

C. Maintain confidentiality regarding victim information;

D. Ensure compliance with all rules as specified by the CST;

E. Only allow contact with minors approved by the CST;

F. Never leave the offender alone with a minor or victim and always be within sight and sound of the offender and the minor/victim during contact;

G. Intervene when high risk situations or behaviors occur by immediately terminating contact and reporting concerns to the CST;

H. Assess the minor's emotional and physical safety on a continuing basis and terminate contact immediately if any aspect of safety is jeopardized; and

I. Report any safety issues including domestic violence or violence toward family members or threats of abuse or violence toward the Approved Supervisor;

J. Maintain open and honest communication with the CST:

1. Regularly report offender's relevant behaviors and attitudes.

2. Respond to inquiries by the CST.

3. Meet with the CST as requested.

4. Provide documentation of contacts.

5. Express any concerns to the CST regarding the offender's non-compliance with the contract or treatment conditions.

5.776 The following shall be specified in the written Approved Supervisor contract:

A. Name(s) of the minor(s) with whom the Approved Supervisor is allowed to oversee any type of contact;

B. Abide by the offender's approved safety plan for contact;

C. If the Approved Supervisor is not in compliance with all of the requirements, the CST may discontinue or modify any contact privileges or the approval status of the Approved Supervisor; and

D. An explanation of an Approved Supervisor's potential civil liability for negligence in enforcing stated rules and limitations.

5.780 Circumstances under Which Criteria May Be Waived

Allowing contact prior to fulfillment of the criteria outlined in Section 5.740 of these Standards and Guidelines should occur only in **rare** circumstances. In addition, the CST shall agree that there is minimal risk of any crossover or additional crimes of opportunity. While it is not appropriate for the criteria to be waived in its entirety for ongoing contact, there may be parts of the criteria that may be waived or postponed.

When making a decision to waive any part of the criteria in Section 5.700 of these Standards, there shall be full consensus of the CST. An explanation of the specific circumstances and reasons shall be documented, including the potential risk to the community, victim(s), and potential victims involved.

5.781 Non-Victim Contact

Occasionally, the CST may approve a broader waiver of 5.740 criteria for a one-time contact only, such as for a minor child's contact with the offender in a therapy session to assist non-victim minor children in adjusting to the offender's removal from the home. Any approval for this kind of closure/explanation session shall be in writing and the CST shall determine all the particulars of that session. If the minor child(ren) has a therapist or an advocate, that person should also be present during that session. The CST shall take every precaution to ensure that the minor children with whom a sexual offender is doing this kind of closure or explanation session are not his/her primary victims.

5.782 Adult Victim Contact

There may be instances when an adult victim desires contact with an offender prior to 5.755 criteria having been achieved. CSTs should staff these situations and determine if contact should be allowed and under what circumstances (e.g. with a therapist present, telephone contact, etc.). Victim safety and offender rehabilitation shall remain the priorities.

6.000 REVISED SEPTEMBER 2017 STANDARDS OF PRACTICE FOR POST-CONVICTION SEX OFFENDER POLYGRAPH TESTING (PCSOT)

6.000 Post-Conviction Sex Offender Polygraph Testing (PCSOT)

The polygraph is used to add incremental validity to treatment planning and risk management decisions regarding sex offenders in community and institutional settings. The concept of "incremental validity" refers to improvements in decision making through the use of additional information sources. Benefits of polygraph testing include improved decision making, deterrence of problem behavior and access to information that might otherwise not be obtained.[121]

Polygraph test results (see Section 6.151 A-D for specific types of test results) shall not be used as the sole determining factor in the supervision and treatment decision-making process.[122] The Community Supervision Team (CST) should consider all existing clinical indicators that provide information about a client's overall presentation. Such indicators may include, but are not limited to, interviews, quality of treatment participation, polygraph examination results and disclosures, scores on dynamic risk assessments, psychological evaluation results, behavioral observations, and collateral reports. These indicators should thoroughly inform decisions pertaining to an offender's progress in treatment, activities in the community, and contact with potentially vulnerable persons.

Polygraph testing is one of several methods of behavioral monitoring. Additional forms of behavioral monitoring include drug/alcohol testing, plethysmograph testing, viewing time (VT) assessment, and other case management practices such as collateral contacts, office and home visits, employment visits, computer and phone monitoring, and increased supervision and treatment requirements.

6.002 Expectation for Honesty

The CST shall set the expectation for honesty and complete disclosure from the offender. Such openness will contribute to community safety, the development of an appropriate treatment plan and successful progression through treatment.

6.010 Recommended Guidelines for Polygraph Exam Timeframes

Please note these timeframes are provided as recommendations for Community Supervision Team (CST) decision-making, which should ultimately be based on the risk, and supervision and treatment needs of the offender.

A. Instant Offense Exam – Implement within first 3 months of denier's intervention, or at the start of sex offense specific treatment.

[121] Gannon, T., Wood, J., Pina, A., Tyler, N., Barnoux, M., & Vasquez, E. (2014). An evaluation of mandatory polygraph testing for sexual offenders in the United Kingdom. *Sexual Abuse: A Journal of Research and Treatment*, 178-203.; Grubin, D., & Madsen, M. (2006). Accuracy and utility of post-conviction polygraph testing of sex offenders. *British Journal of Psychiatry*, 479-483.

[122] Office of Sex Offender Sentencing, Monitoring, Apprehending, Registering and Tracking. (2014). *Sex offender management assessment and planning initiative.* Washington, D.C: US Department of Justice, Office of Justice Programs.

B. Sexual History Exams[123] – Implement within first 12 months of sex offense specific treatment.

C. Maintenance/Monitoring Exams – Implement within first 3 months of sex offense specific treatment, and continue on a regular basis every 6 months thereafter.

6.010 Types of Post-Conviction Polygraph Examinations

There are six different types of Post-Conviction Sex Offender polygraph exams:[124]

- Instant Offense Exams
- Sexual History Exams
- Maintenance Exams
- Sex Offense Monitoring Exams
- Child Contact Assessment Exams
- Specific Issue Exams

CST members, including polygraph examiners, shall maintain the integrity of the distinct types of post-conviction polygraph examinations, and shall not mix questions among the various types of post-conviction exams, other than maintenance and monitoring exams which can be mixed. For example, an exam shall not combine a sexual history question regarding historical sexual offending behavior and a maintenance question regarding current alcohol consumption while under supervision.

6.011 Instant Offense Polygraph Examination

An instant offense exam is an event-specific polygraph for sex offenders who deny any or all important aspects of the allegations pertaining to their present sex offense crime(s) of conviction.[125]

An instant offense polygraph examination shall be used by the CST to manage sex offenders in denial as specified in Section 3.520, or prior to clarification with the victim, if there are any significant discrepancies between the offender and the victim, as specified in Section 5.752 D.

6.012 Sexual History Polygraph Examination

A sexual history exam assesses the sex offender's history of involvement in unknown or unreported offenses and other sexual compulsivity, sexual pre-occupation, or sexual deviancy behaviors. Information and results from these examinations should be provided to the professional members of the CST to add incremental validity to decisions pertaining to risk assessment, risk management and treatment planning.[126]

Sexual history polygraph examination is most effective when initiated within the first year of

[123] For offenders who refuse to answer incriminating sexual history polygraph questions, including incriminating sexual offense history polygraph questions, providers shall refer to Standard 3.160 I.2 to determine how to respond.
[124] The American Polygraph Association identifies five types of polygraph exams: instant offense exams, prior-allegation exams, sexual history disclosure exams, maintenance exams, and sex offense monitoring exams. An issue-specific exam, such as the prior-allegation exam, may also be utilized by CSTs in supervising and treating sex offenders, as appropriate.
[125] American Polygraph Association (2016). *Model Policy for Post-Conviction Sex Offender Testing.* [Electronic version] Retrieved 11.22.2016, from http://www.polygraph.org.
[126] American Polygraph Association (2016). *Model Policy for Post-Conviction Sex Offender Testing.* [Electronic version] Retrieved 11.22.2016, from http://www.polygraph.org.

treatment to assist sex offenders with treatment engagement and progress.[127] The CST shall utilize the sexual history polygraph examination process as part of treatment planning as indicated in Section 3.165 I. 2., and as one clinical indicator to assess treatment progress as identified in Section 3.160 M, when clinically appropriate. For offenders who refuse to answer incriminating sexual offense history questions, including incriminating sexual offense history polygraph questions, providers shall refer to Standard 3.160 I.2 to determine how to respond.

Discussion: The use of the polygraph examination combined with the sexual history documentation prepared by the offender as part of the group process underscores the SOMB's expectation for honesty and compliance from offenders who have agreed to participate in supervision and treatment.

A. The treatment provider shall ensure that the offender has completed a written sexual history disclosure using the SOMB Polygraph Sexual History Packet prior to the examination date. A sexual history polygraph examination should not be conducted until the offender has written his/her sexual history and reviewed it in their treatment program. The treatment provider shall ensure that the polygraph examiner has access to a copy of the offender's SOMB Polygraph Sexual History Packet prior to or at the time of the exam. If the packet is not received by the time of the examination appointment, the examiner shall have the discretion of administering a sexual history polygraph examination or another type of examination. For offenders who refuse to answer incriminating sexual offense history questions, including incriminating sexual offense history polygraph questions, providers shall refer to Standard 3.160 I. 2 to determine how to respond.

   Discussion: Proper polygraph preparation by the offender involves the thorough review of recent and past behaviors. If this preparation has not been completed, the treatment provider should consult with the examiner prior to an exam occurring. Offenders should be prepared to be open and honest with the polygraph examiner as the first step of offender accountability and community safety. Effective preparation has been shown to improve an offender's ability to resolve questions and issues of concern.

B. The sexual history polygraph examination process* shall cover the following areas:

   1. Sexual contact with underage persons (persons younger than age 15 while the offender is age 18 or older);

   2. Sexual contact with relatives whether by blood, marriage, or adoption, or where a relationship has the appearance of a family relationship (a dating or live-in relationship exists with the person(s) natural, step or adoptive parent);

   3. Use of violence to engage in sexual contact including physical restraint and threats of harm or violence toward a victim or victim's family members or pets, through use of a weapon, or through verbal/non-verbal means; and

   4. Sexual offenses (including touching or peeping) against persons who appeared to be asleep, were drugged, intoxicated or unconscious, or were mentally/physically helpless or incapacitated.

[127] Konopasek, J.E. (2015). Expeditious Disclosure of Sexual History via Polygraph Testing: Treatment Outcome and Sex Offense Recidivism. *Journal of Offender Rehabilitation, 54:3,* 194-211.

*For offenders who refuse to answer incriminating sexual offense history questions, including incriminating sexual offense history polygraph questions, providers shall refer to Standard 3.160 I. 2 to determine how to respond.

C. At the discretion of the CST, additional polygraph assessment may be necessary to explore the offender's history of involvement in other paraphilias (e.g., internet-facilitated sexual offending including use of child sexual abuse images) including sexually compulsive behaviors, other sexually deviant activities, or unlawful sexual behaviors.

Discussion: CST members should consult with the examiner regarding addressing the offender's sexual history polygraph examination requirements in a series of narrowly focused examinations (e.g., single issue exam) instead of broader examination methods (e.g., multi-issue exam). The final decision related to the method for the sex history exam is made by the polygraph examiner.

D. The CST shall consider utilizing relevant questions that ask the female offender if she has helped or planned with anyone to commit a sexual offense, either against a minor-aged person, or a forcible sex act against anyone. Another area of consideration is whether she has been present when anyone has committed an illegal sex act. These questions should be covered in the female sex offender's sex history exam, and can also be utilized during a monitoring polygraph exam. For offenders who refuse to answer incriminating sexual offense history questions, including incriminating sexual offense history polygraph questions, providers shall refer to Standard 3.160 I. 2 to determine how to respond.

Discussion: Problematic and concerning behaviors by female offenders may not be detected or covered in the typical sex history questioning.

E. The CST, including the polygraph examiner, should convene a staffing if an offender does not verify his/her sexual history via no significant reactions (indicative of non-deception) on polygraph results. The purpose of the staffing should be to identify how to address this issue in treatment and supervision planning, including any steps necessary to support the offender in successfully completing the sexual history disclosure and polygraph examination process. For offenders who refuse to answer incriminating sexual offense history questions, including incriminating sexual offense history polygraph questions, providers shall refer to Standard 3.160 I. 2 to determine how to respond.

F. Under certain circumstances, the CST can waive the SOMB requirements for fully resolved sexual history polygraph examination results – such as when an offender has already made substantial disclosures in all areas of inquiry and when additional information is unlikely to more fully inform the community supervision team about risk level, sexual deviancy or compulsivity patterns, and related treatment needs. For offenders who refuse to answer incriminating sexual offense history questions, including incriminating sexual offense history polygraph questions, providers shall refer to Standard 3.160 I. 2 to determine how to respond.

G. Sexual history polygraph examinations should generally be delayed for offenders who are denying significant aspects of the instant offense, including any substantial discrepancies between the victim's and offender's account of the abuse (see Section 3.500 regarding managing offenders in denial). Proper procedure dictates that denial surrounding the details of the instant offense be satisfactorily resolved before proceeding to a more general sexual history polygraph. However, when history examinations do occur prior to resolving the index offense, test questions shall exclude reference to the victim(s) of the instant offense.

6.013 Maintenance/Monitoring Polygraph Examination

A maintenance exam thoroughly assesses, either periodically or randomly, the sex offender's compliance with any of the designated terms and conditions of probation, parole, and treatment rules.[128]

A sex offense monitoring exam explores the possibility the sex offender may have been involved in unlawful sexual behaviors including a sexual re-offense during a specified period of time. Other relevant questions dealing with behaviors related to probation and treatment compliance should not be included.[129]

Discussion: Maintenance/monitoring exam questions can be covered on the same exam, however, the examiner should consider saliency of questions covered if utilizing the same exam.

Maintenance/monitoring polygraph examinations shall be employed to periodically assess the offender's honesty with community supervision team members and compliance with supervision and treatment. Maintenance/monitoring polygraph examinations shall be implemented every three to six months, starting within the first 90 days of treatment and then periodically thereafter. A minimum of two maintenance/monitoring polygraphs shall occur on an annual basis, except as allowed by this Section and Section 5.050, and can be completed more frequently based on the offender's risk and need. Maintenance/monitoring polygraphs shall be employed more frequently with those offenders who present as high-risk, have previously unresolved examination results, or may benefit from more active monitoring.

The CST shall regularly assess the ongoing use of maintenance/monitoring polygraphs, and may unanimously elect to adjust the use of maintenance/monitoring polygraphs based on all clinical indicators of an offender's risk and need, which may include prior polygraph results. In the case of an offender who consistently exhibits as lower risk based on such clinical indicators, the CST may decrease the frequency of the maintenance exams to 9 months and monitoring exams to 1 year.[130] In cases where only monitoring exams are being used on an annual basis, maintenance exams may still be employed on an as-needed basis to address specific identified supervision and treatment risk concerns, but it is not appropriate to conduct maintenance exams covering time periods longer than 9 months.

Discussion: The determination of an offender's low risk should be based on all clinical indicators which demonstrate a reduction in risk behavior. This may include polygraph results with no significant reactions (indicative of non-deception) over a consistent period of time, as well as continued amenability and cooperation with treatment, supervision and polygraph examinations.

Discussion: The maintenance/monitoring polygraph conducted in the absence of any new allegations or incidents of concern may be an effective deterrent to high risk or non-compliant behavior.[131] The use of polygraph may reduce involvement in ongoing high risk behaviors, and

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[128] American Polygraph Association (2016). *Model Policy for Post-Conviction Sex Offener Testing*. [Electronic version] Retrieved 11.22.2016, from http://www.polygraph.org

[129] ibid

[130] Note the different timeframes for maintenance (9 months) and monitoring (1 year) exams. The CST can use these timeframes but must address these issues separately during the exam if timeframes are going to be between 9 months and 1 year.

[131] Buttars, A., Huss, T. & Brack, C. (2016). An analysis of an intensive supervision program for sex offenders using propensity scores. *Journal of Offender Rehabilitation*, 61-68.; Grubin, D., Madsen, L., Sosnowski, D., & Warberg,

improve treatment and supervision compliance.[132] *In addition, the expectation of a polygraph exam assists offenders in avoiding or controlling high risk behaviors.*[133] *For this reason, community supervision team members should consider the possible deterrent benefits of randomly scheduled maintenance/monitoring exams for offenders.*

A. Maintenance/monitoring polygraph examinations shall cover a wide variety of sexual behaviors and compliance issues that may be related to victim selection, grooming behaviors, deviancy activities or high risk behaviors. Maintenance/ monitoring polygraph examinations shall prioritize the assessment and monitoring of the offender's involvement in any non-compliance, high-risk, and deviancy behaviors that may change over time. Information obtained from these exams may signal an increase in risk level prior to re-offending if these behaviors were present, or a decrease in risk if they were absent. Narrowing the scope of maintenance/monitoring examinations can sometimes be helpful to address concerns about possible re-offending, and may be useful to resolve the concerns of the community supervision team. The purpose of maintenance/monitoring exams is to identify risk behavior prior to sexual reoffending.

   Discussion: It is generally understood in testing sciences that broader screening examinations, regarding multiple or mixed issues, offer greater screening utility through sensitivity to a broader range of possible concerns, but these tests can slightly diminish validity. More narrowly focused tests offer greater diagnostic specificity to support action or intervention in response to known incidents or specific allegations, and have greater validity. CST members should consult with the examiner regarding the type of monitoring/maintenance exam, and the final decision regarding the type of exam is made by the examiner.[134]

B. Maintenance/monitoring polygraph testing shall be based upon the requirements of the Standards as outlined in this section, including the offender's risk and need. The timing of other polygraph testing, such as sexual history or instant offense exams, shall not be a factor in considering when to complete maintenance/monitoring exams. The CST may increase the frequency of maintenance/monitoring testing if the offender's sexual history disclosure is unresolved.

6.014 Specific Issue Polygraph Examination

Specific issue polygraph examinations assess the details of an offender's involvement in a known or alleged incident, or to help resolve any discrepancies or inconsistencies in the offender's account of a known incident or allegation.

The CST shall not conduct specific issue polygraph examinations on active criminal investigations, unless by agreement with the investigators.

B. (2004). A prospective study of the impact of polygraphy on high risk behaviors in adult sex offenders. *Sexual Abuse: A Journal of Research and Treatment*. 209-222.

[132] Grubin, D.,& Madsen, L. (2006). Accuracy and utility of post-conviction polygraph testing of sex offenders. *British Journal of Psychiatry*, 479-483; Grubin, D., Madsen, L., Sosnowski, D., & Warberg, B. (2004). A prospective study of the impact of polygraphy on high risk behaviors in adult sex offenders. *Sexual Abuse: A Journal of Research and Treatment*. 209-222; Madsen, L., Parsons, S., & Grubin, D. (2004). A preliminary study of the contribution of periodic polygraph testing to the treatment and supervision of sex offenders. *The Journal of Forensic Psychiatry and Psychology*, 682-695.

[133] Grubin, D., Madsen, L., Sosnowski, D., & Warberg, B. (2004). A prospective study of the impact of polygraphy on high risk behaviors in adult sex offenders. *Sexual Abuse: A Journal of Research and Treatment*. 209-222.

[134] National Research Council (2003). *The Polygraph and Lie Detection.* Washington, DC: National Academies Press. Retrieved from: www.nap.edu/openbook.php?isbn=0309084369.

6.015 Child Contact Assessment Polygraph Examination

Child contact assessment (CCA) polygraph examinations shall be used to assist the community supervision team in making recommendations about contact with the offender's own children who are not already known to be victims or siblings of victims. The CCA polygraph shall occur prior to the completion of the child contact assessment (pursuant to Standard 5.700). This examination is conducted in the absence of known or alleged offenses against the offender's own children, and is conducted for the purpose of gathering information to assist in the assessment of the offender's potential risk to offend against his/her own children. For offenders who refuse to answer incriminating sexual offense history questions, including incriminating sexual offense history polygraph questions, providers shall refer to Standard 3.160 I. 2 to determine how to respond.

6.020 Communication with the Offender

Informing test subjects of potential areas of inquiry is a generally accepted practice by CST members. However, the CST shall not advise offenders of specific test questions prior to the scheduled appointment. The CST shall inform the offender regarding the type of examination.

Discussion: Discussing potential sanctions before or during the polygraph exam process, by any CST members, can have a negative impact on the exam results and should be avoided.

6.021 Communication with the Examiner

CST members shall discuss and collaborate with the examiner on the type of exam to be administered as well as any specific areas of concern. The examiner shall notify the CST, if known, when a polygraph examination is scheduled, and request needed information based upon the type of exam to be administered. The CST should provide supporting documentation related to the areas of concern, if available and appropriate.

6.022 Examiner Responsibility for Test Questions

The examiner shall make the final determination of questions used, and determine whether to administer a broader or more narrowly focused examination within the scope of the requested polygraph exam. The examiner shall note the reasons for the change in focus of the examination in the exam report, if such a change is made.

6.030 Follow-up Examinations

If the examination has unresolved responses to any test questions, communication between CST members shall occur to determine the best course of action, including whether or not to do a follow-up exam, the timeframe for any follow-up exam, and the areas of focus for any potential follow-up exam (See Section 5.600).

The CST should prioritize the investigation of more recent behaviors when evaluating the offender's present stability or dynamic risk level. The CST should generally require that all test questions and all time periods are satisfactorily resolved before moving on to another maintenance/monitoring exam with different questions or time-frames (See Section 5.600).

Per the APA model policy, the examiner shall discuss with the CST the use of the successive hurdles approach to polygraph to maximize both the informational efficiency and sensitivity of multiple or mixed-issue screening polygraphs, and the diagnostic efficiency and specificity of

specific issue exams. Follow-up examinations should utilize a single-issue technique whenever increased validity is needed to resolve an issue.[135]

Discussion: A successive hurdles approach may result in a focus on more concerning risk behavior and no longer testing on less serious risk factors that can be verified through other clinical indicators. It is not necessary to resolve all issues in follow-up maintenance/monitoring exams, but if the CST believes it important to return to a previously unresolved issue at a later date, timeframe parameters outlined in Section 6.013 must be followed.

A. Timeframes for follow-up examination shall be based on all clinical indicators of risk, need, and protective factors. Follow-up maintenance/monitoring exams should occur more frequently than the minimum required timeframe for such exams, and it is recommended that it occur within 60 days of the initial examination (see Section 5.630 and 5.655). The timeframe for testing shall be prioritized based on the offender's level of risk, and can be adjusted based upon the offender's preparedness to address and resolve any remaining issues of concern.

B. Resolution of remaining concerns upon follow-up testing shall be regarded as satisfactory resolution of the earlier test results.

Discussion: The follow-up exam may cover the same timeframe as the unresolved test, or it may extend beyond the original timeframe to include the time lapse between the original exam and the follow-up. When scheduling the next maintenance exam, it is important to include timeframes not accounted for in previous testing. As outlined in Section 6.013, it is still the responsibility of the CST to ensure a minimum of 2 exams per year.

C. In most cases it is recommended that the initial follow-up examinations be completed with the same examiner, but the CST can change examiners for later follow-up examinations, if appropriate. If a change in examiner takes place, the CST shall provide the results of the unresolved exams to the new examiner.

Discussion: Non-deceptive test results are considered conclusive and the issue(s) under investigation shall be considered satisfactorily resolved. However, all clinical indicators of risk, need, and protective factors should be considered, including polygraph results. Non-deceptive test results alone do not ensure safety on the part of the offender, nor should they automatically result in reduced monitoring on the part of the community supervision team.

6.032 Preventing Splitting and Triangulation

Team members shall not allow splitting or triangulating behaviors, and splitting efforts by the offender shall be communicated to other team members. Treatment providers and supervising officers shall not offer the offender excuses or justifications for deceptive or unresolved reactions to polygraph test questions; it is the offender's responsibility to explain such reactions to the team.

6.033 Technical Expertise of the Examiner

Questions regarding the technical aspects of the polygraph shall be referred to the polygraph

[135] American Polygraph Association (2016). *Model Policy for Post-Conviction Sex Offender Testing*. [Electronic version] Retrieved 11.22.2016, from http://www.polygraph.org. For more information on the successive hurdles approach, see the APA Model Policy.

examiner. CST members shall not attempt to educate offenders regarding how to pass or defeat the polygraph test, but shall limit their discussion to the need for honesty and disclosure. When any team member has difficulty understanding or interpreting written polygraph reports or results, he or she shall contact the polygraph examiner for clarification and refrain from interpreting polygraph results beyond what is contained in the report.

6.100 Administration of the Polygraph Examination

Polygraph examiners shall adhere to the established ethics, standards, and practices of the American Polygraph Association (APA) and the American Society for Testing and Materials (ASTM).

6.110 Equipment and Instrumentation

Examiners shall use a computerized polygraph system consisting of five or more channel polygraph instrument that will simultaneously record the physiological phenomena of abdominal and thoracic respiration, electro-dermal activity, and changes in cardiovascular activity, and additional component sensors to monitor and record in-test behavior.

6.120 Duration of Examination

Each examination (including the pre-test, in-test, and post-test phases) shall be scheduled for a minimum of 90 minutes in duration. Examiners shall not conduct more than five post-conviction examinations per day.

6.130 Adherence to Recognized Standards

Polygraph examiners shall conduct all polygraph examinations in a manner that is consistent with the accepted standard of practice within the professional polygraph community.

Discussion: In order to avoid a conflict of interest with an in-house polygraph examiner, the integrity of the three distinct roles/perspectives of the CST must be preserved. The polygraph examiner and therapist or supervising officer must never be the same person. In community settings, the offender shall not be mandated to test with the in-house examiner.

6.140 Testing Procedures

Examiners shall use examination techniques recognized by the American Polygraph Association (APA) as acceptable for Post-Conviction Sex Offender Testing (PCSOT).

6.141 Authorization and Release

The examiner shall obtain the offender's agreement, in writing or on the audio/video recording, to **4.1110 Continued Placement of a <u>Full Operating Level Polygraph Examiner</u> on the Provider List:** a standard waiver/release statement. The language of the statement shall minimally include the offender's voluntary consent to take the test, that all information and results will be released to professional members of the community supervision team, an advisement that admission of involvement in unlawful activities will not be concealed from authorities, and a statement regarding the requirement for audio/video recording of each examination.

For offenders with a developmental disability, the examiner shall obtain the written agreement of the offender with a developmental disability, and if applicable, the legal guardian, for participation in the polygraph examination and the release of information authorization.

Discussion: Polygraph examiners are not mandatory child abuse reporters by statute; this includes polygraph examiners with clinical training. All members of the community supervision team who are mandatory child abuse reporters are responsible for assuring the timely and accurate reporting of child abuse to the appropriate authorities.

6.142 Case Background Information

The examiner shall request and review all pertinent and available case facts within a time frame sufficient to prepare for the examination.

Discussion: The supervising officer or treatment provider should ensure that the polygraph examiner conducting the current exam receives a copy of the Pre-Sentence Investigation Report (PSIR) and/or police report(s), the sexual history disclosure packet, the sex offense-specific evaluation, the most recent polygraph report(s), and information relevant to clarifying a previously deceptive or unresolved examination (in addition to any other pertinent information about the purpose of the current examination).

6.143 Offender Background Information

Prior to beginning the examination, the examiner shall elicit relevant personal information from the offender consisting of brief personal and demographic background information, case background information, and medical/psychiatric health information (including medications) pertaining to the offender's suitability for polygraph testing.

6.144 Review of Testing Procedures

The testing process shall be explained to the offender, including an explanation of the instrumentation used.

6.145 Pre-test Interview

The examiner shall conduct a thorough pre-test interview, including a detailed discussion of each issue of concern. There shall be an open dialog with the offender to confirm his/her version of all issues under investigation.

6.146 Test Questions

Before proceeding to the in-test phase of an examination, the examiner shall review and explain all test questions to the offender. The examiner shall not proceed until he/she is satisfied with the offender's response to each issue of concern.

A. Question construction shall be:

1. Simple, direct and easily understood by the examinee;

2. Behaviorally descriptive of the offender’s involvement in an issue of concern (questions about knowledge, truthfulness, or another person's behavior are considered less desirable);

3. Time limited (date of incident or time-frame);

4. Absent of assumptions about guilt or deception;

5. Free of legal terms and jargon; and

6. Avoid the use of mental state or motivational terminology.

B. While the community supervision team members shall communicate all issues of concern to the examiner in advance of the examination date, the exact language of the test questions shall be determined by the examiner at the time of the examination.

6.147 Number of Test Charts

Three to five primary test charts shall be administered on the exam issue(s).

6.148 Post-Test Review

The examiner shall review initial test results with the offender. Offenders shall be given the opportunity to explain or resolve any reactions or inconsistencies.

6.149 Examination Recording

Recording (audio and video) of polygraph examinations shall be required. Audio and video recording of the entire examination shall be maintained for a minimum of three years from the date of the examination.

6.150 Examination Results

All testing data shall be hand scored by the examiner. Computerized scoring algorithms may be used for comparative purposes and quality assurance in the field.

6.151 Test Results

The examiner shall render an empirically based opinion regarding the examinee's truthfulness or deception to each test question.

A. Examiners shall render an empirically based opinion that the test results indicate the examinee was deceptive whenever there are significant physiological responses that meet established criteria.

B. Examiners shall render an empirically based opinion that the test results indicate the examinee was non-deceptive (i.e. truthful) whenever there are no significant physiological responses that meet established criteria.

C. Examiners shall render “no opinion” whenever test results yield “inconclusive” scores, or whenever the overall set of test data do not allow the examiner to render an empirically based opinion regarding individual test questions. Examiners shall note in the examination report whenever it is suspected that an examinee has attempted to falsify or manipulate the test results, and whether the examinee was forthcoming in explaining his or her in-test behavior.

Discussion: "No opinion" is synonymous with "inconclusive."

6.152 Test Results Based on All Available Information

Consistent with other professional standards, the examiner shall be responsible for rendering an empirically based opinion regarding a polygraph examination. The opinion shall be based on all information gathered during the examination process. The computer algorithm shall never be the sole determining factor in any examination.

6.153 Prohibition Against Mixed Results

To reduce the likelihood of erroneous test results, examiners shall not conclude the offender is deceptive in response to one or more test questions and non-deceptive in response to other test questions within the same examination.

6.160 Examination Report

Examiners shall issue a written report to all members of the community supervision team within fourteen days of the examination. The report shall include factual and objective accounts of the pertinent information developed during the examination, including statements made by the examinee during the pre-test and post-test interviews.

6.161 Content of the Examination Report

All polygraph examination written reports shall include the following information:

1. Date of examination;
2. Beginning and ending times of examination;
3. Reason for examination;
4. Referring or requesting agents/agencies (all members of the CST);
5. Name of offender;
6. Location of offender in the criminal justice system (probation, parole, etc.);
7. Case background (instant offense and conviction);
8. Any pertinent information obtained outside the exam (collateral information if available);
9. Brief demographic information (marital status, children, living arrangements, occupation, employment status, etc.);
10. Statement attesting to the offender's suitability for polygraph testing (medical/psychiatric/developmental);
11. List of offender's medications;

12. Date of last post-conviction examination (if known);

13. Summary of pre-test and post-test interviews, including disclosures or other relevant information provided by the offender;

14. Examination questions and answers;

15. Examination results;

16. Reasons for inability to complete exam (if applicable); and

17. Any additional information deemed relevant by the polygraph examiner (e.g., behavioral observations or verbal statements).

6.162 Raw Data and Numerical Scores

All numerical and computer scores shall be considered raw data and therefore shall not be disclosed in written examination reports.

6.163 Information Released only to Professionals

Written polygraph reports and related work products shall be released only to CST members, the court, parole board or other releasing agency, or other professionals at the discretion of the community supervision team.

6.164 Communication with the Examiner after Testing

Following the completion of the examination and post-test review, examiners shall not discuss polygraph results with the offender, or the offender's family members, unless done in the context of a formal case staffing.

6.170 Quality Assurance

Examiners shall seek peer review of at least two examinations per year using the protocol. Additional peer reviews may be requested by the community supervision team. Quality assurance reviews shall consist of a systematic review of the examination report, test data, test questions, scored results, computer score (if available), audio/video recording, and collateral information. Documentation of six quality assurance peer reviews shall be submitted to the SOMB at the time of re-application. The purpose of the Quality Assurance Protocol shall be to facilitate a second professional opinion regarding a particular examination, to gain professional consensus whenever possible, and to formulate recommendations for the community supervision team.

Discussion: The Quality Assurance Protocol is intended to advise members of the CST on the polygraph test about the strengths and limitations of a particular test, and to provide examiners with a formal vehicle for gaining professional feedback and consensus. Quality assurance activities include: compliance with standards of practice, certification requirements, ongoing training, supervision and oversight, options for recourse in the event of identified problems, and program evaluation. Quality assurance activities take place at varying levels of formality, including informal data checks via audio/video recording, procedural or follow-up case-staffing with the examiner, collaborative peer review, blind review, panel review, or referral to an outside agency for quality assurance review.

6.171 Initiating the Quality Assurance Review

With the exception of exams required for reapplication purposes, quality assurance reviews shall be initiated by a member of the community supervision team. Quality assurance reviews may be initiated in response to a variety of circumstances, including but not limited to:

A. A formal or informal complaint regarding non-compliance with these Standards, or when critical decisions may be influenced by the information or results from the polygraph test.

B. When separate examinations yield differing test results regarding the same issue(s) and/or time period. This review would then be completed by the two examiners whose examinations yielded differing results. The purpose of this review is to clarify the reasons for the differing test results and formulate a recommendation for the community supervision team. If consensus cannot be reached, the team shall consult with a third, independent, SOMB listed full operating level polygraph examiner, agreed upon by both polygraph examiners, to review the conflicting information and offer an opinion regarding the issue. If differences in test results remain unresolved, both examinations shall be set aside and a new polygraph examination shall be conducted. Whenever consensus cannot be reached, the community supervision team must err on the side of community safety when considering their response.

C. When an examiner determines the test subject has attempted to use manipulative techniques to alter the test results. The purpose of the review is to confirm the offender's use of manipulative techniques prior to the imposition of sanctions or consequences for non-cooperation. This review may not be necessary when the offender admits non-cooperation, explains his or her in-test behavior, and is forthcoming in discussing his or her knowledge of the polygraph technique. In these cases the test results may be regarded as inconclusive or unresolved until the issues are subject to re-examination.

6.172 Selection of the Reviewing Examiner

When initiating a quality assurance review, the CST members shall contact the original examiner and, together with the original examiner, select an independent, full-operating level polygraph examiner to complete an objective peer review.

The reviewing examiner shall contact the original examiner with any questions and feedback, and shall complete the Quality Assurance Protocol and the one-page Quality Assurance Summary Report together with the original examiner.

Discussion: It should not be assumed that a reviewer or reviewers present more expertise than the original examiner. Studies have found that results obtained by original examiners have outperformed those of subsequent reviewers (National Academy of Sciences, 2003). Quality assurance reviews serve only to offer an additional professional opinion to further advise community supervision team members regarding a polygraph test whose decisions may be affected by the information and results obtained.

6.173 Conclusions From the Quality Assurance Review

Community supervision team members shall include the one-page Quality Assurance Summary Report in the offender's treatment and supervision files. Quality assurance reviewers shall refrain from making global or generalized conclusions regarding an examiner's work or competence

(which cannot be done based upon a single examination). Unless an empirical flaw is identified, the reviewing examiner shall endorse the original examiner's reported results, and shall limit professional opinions to the following conclusions:

A. Examination is supported - results shall be accepted;

B. Examination is not supported - results shall be set aside; or

C. Examination is supported but qualified by identifiable empirical limitations - results may be set aside or accepted with reasonable caution. Such qualifying limitations may include identifiable empirical limitations pertaining to offender suitability, data quality, and clarity of the issue/s under investigation, and are often noted by the original examiner in the examination report.

Discussion: Setting aside an examination result does not include removal of the examination report from the offender's supervision and treatment files, but should include the addition of documentation regarding the community supervision team's response.

6.200 Use of Polygraph with Special Considerations

The CST shall address any special considerations, such as severe medical, psychiatric, or developmental conditions that may affect an offender's suitability for polygraph testing. When deciding whether to use polygraph testing with such offenders, the CST shall consider the probable benefits of testing, including improved decision-making, deterrence of problem behavior, and the value of additional disclosed information that might otherwise not be obtained.

6.210 Determination of Suitability for Testing

The CST shall have the authority to determine whether to use polygraph testing when there are special considerations. In dealing with special considerations, the CST shall consult with the examiner before deciding whether to employ polygraph testing. Polygraph examinations shall not be employed with such offenders unless the CST determines that such testing would add incremental validity to important treatment decisions. Offenders who are acutely psychotic, suicidal, or have un-stabilized serious mental health conditions, including dementia, are generally not suitable for polygraph testing. In addition, offenders suffering from serious injury or illness, or under the influence of non-prescribed controlled substances are generally not suitable for polygraph testing. Offenders' mental status results indicating a lack of clear awareness of the concepts of truthfulness or lying, or a lack of capacity to anticipate consequences for telling the truth or lying, based on a mental or emotional condition, may not be suitable for polygraph testing. Polygraph examiners shall not test offenders who present as clearly unsuitable for polygraph testing at the time of the examination. The CST shall periodically review each offender's suitability for polygraph testing. In cases where the offender is determined to be unsuitable for polygraph testing, the CST shall consider other forms of behavioral monitoring.

6.211 Documentation of Special Considerations

The polygraph examiner shall obtain and note in the examination report a list of the offender's prescription medication, any medical or psychiatric conditions, and any other special considerations as identified in this section. The CST shall advise all offenders to continue taking prescription as directed by their medical or psychiatric professional.

Discussion: The CST may consult with the offender's physician or psychiatrist before employing polygraph examinations in such cases. Use of prescribed medication for either a medical or psychiatric condition may or may not impact an offender's suitability for polygraph testing. Persons who function optimally while taking prescribed medication may also produce polygraph data of optimal interpretable quality. However, persons who take multiple prescription medications may be more likely than others to exhibit polygraph test data of marginal interpretable quality.

6.212 Release of Information

Offenders with special considerations, and if applicable their legal guardian, shall be required to execute appropriate authorizations so that the CST can consult with and obtain records from professionals who are treating or who have treated in the past those offenders suffering from medical, mental or emotional conditions.

6.213 Sensitivity to Special Considerations

If the CST determines that it is appropriate to use a polygraph examination with an offender who presents with special considerations, the examiner shall conduct the examination in a manner that is sensitive to the offender's physical, mental, or emotional condition. The examiner shall note in the examination report those conditions that may have affected the offender's suitability for testing.

Discussion: Polygraph examinations completed on special population offenders (see definition in Definitions section) may be regarded as "qualified" and the test results should be viewed with caution. In this context, "qualified" means that the test results may not have the same level of validity as test results that are not complicated by special considerations.

6.220 Language Barriers

The need for language translation, including both foreign languages and sign languages, shall be assessed by the CST on a case-by-case basis.

Discussion: Polygraph examinations completed with the aid of a language interpreter should be regarded as "qualified" and the test results should be viewed with caution.

6.221 Selection of Interpreters

The polygraph examiner shall utilize a court certified interpreter, whenever possible. It is important that idiomatic language usage be done accurately and consistently across each successive test chart. Offender's relatives or friends shall not serve as interpreters for polygraph examinations. The examiner shall inform the interpreter in advance about the process of the polygraph test. The examiner shall obtain from the interpreter a written translation, including a mirror translation, of each question presented during the in-test phase of an examination. This translation shall be prepared prior to the in-test phase and shall be maintained as part of the polygraph examination record.

6.230 Cultural Awareness

Polygraph examiners shall be sensitive to ethnic or cultural characteristics when conducting examinations. Polygraph examiners shall attempt to elicit information regarding ethnic or cultural

characteristics in advance of the examination date and shall conduct the examination in a manner that is sensitive to those ethnic or cultural characteristics.

6.240 Managing Offender Manipulation of Special Consideration

The CST shall convene a staffing and case review for all offenders who are determined to be malingering, feigning, or exploiting their special considerations as described in this section for purposes of avoiding polygraph examinations. The purposes of the staffing are to determine whether sanctions should be employed, whether additional behavioral restrictions are employed, or in extreme cases whether removal from community supervision should be considered.

7.000
CONTINUITY OF CARE AND INFORMATION SHARING

Continuity of care is the process of delivering seamless service through integration, coordination and the sharing of information between MDT/CST members, including treatment providers. Due to the length of time many clients may be involved in treatment, the likelihood of changing providers is increased, resulting in additional challenges to continuity of care and information sharing. In an effort to maintain protective factors and reduce negative impacts to the client, it is important for all members of the current treatment team (MDT/CST) to collaborate with one another to avoid disruption to the continuity of care, keeping in mind continuity of care pertains to those clients beginning treatment, those returning to treatment, as well as those in aftercare programs. Continuity of care values the progress a client has achieved in treatment and supervision, and increases the client's investment in treatment by aligning services with individual needs.

7.000 Continuity of Care

7.010 Value and benefit of continuity of care

A. Continuity increases a client's investment in treatment and supervision, and leads to improved outcomes.

B. Continuity values and recognizes progress that has been achieved.

C. Continuity emphasizes the value of ongoing assessment of current needs.

D. Continuity prevents unwarranted repetition of services.

E. Continuity contributes to rapport building and aids in the therapeutic alliance.

7.020 Members of the MDT/CST should prioritize continuity of care through collaboration with past and present service providers. Examples include, but are not limited to, a client being sentenced to the Department of Corrections after a period of community supervision, and transitions between judicial districts.

7.030 Upon initiating services with a client, the MDT/CST should determine how to ensure continuity.

A. Treatment Providers shall obtain signed releases and request previous treatment records.

B. Treatment Providers shall have a structured process to assess current treatment needs. This process shall incorporate past records when available; however, the absence of records does not eliminate the need to assess current treatment needs.

C. Treatment providers and evaluators shall make every reasonable effort to identify and obtain past treatment records. In the absence of such records, it is the responsibility of the Treatment Provider to conduct a thorough and collaborative treatment review with the client, to determine what treatment has been completed, what components of treatment need additional

focus, and what components of treatment have not yet been completed. See Appendix F for an example.

Discussion: Treatment decisions shall be based on individualized risks, needs and responsivity factors, and requirements to repeat previously completed work (e.g. non-deceptive polygraph examination results, completed treatment components) should only be required with documented rationale for why repetition is needed.

D. Treatment Providers shall use this information to determine current treatment needs and as a basis for initiating communication with MDT/CST members regarding treatment needs

E. Other members of the MDT/CST (including polygraph examiners and supervising officers) should communicate with previous providers to determine service needs; this may include the continuation of services or implementation of new services.

7.040 MDT/CST members, including treatment providers, should determine the level of service that is needed in relationship to what has already been completed.

A. Previously approved conditions should not be modified solely based on a change in MDT/CST membership.

B. Treatment Providers shall have an identified system to gather information through collateral reports and client interviews, which gives them the ability to assess the treatment content areas outlined in the Standards. Treatment Providers shall use this information to determine level of progress, treatment areas of continued focus, and treatment areas that have been completed. A sample intake assessment form can be found in Appendix F.

C. Other members of the MDT/CST should have an identified system to gather information, either through collateral reports or client interviews, which gives them the ability to assess the previous services, provisions and level of community access, including 5.700 criteria and contact with minors. MDT/CST members should use this information to determine level of progress, service areas of continued focus, and level of community access.

Discussion: This process should include individuals who can provide information related to previous services, community access, previously approved conditions and/or restrictions. This can include, but is not limited to: support persons, family members, professionals, and previous providers. MDT/CST members, including treatment providers, should be mindful of the impacts to clients, family, and the community, when previously approved conditions are modified. Rationale for such a modification should be documented and connected to risk, need, and responsivity.

7.100 Transition Points and continuity of care consideration

Throughout the continuum of services there may be a variety of transition points. The following sections are intended to provide guidance regarding some transition points, but this is not intended to be an exhaustive list of all possible transition points.

A. Clients changing treatment providers.

1. Clients who have been granted permission for community activities should not have these privileges removed solely based on a change in treatment providers, unless compelling circumstances are present.

2. Current treatment providers may continue previously achieved conditions (e.g. contact with children) when such approval is documented by the previous treatment provider, and there is no new information to indicate such condition should be restricted.

   Discussion: For example, a previously granted condition, such as visitation with children, may need to be continued in the community with comparable safeguards (e.g. allowing supervised contact with children for an individual who previously had visitation within a structured environment).

3. Members of the MDT/CST should discuss current privileges and activities and determine if these privileges and activities can be maintained in a manner in which community and victim safety is not compromised.

B. Clients being released from the Department of Corrections (DOC) facilities who have been receiving treatment in the Sex Offender Treatment and Monitoring Program (SOTMP):

1. Members of the CST should review basic needs that the client will need to access in the community and develop an interim safety plan to meet these needs while the client is waiting to begin treatment in the community. A sample interim safety plan can be found in Appendix K.

2. Clients who have been granted permission for privileges or activities should not have these privileges or activities removed solely based on a change in living environment, unless compelling circumstances are present.

3. Members of the CST should discuss current privileges and activities and determine how these privileges and activities can be maintained in a manner in which community and victim safety is not compromised.

   Discussion: For example a previously granted condition such as visitation with children may need to be continued in the community with comparable safeguards (e.g. allowing supervised contact with children for an individual who previously had visitation within a structured environment).

4. When a client is released from the DOC SOTMP on parole or accepted into Community Corrections, the SOTMP treatment provider shall send all records, including a discharge summary and Risk Management Plan/Personal Change Contract, which:

   a. Describe the level of cooperation and institutional behavior.

   b. Describe participation in treatment, including treatment objectives addressed, completed, and left to complete.

   c. Suggest specific conditions of parole, including adjunct treatment recommendations.

   d. Indicate ongoing risk and protective factors

   e. Identify any Approved support person(s)

   f. Indicate length of time and engagement in treatment

C. Clients returning to treatment/supervision after a period of time out of treatment/supervision:

1. Members of the MDT/CST, including the treatment provider and evaluator should have an identified system to gather information through collateral reports and client interviews, which gives them the ability to assess and determine privileges, activities and the level of treatment needs. See Appendix E for a sample matrix for recommendations.

7.200 Information Sharing

A. Importance of Information Sharing

1. Current provider: Treatment Provider shall request all relevant and applicable previous records and will complete an assessment in the absence of such records. See Appendix F for a sample intake assessment.

2. Previous provider(s): Upon receipt of a signed release of information the Treatment Provider shall release past treatment records to include: Individual Treatment Plan, Progress Summaries, summary of polygraph results, Discharge Summaries, and additional adjunct services provided.

3. Supervising officer: Facilitate the exchange of relevant and applicable records.

B. Releases of Information

1. Treatment providers, evaluators, polygraph examiners, and supervising officers shall be aware of and comply with all applicable laws and rules related to confidentiality and releasing of information (e.g. HIPAA, FERPA, 42 CFR, Mental Health Practice Act, Professional and Ethical codes of conduct).

2. Members of the CST/MDT should also comply with relevant agency policies regarding information sharing.

C. Records

1. Treatment Providers, evaluators, polygraph examiners, and supervising officers should follow applicable policy and statutes related to records retention.

2. Court files are considered a permanent record and some information, such as discharge summaries, may be filed with the courts. By logging such information in the court record, it will remain available to clients and other parties to the case, subject to the court's discretion. It is recommended that Treatment Providers provide this information to ensure the client's involvement in treatment is part of the permanent court record and, if appropriate, may be considered by the court in future decision making.

a. A court filing document for submitting a recommendation regarding registration for juveniles can be found in the appendices of those Standards.

b. A court filing document for submitting information regarding participation in treatment for adults can be found in Appendix J.

3. Discharge Summaries

a. Supervising Officers: Discharge information should be recorded by the supervising officer at the termination of community supervision, and should be available in the file and should include records of:

    1. Treatment progress

    2. Successful or unsuccessful completion of treatment

    3. Auxiliary treatment

    4. Community stability

    5. Residence

    6. Compliance with the supervision plan and conditions of probation/parole/community corrections

    7. Most current risk assessment

b. Treatment Provider: Discharge information shall be recorded by the Treatment Provider, and shall include, but not be limited to, the following:

    1. Treatment goals and objectives completed

    2. Current level of risk, including risk and protective factors

    3. Successful or unsuccessful completion of treatment

    4. Aftercare recommendations, if applicable

8.000
VICTIM IMPACT AND A VICTIM CENTERED APPROACH

8.000 Sexual violence is a problem in Colorado. As communities are forced to face the issue of sexual abuse, many efforts are directed towards issues other than the victim who has been violated, the child robbed of their childhood, and the recovery and healing of the victims and their families. Victims can be overlooked as the criminal justice system focuses on the legal issues and the needs of the offender.

These Standards are designed to address the assessment, evaluation, treatment and monitoring of adult sex offenders. In order to accomplish the mission of effective management of adult sexual offenders and eliminating sexual re-offense, professionals must first start with understanding the trauma and suffering of victims. This section provides some information for professionals working with adult sex offenders and juveniles who have committed sexual offenses on the impact of sexual assault and the needs of victims.

In Colorado an estimated 1 in 4 women and 1 in 6 men will experience a sexual assault or attempted sexual assault in their lifetime.[136] Most victims first experience sexual assault as children or adolescents. Sexual assault is the most under reported crime in the United States. Only an estimated 16 – 19% of sexual crimes are reported to law enforcement. Far fewer are prosecuted. Research indicates the younger the victim and the closer the relationship, the less likely a victim will report.[137]

Sexual crimes violate victims. Victims may experience chronic and severe mental and physical health symptoms, as well as social, familial, economic and spiritual harm. These symptoms cross over into all aspects of victims' lives, and victims often face long term impact and continue to struggle for recovery over the course of their lifetimes. Trauma from sexual assault changes the victim's world view, self-perception and sense of power and control. Family members of victims and communities as a whole are also negatively impacted by sexual offenses. While the effects of sexual assault on victims are unique and may vary over time, common consequences of sexual assault include:

- fear
- anxiety
- hypervigilance
- self-blame
- guilt
- shame
- depression
- anger
- irritability
- avoidance
- intrusive thoughts
- disordered eating
- sexual behavior problems
- substance abuse
- self-injuring behaviors
- suicidal ideation and attempts
- failure to identify their experience as sexual assault or a crime
- minimization of their experience
- loss of trust
- low self-esteem
- impaired sense of self and identity

[136] Black, Michele C., et al. (2010) *National Intimate Partner and Sexual Violence Survey*. Centers for Disease Control and Prevention; Dube, S.R., et al. (2005). Long term consequences of childhood sexual abuse by gender of victim. *American Journal of Preventive Medicine*, 28(5), 430-438.

[137] Kilpatick, D., & McCauley, J. (2009). *Understanding National Rape Statistics*. National Resource Center on Domestic Violence; Tjaden, P. & Thonnes, N. (2006). Extent, Nature and Consequences of rape victimization: Findings from the National Violence Against Women Survey. U.S. Department of Justice.

- flashbacks
- nightmares and sleeping problems
- panic attacks
- Post-Traumatic Stress Disorder
- dissociative disorders
- physiological effects, such as headaches / chronic pain
- memory impairment
- difficulty with and loss of relationships and intimacy
- isolation
- loss of independence
- financial loss
- increased vulnerability to other victimizations

Often victims report significant distress over not being believed and feelings of intense guilt and shame. Many victims and their family members have been subjected by the offender to long term and intentional grooming behaviors. Victim impact is substantially reduced when victims are believed, protected and adequately supported. Acknowledging and addressing the impact to victims can aid in their long term health and recovery. Recovery and healing of victims is possible and enhanced when teams operate with a victim centered approach.

8.100 The Community Supervision Team shall operate with a victim centered approach.

A victim centered approach means that the needs and interests of victims require paramount attention by professionals working with sexual offenders. Individuals and programs working with sexual offenders should always have the victim and potential victims in mind. This means a commitment to protecting victims, not re-victimizing, being sensitive to victim issues and responsive to victim needs. A victim centered approach requires an avenue to receive victim input and provide information to victims. This balanced approach has many benefits, including improved treatment and supervision of the offender, increased accountability, enhanced support for victims and a safer community. Collaboration and information sharing enhances the supervision team's ability to maintain a victim centered approach.

Understanding these offenses from the perspective of the victim is important to comprehend the gravity of the offending behavior and see the full picture. Awareness of the impact of sexual assault is necessary for providers to operate with a victim centered approach. Professionals must recognize the harm done to victims, and apply this knowledge, to work effectively with offenders to internalize and demonstrate long term behavioral change. The impact to the victim informs and guides the decision making process and assists professionals in prioritizing the safety and needs of victims of sexual crimes.

8.200 The supervision team should help inform victims regarding the treatment and supervision process and share information on how this process demonstrates the commitment towards victim recovery, community safety and no new victims.

A. Teams should respect the victims' wishes regarding their level of involvement and also understand that their interest may change over time.

B. When communicating with victims teams should consider what information can be shared and explain that not all information can be shared and why.

Discussion: Teams should discuss what information can and should be shared, taking into account what information is valuable for the victim, for the victim to feel safe, and for the victim to feel that the community as a whole is being protected. Teams have legal and ethical considerations when determining what information is appropriate for sharing with victims and

should exercise good professional judgment. Victims are assisted by understanding why decisions are made in the interest of public safety. Even with support systems in place, the criminal justice system is still difficult for victims. Teams can honor and contribute to justice for victims by operating with a victim centered approach.

C. Ongoing training regarding sexual victimization is recommended for all supervision team members and required by these standards to be an approved evaluator, polygraph examiner or treatment provider. Teams should (shall for juvenile) include a victim representative on the supervision team to ensure a victim centered approach is being implemented.

Colorado Statutes and Guidance Pertaining to Victims

The Colorado Revised Statutes state, "The Sex Offender Management Board shall develop and implement methods of intervention for adult sex offenders, which methods have as a priority the physical and psychological safety of victims and potential victims and which are appropriate to the assessed needs of the particular offender, so long as there is no reduction in the safety of victims and potential victims."

The Colorado Victims' Rights Act (VRA) was passed by the voters in 1992. This Victims' Bill of Rights is part of the Colorado Constitution and ensures that victims have a right to be treated with fairness, respect and dignity and have a right to be heard when relevant informed and present at all critical stages of the criminal justice system. The legislative declaration of the Colorado Revised Statutes states, "The general assembly hereby finds and declares that the full and voluntary cooperation of victims of and witnesses to crimes with state and local law enforcement agencies as to such crimes is imperative for the general effectiveness and well-being of the criminal justice system of this state. It is the intent of this part 3, therefore, to assure that all victims of and witnesses to crimes are honored and protected by law enforcement agencies, prosecutors, and judges in a manner no less vigorous than the protection afforded criminal defendants. (Please see C.R.S. Article 4.1 of Title 24 for a listing of all victims' rights.) All post-sentencing agencies have obligations under the VRA though victims must "opt in" to receive notification after sentencing.

For more information regarding victim considerations in the school environment, please see the SOMB School Resource Guide.

Colorado has one of the most comprehensive statutes pertaining to victims' rights in the nation. Victim services personnel exist in all levels of the criminal justice system, including law enforcement, prosecution, probation, community corrections, Department of Corrections and Division of Youth Corrections.

Supporting Victims

The following are common needs of sexual assault victims and ways in which members of the community supervision team can support victims and contribute to their healing and recovery:

Needs:

- Caring, compassionate response
- Physical and psychological safety/protection
- Being believed
- Therapy and other resources

- Opportunities for input
- Information regarding the offender management, supervision and treatment
- Accurate information being provided to the offender's and victim's support systems

Support:

- Listen to victims and allow them to be heard
- Provide information about team members' roles and responsibilities
- Reassure victims that the abuse was not their fault
- Hold the offender fully accountable
- Validate the victims' experience
- Acknowledge victims' strengths and ability to heal/recover
- Be clear regarding what information can and cannot be shared
- Be willing to repeat information
- Be sensitive to where victims are in their recovery process
- Advocate, as needed, for therapy for victims
- Recognize the impact of the trauma on the victims' behaviors, beliefs and emotions, and how those may be expressed
- Thank victims for reporting and going through the very difficult criminal justice process
- Recognize the importance of how clarification, contact or reunification are implemented (refer to section 5.000)

Common Victim Concerns and Safety Issues

- Location of the offender
- The negative impact of the victim encountering the offender in the community, especially in intra-familial cases, such as family functions
- The offender being able to manipulate the CST members in the same ways he/she manipulated the victim and victim's family
- Lack of trust that information regarding the offender's treatment and supervision is being provided
- The conditions of supervision, such as allowing contact with minors
- The offender continuing to deny, minimize or blame the victim for the abuse
- Whether or not the offender is demonstrating engagement in treatment and changing their behavior
- Whether or not the offender is telling the truth, demonstrating honesty through polygraphs or other means, and compliant on supervision
- Whether or not the offender is expressing genuine remorse for the abuse

9.000
STANDARDS FOR PLETHYSMOGRAPHY

9.100 Standards of Practice for Plethysmograph Examiners

9.110 A plethysmograph examiner shall adhere to the "Guidelines for the Use of the Penile Plethysmograph," published by the Association for the Treatment of Sexual Abusers, ATSA Practitioner's Handbook[138] (See Appendix L-1 and L-3) and shall demonstrate competency according to professional standards and conduct plethysmograph examinations in a manner that is consistent with the reasonably accepted standard of practice in the plethysmograph examination community.

9.120 Plethysmograph examiners shall adhere to the following specific procedures during the administration of each examination:

A. The examiner shall obtain the informed assent of the offender for the plethysmograph examination, and shall inform an offender of the examination methods, how the information will be used, and to whom it will be given. The examiner shall also inform the offender about the nature of the evaluator's relationship with the offender and with the court. The examiner shall respect an offender's right to be fully informed about the examination procedures, and results of the examination should be shared with the offender and any questions clarified;

B. The examinee shall also sign a standard waiver/release of information statement. The language of the statement should be coordinated prior to the plethysmograph examination with the therapist, probation/parole officer, community corrections case manager, or prison treatment provider;

C. The examiner shall elicit relevant biographical and medical history information from the examinee prior to administering the actual plethysmograph examination;

D. The testing process shall be completely explained to the examinee, including an explanation of the instrumentation used and causes of general nervous tension;

E. Test results shall be reviewed with the examinee; and

F. The examiner must have received all pertinent and available case facts within a time frame sufficient to prepare for the examination.

9.130 Plethysmograph examinations should never be used in isolation. The results must be utilized in conjunction with other evaluative measures or as a part of a treatment program to effectively assess risk.

[138] Plethysmographic testing measuring physiological changes associated with sexual arousal are also available for female sex offenders.

10.000
RECOMMENDATIONS FOR MANAGEMENT AND INFORMATION SHARING ON ALLEGED SEX OFFENDERS PRIOR TO CONVICTION

Discussion: Following are recommendations for the management of alleged sex offenders prior to conviction. Although the Sex Offender Management Board has no authority to set standards for alleged sex offenders prior to conviction, the SOMB strongly recommends that these guidelines be followed in order to establish both the data and practices to support the later assessment, treatment, and behavioral monitoring of convicted sex offenders.

1. Investigation of reports to law enforcement and child protection services.

Information that will contribute to the future assessment of an alleged sexual offender and preserve evidence is best obtained through a thorough and objective investigation in which the well-being of the alleged victim is of primary importance.

Investigations that preserve the well-being of the alleged victim include such approaches as:

- Providing immediate medical referral
- Minimizing the number of interviews of children
- Using a child advocacy center to interview children; increasing the comfort level of the adult alleged sexual assault victim being interviewed as much as possible
- Removing the alleged perpetrator, rather than the child alleged to be a victim of sexual abuse from the home
- Using forensic medical examinations that meet the standards set by the Colorado Coalition Against Sexual Assault[139]
- Providing emotional support (and victim advocacy services) to the alleged victim
- Using community-based protocols for the response to alleged victims of sexual abuse[140]

2. Documentation of sexual abuse.

Complete documentation will assist in developing future treatment and supervision plans and in protecting the alleged victim and the community. Both child protection and law enforcement investigative reports should provide detailed information on the behavior of the alleged perpetrator related to and including the sexual offending behavior.

Investigative reports should include information that describes:

- The dynamics of the alleged abuse
- Alleged offender patterns of grooming (preparing) the victim
- The ways in which the alleged offender discouraged disclosure
- Presence of child pornography
- Amount of violence and/or coercion

[139]For copies of the *Colorado Sexual Assault Forensic Examination Protocol*, which also includes valuable appendices such as the numbers of rape crisis hotlines in Colorado, contact the Colorado Coalition Against Sexual Assault, P.O Box 18633, Denver, CO 80218.

[140] For a victim-center protocol for responding to sexual assault, please see *Looking Back, Moving Forward: A Guidebook for Communities Responding to Sexual Assault*, published by the National Victim Center, 2111 Wilson Boulevard, Suite 300, Arlington, VA 22201, (703) 276-2880.

- Any direct or indirect corroboration of the offense
- Evidence of other sexual misconduct

Such information will not only assist in the prosecution of the case but will also contribute to assessment by the pre-sentence investigator, the judge, and the treatment provider/evaluator who will conduct a sex offense-specific evaluation. Such documentation can also assist in confronting offender denial and can establish a modus operandi in the event of future crimes by the offender.

3. Specialized job duties and training.

Whenever possible, investigation and prosecution of sexual assault cases should be assigned to individuals specifically trained to work in this area. Trained individuals are least likely to cause additional trauma to the alleged victim and their investigations are most likely to result in a prosecutable case.

4. Teamwork among law enforcement, child protection services and prosecution.

A team approach to the investigation, review, and case management of sexual abuse reports is vital to the successful prosecution of alleged sexual offenders. Regular meetings of the team enhance community safety and increase the effectiveness of the team. Information should be routinely updated on the status of dependency/neglect petitions, which cases are being criminally filed, and the status of placement decisions.

5. Removal of the perpetrator from the home in intra-familial sexual abuse cases.

Whenever possible, the perpetrator, not the alleged victim should be removed from the home.

6. Family Reunification is dangerous.

In child sexual abuse cases, family reunification is dangerous. When family reunification is a goal of the child protection agency, family reunification should be avoided until after disposition of the criminal case. Before recommending contact with a child victim or any potential victims, responsible parties shall 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.

A. In addition, the following criteria should 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 and the 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. For offenders who refuse to answer incriminating sexual offense history questions, including incriminating sexual offense history polygraph questions, providers shall refer to Standard 3.160 I. 2;

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

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

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

1. There must be provisions for 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 known 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; and

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 caregiver should be available. The potential supervisor must complete training addressing sexual offending and safe and effective visitation supervision.

7. Referrals for sex offense-specific evaluations.

When an alleged sexual offender is referred for evaluation and assessment, the referral should be to an evaluator/provider who meets the *Standards and Guidelines* for the evaluation of sex offenders. (Section 16-11.7-106 C.R.S requires the Department of Human Services to refer *convicted* sex offenders to evaluators who meet these Standards.) However, such an evaluation often will not take the place of the sex offense-specific evaluation required at the pre-sentence investigation, if the individual is convicted in a criminal case.

8. Forwarding of child protection services reports to the pre-sentence investigator.

In cases where the report of an intra-familial sexual assault results in a conviction, the child protection agency should provide the probation department, upon request and with a signed release of information by the offender, with copies of the intake report and the sex offense-specific evaluation in time for the court date.

9. Pre-trial conditions.

With the exception of offense-specific treatment requirements, bond supervision conditions should be similar to the specialized conditions of probation or parole, particularly the prohibition of contact with the alleged victim and, if the victim is a child, with the alleged victim and all other children.

Appendix A
SEX OFFENDER MANAGEMENT BOARD ADMINISTRATIVE POLICIES

This appendix is designed for listed treatment providers, evaluators, and polygraph examiners pursuant to section 16-11.7-101-09, C.R.S., as well as those who have filed an Intent to Apply for listing status with the Sex Offender Management Board (SOMB), to explain the requirements of listing and the process of denial of placement to the list, complaints, and appeal. The SOMB does not have professional licensing authority, but rather statutory authority pursuant to section 16-11.7-101, *et. seq.* The provisions of these standards constitute the process of the SOMB related to listing, denial of placement, complaints and appeal.

A. LISTING AS A PROVIDER

1. This appendix applies to treatment providers, evaluators, and polygraph examiners who are listed in the following categories:

   - Intent to Apply for listing status (polygraph examiners only)
   - Associate level provider status
   - Full Operating level provider status
   - Clinical Supervisor status
   - Not currently practicing status

2. Providers not on the SOMB approved provider list, including any provider who is denied placement or removed from the Provider List, shall not provide any sex offense-specific services pursuant to statute in Colorado to convicted adult sex offenders or juveniles who have committed sexual offenses. No referral source shall use any provider not on the approved provider list, denied placement or removed from the provider list per 16-11.7-106 C.R.S.

3. Approved providers shall submit data consistent with the SOMB's data collection plan and participate in, and cooperate with, SOMB research projects related to evaluation or implementation of the Standards or sex offender management in Colorado in accordance with sections 16-11.7-103 (4) (d), 16-11.7-103 (4) (h) (II), and 16-11.7-103 (4) (k), C.R.S.

4. Confidentiality of SOMB Files: The following information in the SOMB files, including application materials, for applicants, individuals on the provider list, and those who have filed an Intent to Apply is considered confidential and is not available to the public, including listed providers: background investigations, criminal history checks, school transcripts, letters of recommendation, trade secrets, confidential commercial data including applicant forms created for business use, curriculum developed for the business and clinical evaluations, and information that, if disclosed, would interfere with the deliberative process of the SOMB's Application Review Committee(s) (ARC), and if disclosed to the public would stifle honest participation by the ARC. The Colorado Open Records Act applies to other materials (Section 24-72-201, C.R.S.).

B. DENIAL OF PLACEMENT ON THE PROVIDER LIST

The SOMB reserves the right to deny placement on the Provider List to any applicant to be a treatment provider, evaluator, or clinical polygraph examiner under these Standards. Reasons for denial include but are not limited to:

1. The SOMB determines that the applicant does not demonstrate the qualifications required by these *Standards*;

2. The SOMB determines that the applicant is not in compliance with the *Standards* of practice outlined in these *Standards*;

3. The applicant fails to provide the necessary materials for application as outlined in the application materials and the administrative policies and procedures;

4. The SOMB determines that the applicant exhibits factors (boundaries, impairments, etc.) which renders the applicant unable to treat clients;

5. The SOMB determines that the results of the background investigation, the references given or any other aspect of the application process are unsatisfactory.

C. APPEAL PROCESS FOR DENIED PLACEMENT OR ANY SPECIFIC LISTING STATUS ON THE PROVIDER LIST

Any applicant who is denied placement on the Provider List or any specific status (e.g., Intent to Apply for polygraph examiners, a new listing category, or moving up to a higher provider level) on the Provider List will be supplied with a letter from the Application Review Committee (ARC) outlining the reasons for the denial and notifying the applicant of his or her right to appeal to the full SOMB. Appeals will be conducted in the following manner:

1. The applicant/listed provider must submit a request to the SOMB for an appeal in writing within 30 days of the notification of denial of placement or of any specific status on the Provider List to the SOMB.

2. The SOMB appeal process will consider only information that is relevant to the reasons for denial outlined by the ARC in the denial letter. Any information outside of the scope of the reasons for the denial will not be considered by the SOMB in the appeal process.

3. Instead of appearing in person at the appeal, the applicant/listed provider may request to participate by alternate electronic means with the SOMB.

4. Appeals will be governed by Section D of this appendix.

D. COMPLAINT AGAINST A LISTED PROVIDER

When a complaint is made to the SOMB about a Treatment Provider, Evaluator, or Polygraph Examiner on the Provider List, the complaint shall be made in writing to the SOMB and signed by the complainant. The appropriate complaint forms are available on the SOMB website. All complaints against treatment providers and evaluators on the Provider List will be forwarded for investigation and review to DORA pursuant to section 16-11.7-106(7)(a)(I), C.R.S. Concurrently, the SOMB will

review the complaint for potential action pursuant to section 16-11.7-106(7)(b)(I), C.R.S. All complaints against polygraph examiners on the Provider List will not be forwarded to DORA.

Complaints regarding Treatment Providers, Evaluators, and Polygraph Examiners who have never been listed or who were not listed on the Provider List at the time of the complaint, or who have not filed an Intent to Apply for listing status, are not appropriate for SOMB intervention. The SOMB will inform complainants that it does not have the authority to intervene in these cases but may refer complaints against Treatment Providers and Evaluators to DORA for further action. Complaints appropriate for SOMB intervention are those complaints against sex offender Treatment Providers, Evaluators, and Polygraph Examiners, who are on the Provider List, or who have filed an Intent to Apply for listing status, or who were on the Provider List or under Intent to Apply listing status at the time of the alleged violation. Complaints against a listed provider regarding actions of unlisted persons under the supervision of that individual, including those who have filed an Intent to Apply, are also appropriate for SOMB intervention.

Complaints will be addressed in the following manner:

1. All complaints will be subject to an initial administrative review by the staff of the SOMB. This review will determine if the complaint process has been followed using the proper forms available on the SOMB website. Insufficient or improper filings may not be accepted for review and the SOMB staff will provide written notice of the deficiencies to the complainant.

2. SOMB staff will forward complaints to the ARC for review and will notify the complainant in writing of the receipt of the complaint.

    a. If the complaint fails to allege a Standards violation sufficiently, the ARC will notify the complainant in writing.

    b. Determinations under section 2.a. above are final and not subject to appeal.

3. If a complaint sufficiently alleges a Standards violation, ARC's review of the complaint (a process separate from any review contemplated or completed by DORA) may take any of the following actions (please note that these actions may be independent from any action taken by DORA and may or may not be the same as DORA's results):

    a. Determine complaint unfounded, and notify complainant and identified provider in writing.

        OUTCOME: No formal actions will appear on file for this identified provider regarding this complaint.

    b. Request clarifying information from the complainant and/or the identified provider.

    c. Contact the identified provider to determine if the complaint can be resolved informally through mutual agreement between the identified provider and the ARC. If mutual agreement can be reached, the complaint will be determined to be unfounded. The complainant will be notified verbally of the mutual agreement and in writing that the complaint will be unfounded. As an unfounded complaint, the results of the mutual agreement will remain confidential and neither party shall disclose the results of the mutual agreement or that a mutual agreement has been reached. All inquiries to the SOMB regarding the identified provider will be responded to by disclosing only that the

identified provider does not have any founded complaints against him/her (unless there was a prior founded complaint).

OUTCOME: No formal actions will appear on file for this identified provider regarding this complaint.

d. Request both parties appear before the ARC. Either party may request alternate electronic means with the ARC in lieu of appearing in person. The request to appear electronically must be made at the time of the request by the ARC to appear. Any decision to conduct a hearing is made at the sole discretion of the ARC. If the ARC holds a hearing regarding the complaint, the following procedures apply:

1. Both the complainant and identified provider will be notified in writing of the date, time and place for the hearing.

2. If mutual agreement resolving the complaint can be reached, the complaint will be determined to be unfounded. The complainant and identified provider will be notified in writing that the complaint will be unfounded. As an unfounded complaint, the results of the mutual agreement will remain confidential and neither party shall disclose the results of the mutual agreement or that a mutual agreement has been reached. All inquiries to the SOMB regarding the identified provider will be responded to by disclosing only that the identified provider does not have any founded complaints against him/her (unless there was a prior founded complaint).

OUTCOME: No formal actions will appear on file for this identified provider regarding this complaint.

e. Initiate and conduct an investigation of the information contained in the complaint either directly or through staff, investigators or consultants.

1. Conclude that a complaint is unfounded and the identified provider is notified of the results of the complaint

OUTCOME: No formal actions will appear on file for this identified provider regarding this complaint.

2. Conclude that a complaint is founded, and the identified provider is notified of the outcome of the complaint, which may include being issued a Letter of Removal from the Provider List. Any founded complaint in one approval category shall result in a review of the individual's other approval categories, and may impact these other approval categories as well (e.g., a founded complaint against an evaluator may impact the individual's treatment provider status as well).

OUTCOME: Referral sources will be notified and the identified provider will be taken off the list either 31 days from the date of issue of the Letter of Removal *OR* following the completion of the appeal process should either party appeal the decision. If the situation warrants, the SOMB may exercise the option of seeking guidance from the Office of the Attorney General for possible legal action.

An appeal of a founded complaint by the ARC may be taken to the SOMB pursuant to Section D of this appendix.

E. APPEALS

Any complainant or identified provider who wishes to appeal a finding on a complaint may appeal the decision to the SOMB. Appeals regarding findings on complaints will be conducted in the following manner:

1. A request for appeal must be submitted to the SOMB in writing within 30 days of the date of the complaint finding letter.

2. Both parties will receive notification of the date, time and place of the appeal and the deadline for submission of additional materials. These additional materials must be limited to 10 pages and 25 copies must be received by the SOMB 30 days prior to the hearing. Materials received after the deadline or not prepared according to these instructions will not be reviewed at the appeal.

3. The SOMB will only consider information specific to the finding outlined by the ARC in the complaint finding letter.

4. Copies of the complaint materials (subject to redactions or other protections to comply with statutorily contemplated confidentiality concerns) considered by ARC will be provided to the SOMB and the parties at least 30 days prior to the hearing and the parties and the SOMB are expected to make every effort to maintain confidentiality of the materials.

5. Either party may request alternate electronic means with the SOMB in lieu of appearing in person. The request must be made in writing at the time of the request for the appeal.

6. Appeals will be scheduled in conjunction with regular SOMB meetings. The appellant must confirm, in writing, their ability to attend the scheduled appeal; failure of the appellant to do so may result in the appeal being dismissed. The SOMB staff and the SOMB chairperson will jointly review requests for a rescheduling of an appeal. Parties will be notified verbally or in writing, as applicable, regarding the decision on their request to reschedule. Requests to reschedule will be reviewed based on reasonable cause.

7. Either party may bring one representative with them. Appeal hearings (in person or via electronic means) will be 80 minutes long: 20 minutes for presentation by the ARC; 20 minutes for a verbal presentation by the complainant; 20 minutes for the identified provider; and 20 minutes for questions and discussion by the Board. Applicable time periods may be modified upon request, by either party or a SOMB member, followed by a motion by a SOMB member and a vote on the motion.

8. There must be a quorum of the SOMB to hear an appeal. ARC members count towards establishing a quorum, but must abstain from voting on the appeal per SOMB by-laws.

9. The SOMB will consider appeals in open hearing and audio record the proceedings for the record unless certain material must be considered by the SOMB in executive session pursuant to section 24-6-402 (3) (a) (III), C.R.S. Any vote will occur in open session.

10. The SOMB must vote on the original findings of the ARC. They must vote in one of the following three ways:

    - Accept the finding of a Standards violation by the ARC.
    - Reject the finding of a Standards violation by the ARC.

- Accept the Standards violation by the ARC and change the proposed sanction imposed by ARC.

11. The results of the appeal will be documented via letter sent to both parties within 30 days of the date of the appeal hearing.

12. Complaint records will be retained for 20 years per the Division of Criminal Justice Records Retention Policy.

13. The appeal process in Appendix F is the sole SOMB remedy for a provider denied placement on or any specific status on the Provider List, or resolution of a complaint(s). The decision of the SOMB is final.

Contact information and relevant forms related to this appendix may be found on the SOMB website.

Appendix B
GUIDANCE REGARDING VICTIM/FAMILY MEMBER READINESS FOR CONTACT, CLARIFICATION, OR REUNIFICATION

The following are considerations for Community Supervision Teams (CSTs) in determining readiness and ability to make informed decisions for individuals who have been victimized and have requested contact, clarification, or reunification, as well as readiness for parents/guardians and other children in the home. These are not to be construed as expectations that the victim must meet, but for the CST to be knowledgeable and able to assess family readiness. It is important to consider the following areas as a means of ensuring that the individual is not placed in a situation that could result in further victimization or could compromise their physical or emotional safety or well-being.

Victim Readiness

Contact and Clarification:

The person who has been victimized is able, based on their age and developmental level, to:

- Acknowledge and talk about the abuse and the impact of the abuse without minimizing the scope (e.g. does not excuse the abuse based on frequency, beliefs about the offender's intent, etc.)
- Accurately assess and identify the offender's responsibility for the abuse and aftermath and does not blame self.
- Place responsibility on the offender and does not minimize or deny responsibility based on fear of repercussions.
- Avoid perceiving self as destroyer or protector of the family.
- Demonstrate assertiveness skills and is willing to disclose any further abuse or violations of a safety plan.
- Demonstrate a reduction of symptoms and is not actively experiencing Post Traumatic Stress Disorder.
- Express feeling safe, supported, protected and in control, but not controlling.
- Maintain positive and supportive relationships with those who have demonstrated an ability to support them.
- Demonstrate healthy boundaries, self-respect and empowerment.

Reunification:

In comparison to contact or clarification, which typically occurs at specified periods of time and can often be highly structured, reunification occurs over an extended period of time, following clarification, and often without high levels of external structure. The following areas should be considered in addition to the factors listed above.

The person who has been victimized is able to:

- Demonstrate awareness of previous grooming tactics of the offender.
- Recognize ongoing grooming patterns.
- Exercise assertiveness skills and confront the offender as needed.
- Identify and seek out external support if needed.

Non-Offending Parent or Guardian Readiness

The non-offending parent or guardian:

- Believes the victim's report of the abuse.
- Recognizes and understands, without minimizing, the impact of the abuse on the victim.
- Holds the offender solely responsible for the abuse without blaming the victim in any way.
- Has received appropriate education regarding their role as a non-offending parent.
- Demonstrates the ability to be supportive and protective of the victim.
- Is more concerned with victim impact and recovery than consequences or inconveniences for the offender.
- Has received appropriate education regarding sexual offender behavior.
- Has received full disclosure of the extent of the offender's sexual offense(s)/abusive behavior(s).
- Is aware of the grooming tactics used by the offender for not only the victim, but also other family members.
- Supports and implements the family safety plan.
- Demonstrates the ability to recognize and react properly to signs of high risk or offending behavior.
- Can demonstrate assertiveness skills that would allow him/her to confront the offender and is willing to disclose high risk or offending behavior.

Secondary Victim, Sibling or Other Children in the Home Readiness

This individual:

- Has an understanding of the nature of abuse and the impact on the victim.
- Does not blame the victim or minimize the abuse.
- Understands the offender is solely responsible for the abuse.
- Has received information about offender treatment and high risk and grooming behaviors.
- Can express the ways the abuse has affected and impacted his/her life.
- Demonstrates healthy boundaries, including the ability to identify and set limits regarding personal space and privacy.
- Is aware of the family safety plan.

Appendix C
YOUNG ADULT MODIFICATION PROTOCOL

Young Adult Modification Protocol[141]

The SOMB recognizes that due to responsivity[142] issues and the unique needs of some young adults, applying the Adult Standards without flexibility can be problematic. A different approach may be needed when addressing the unique challenges a portion of this population poses.

Neurobiological research gives us a deeper understanding of adolescent and young adult brain development. This research indicates that the brains of many young adults, ages 18 to 25, are still developing thus it is imperative for CST/MDT members to assess and treat this population and consider allowing exceptions according to each individual regardless of where they are in the criminal justice system.[143,144,145,146,147,148,149,150]

Offenders, ages 18-25 may be more inclined to make poor decisions. This may or may not be related to risk for recidivism. It is important for the CST/MDT to evaluate an offender's problematic behavior, specifically, when responding to violation or rule breaking behavior, to best determine whether or not it signifies an increase in risk and if so, what needs exist and what response best addresses those needs and manages risks. Such assessment should include strengths and protective factors.[151] The nature and severity of the behavior and the degree which it relates to risk should be commensurate with the appropriate interventions. Risk of harm to others must not be ignored and should be balanced when assessing impulsive behavior typical in adolescence versus criminal, anti-social characteristics which are indicative of risk.

[141] The following document was referenced throughout the development of this appendix: Center for Sex Offender Management (CSOM). (2014). Transition-Aged Individuals who have Committed Sex Offenses: Considerations for the Emerging Population. Retrieved from: http://www.csom.org/pubs/CSOM-Considerations-Emerging-Adult-Population.pdf.

[142] The Responsivity Principle means that correctional services are more effective when treatment and management services use methods which are generally more effective with offenders and when these services are individualized in response to the culture, learning style, cognitive abilities, etc. of the individual.

[143] Teicher, M., Anderson, S., Polcari, A., Anderson, C., & Navalta, C. (2002). Developmental neurobiology of childhood stress and trauma. *Psychiatric Clinics of North America,* 25, 397-426.

[144] Perry, D. (2006). Applying Principles of Neurodevelopment to Clinical Work with Maltreated and Traumatized Youth: The Neurosequential Model of Therapeutics. In Nancy Boyd (Ed.), *Working with Traumatized Children in Child Welfare* (pp. 27-52).

[145] Siegel, D.J. (2006). Brain, mind, and behavior. In D. Wedding & M. Stuber (Eds.), *Behavior and Medicine, Fourth Edition*. Cambridge, MA: Hogrefe & Huber.

[146] Siegel, D.J. (2006). An interpersonal neurobiology approach to psychotherapy: How awareness, mirror neurons and neural plasticity contribute to the development of well-being. *Psychiatric Annals, 36(4),* 248-258.

[147] Steinberg, L. (2012). Should the science of adolescent brain development inform public policy? Issues in Science and Technology. Retrieved from: http://www.issues.org/28.3/steinberg.html.

[148] Steinberg, L. (2008). A social neuroscience perspective on adolescent risk-taking. *Developmental Review, 28,* 78-106.

[149] Steinberg, L., Cauffman, E., Woolard, J., Graham, S., & Banich, M. (2009). Are Adolescents Less Mature Than Adults? Minors' Access to Abortion, the Juvenile Death Penalty, and the Alleged APA "Flip-Flop. *American Psychologist, 64*, 583–594.

[150] Steinberg, L. & Scott, E. (2003). Less Guilty by Reason of Adolescence: Developmental Immaturity, Diminished Responsibility, and the Juvenile Death Penalty. *American Psychologist*, 58, 1009–1018.

[151] Protective factors are conditions or attributes (skills, strengths, resources, supports or coping strategies) in individuals, families, communities or the larger society that help people deal more effectively with stressful events and mitigate or eliminate risk in families and communities.

Many young adults may present more like an adolescent rather than an adult. Research indicates over responding to non-criminal violations with this population can cause more harm than good for both the offender and the community.[152]

Guiding Principles:

The following guiding principles, in addition to the guiding principles in the Adult Standards, are for Community Supervision Teams (CSTs)/Multi-Disciplinary Teams (MDTs) considering a recommendation of making exceptions to the Adult Standards for a specific Young Adult population.

1. Victim and Community Safety are paramount. See Guiding Principle #3 in the Adult Standards and Guidelines for further detail.

2. Victim self- determination regarding involvement and input. See Guiding Principle #7 in the Adult Standards and Guidelines for further detail.

3. Sexual offenses cause harm.

4. Psychological well-being of victims is critical.

5. Focus needs to be on promoting strengths/health to reduce risk.

6. Emphasis on developing pro-social support systems.

7. Ensuring offender accountability for offending behavior.

8. Treatment planning includes development of social/interpersonal skills.

9. Treatment planning takes into account stages of brain development.

10. Not to minimize the impact to the victim but to improve/creating pathways for more effective treatment.

11. Collaboration of CST/MDT and review factors 1-10.

Exclusionary Criteria:

(If previous records indicate or current testing establishes that one of the following is true)

- Primary sexual interest/arousal in pre-pubescent individuals

- Clear documented pattern of sexual sadism

- Sexually Violent Predator

[152] Teicher, M., Anderson, S., Polcari, A., Anderson, C., & Navalta, C. (2002). Developmental neurobiology of childhood stress and trauma. *Psychiatric Clinics of North America*, 25, 397-426.

- Psychopathy
- Meets criteria for mental abnormality (Millon Clinical Multiaxial Inventory)

Protective Factors:

1. In school/stable employment
2. Living in a home and receiving developmentally appropriate supervision
3. Pro-social support system
4. Maturation
5. No substance abuse
6. No delinquent lifestyle
7. Absence of severe MH-Axis I or II
8. Compliance with treatment and supervision expectations
9. Amenable to treatment, willingness to engage
10. Lack of known multiple offenses

CSTs and MDTs are encouraged to look at young adult offenders, and develop individualized treatment plans and containment efforts based on the maturation and risk of the individual. Independent living skills, risk and protective factors should be discussed by CSTs/MDTs and factored into programming for the offender. CSTs/MDTs should consider consulting with other experienced adult or juvenile practitioners to assist in the development of effective treatment and supervision as well as to identify possible resources that may aid in information gathering. In some cases it may be appropriate to use juvenile risk assessments with this population for informational purposes only, and with the understanding that using a juvenile risk assessment instrument on an individual over the age of 18 is not a validated assessment of risk. The CST/MDT based on a unanimous decision, is empowered to make exceptions to specific standards as needed and changes shall be clearly documented. After conducting a thorough evaluation in accordance with section 2.000 of the Standards, evaluators should document any recommendation to vary from, or waive a Standard with the appropriate rationale for such.

Risk in young adults will likely be best mitigated by ensuring the CST/MDT pays close and careful attention to risk, need, and responsivity principles[153] as well as dynamic and static risk factors and ensures all of these are assessed and addressed as major treatment targets. "Treatment should use methods, and be delivered in such a way as to maximize participants' ability to learn. To achieve this, treatment programs

[153] The Risk Needs Responsivity (RNR) model indicates that the comprehensiveness, intensity and duration of treatment provided to individual offenders should be proportionate to the degree of risk that they present (the *Risk* principle), that treatment should be appropriately targeted at participant characteristics which contribute to their 3 risk (the *Need* principle), and that treatment should delivered in a way that facilitates meaningful participation and learning (the *Responsivity* Principle). DOC SOTMP Evaluation, 2012, Central Coast Clinical & Forensic Psychology Services.

should selectively employ methods that have generally been shown to work. Further, participants' response to treatment will be enhanced by effortful attendance to their individual learning style, abilities and culture."[154]

It is important for CSTs to consider Section 5.7 in the Adult Standards when addressing issues of sibling/child contact. Standard 5.780 specifies circumstances when parts of 5.7 may be waived with unanimous decision of the CST. This might allow contact with adolescents in unique situations. CSTs/MDTs are encouraged to review young adult situations, and make decisions that help the offender be successful while maintaining community safety.

[154] Andrews, D. A. & Bonta, J. (2006).*The Psychology of Criminal Conduct* (4th ed.).Newark, NJ: LexisNexis.

YOUNG ADULT MODIFICATION PROTOCOL

CRITERIA CHECKLIST

Instructions:

This form should be completed by the CST/MDT and serves as documentation for the client file. As new information becomes available, the CST/MDT should re-evaluate the inclusionary and exclusionary items to determine if there has been any change. An offender who meets criteria for the Young Adult Modifications at one point in treatment, may not meet the criteria at subsequent points in treatment, and therefore any modification to the Standards should not be considered automatic grounds for future modifications.

Protocol for determining if the Individual meets criteria for Young Adult Modifications

Inclusionary Items: If you select YES to any of the following item, continue to Exclusionary Items.

Yes___ No____ Individual is aged 18-21 and adjudicated delinquent for a sex crime that occurred prior to the age of 18, subsequently convicted of a non-sex crime as an adult while remaining in the DYC.

Yes___ No____ Individual is aged 18-25, convicted as an adult for a non-sex crime with a history of a sexual offense.

Yes___ No____ Individual is aged 18-25, convicted of a sex crime that occurred prior to age 18.

Yes___ No____ Individual is aged 18-25, convicted as an adult for a sex crime (includes failure to register).

Yes___ No____ Individual is under the age of 18, charged and convicted as an adult for a sex crime and sentenced to YOS.

Exclusionary Items: If you select YES to any of the following items, the individual will not meet criteria for Young Adult Modifications, and the applicable Standards shall be followed.

Yes___ No____ Primary Sexual Interest/arousal in pre-pubescent individuals.

Yes___ No____ Clear and documented pattern of sexual sadism.

Yes___ No____ Sexually Violent Predator as determined by the SVPASI.

Yes___ No____ Psychopathy (as determined by the PCL-R)

Yes___ No____ Meets criteria for mental abnormality as referenced in C.R.S. 16-11.7-103(4)(c.5) and determined by the SVPASI.

_____ _____

Treatment Provider Signature Date Supervising Officer Signature Date

YOUNG ADULT MODIFICATION PROTOCOL
CRITERIA FLOW CHART

Individual is convicted or adjudicated of a sexual offense.

Yes

Is the Individual between the ages of 18-25 (or under the age of 18, charged and convicted as an adult)?

No → Follow applicable standards

Yes

Is any of the following True?

1. Aged 18-21 adjudicated delinquent for a sexual crime that occurred prior to age 18, subsequently convicted of a non-sex crime as an adult while remaining in the DYC.
2. Aged 18-25, convicted as an adult for non-sex crime with a history of a sex offense.
3. Aged 18-25, convicted of a sex crime that occurred prior to age 18.
4. Aged 18-25, convicted as an adult for a sex crime (includes failure to register).
5. An individual under the age of 18, charged and convicted as an adult for a sex crime and placed in YOS.

No → Follow applicable standards

Yes

Previous records or, if indicated, current testing establishes that one of the following is true;

1. Primary sexual interest/arousal in pre-pubescent individuals.
2. Clear documented pattern of sexual sadism.
3. Sexually Violent Predator (as designated by SVP instrument)
4. Psychopathy (as determined by PCL-R)
5. Meets criteria for mental abnormality as referenced in C.R.S. 16-11.7-103(4)(c.5) and determined by the SVPASI

Yes → Follow applicable standards

No

Young Adult Modification Protocol

Appendix D
GUIDELINES FOR THE USE OF SEXUALLY STIMULATING MATERIALS

Applicable Standards from the *Standards and Guidelines for the Assessment, Evaluation, Treatment and Behavioral Monitoring of Adult Sex Offenders (Adult Standards):*

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

J. Offenders shall not access, possess, utilize, or subscribe to any sexually oriented material or material related to their offending behavior to include, but not limited to, mail, computer, television, or telephone, nor patronize any place where such material or entertainment is available.

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 Community Supervision Team (CST) to manage the offender during his/her term of supervision.

A. Community and victim safety, and risk management are paramount when making decisions about the management and/or treatment of offenders.

Applicable Standards (i.e. Additional Conditions of Supervision) from the *Standards and Guidelines for the Evaluation, Assessment, Treatment and Supervision of Juveniles Who Have Committed Sexual Offenses (Juvenile Standards):*

Appendix J (12) You shall not possess or view any pornographic, X-rated or inappropriate sexually arousing material and you will not go to or loiter in areas where pornographic materials are sold, rented, or distributed. This includes, but is not limited to phone sex lines, computer generated pornography, and other cable stations that show nudity or sexually explicit material.

INTRODUCTION: Why is the SOMB addressing the issue of sexually stimulating materials?

The primary purpose for this appendix is to provide explanation and guidance to Community Supervision Teams (CSTs) and Multi-Disciplinary Teams (MDTs) regarding Adult Standard 5.620 and Juvenile Appendix J (12). In offering this guidance, the SOMB also seeks to enhance community and victim safety by specifically focusing on the individual risk, needs, and responsivity factors for each adult or juvenile who has sexually offended.

A goal of treatment is to help adults and juveniles who have sexually offended to gain an increased understanding of healthy, non-abusive sexuality. To achieve this treatment goal, treatment providers and supervision officers must engage the adult or juvenile in non-judgmental discussion of sexual topics and materials. The CST/MDT should support the development of healthy sexual relationships, when appropriate, that involve consent, reciprocity, and mutuality. In addition, other aspects of sexuality,

including masturbation, should be addressed with the adult or juvenile who has sexually offended. The ultimate goal of treatment and supervision is to assist the adult or juvenile with ceasing the victimization of others and of the reinforcement of deviant sexual arousal/interest and patterns of behavior.

It is understood that certain materials, such as sexually oriented or explicit materials, shall be prohibited, and that although the research on the impact of these materials is mixed, they may have a potentially negative impact on the propensity to sexually offend. However, other non-sexually oriented materials that are sexually stimulating in nature, as determined on an individualized basis, may have no such negative impact. Prohibiting all stimulating sexual materials for all adults and juveniles who have sexually offended may be counterproductive in that they may not adversely influence sexual deviancy, but may discourage an open discussion about sexual practices, interests, and patterns of behavior. Further blanket prohibitions on sexually stimulating materials also eliminate the opportunity for the CST/MDT to support the adult or juvenile in the development of non-abusive, healthy practices. Finally, given the primary goal of enhanced community and victim safety, the development of healthy sexuality can lead to decreased deviant sexual arousal/interest and patterns of behavior.

The following sections of this appendix will outline recommendations to the CST/MDT on how to make a determination about the types of sexually stimulating materials that may be allowed and disallowed for the individual adult or juvenile who has sexually offended.

Definitions:

For the purposes of this appendix, sexually oriented or explicit material is defined as pornographic images, videos, and narratives that may be viewed in print or on electronic devices such as a computer, television, gaming system, DVD player, VCR, video camera, voice recorder, pager, telephone, or cell or smart phone, and that require the viewer to be age 18 to purchase. Such materials are developed and viewed explicitly for sexual gratification purposes. On the other hand, sexually stimulating materials are non-pornographic materials that may lead to sexual interest or arousal, but were not developed exclusively with that goal in mind. Examples of materials that may be sexually stimulating depending upon the adult or juvenile who have sexually offended include incidental nudity within the context of a non-pornographic movie, sexually suggestive images, and non-sexual images such as underwear advertisements and pictures of children.

Nudity is neither sexually stimulating material in and of itself, nor does the fact that the representation or person viewed being clothed necessarily render it not sexually stimulating. The concern is a pornographic depiction emphasizing sexual/human devaluation. It is the context of the nudity and the thoughts generated in the mind of the adult or juvenile who has sexually offended that should be the concern of the CST/MDT when applying the concepts contained in this appendix. The CST/MDT should be mindful that the conviction or adjudication for a sexual offense does not render the adult or juvenile asexual, and this is not the goal of treatment or supervision. Instead, the goal is to develop an understanding of safe, non-abusive, and healthy sexual practices.

Victim Safety and Risk Issues:

When considering the potential relationship between sexually stimulating materials and sexual offending behavior, the CST/MDT is inevitably concerned with the propensity to re-engage in risky/harmful behavior that could potentially place the community and victims at risk by the adult

or juvenile who has sexually offended. Allowing adults or juveniles the ability to have access to sexually stimulating materials may be viewed as socially undesirable, even if it contributes to overall health and pro-social growth. Therefore, the CST/MDT must always employ strategies to reduce risk and increase the opportunity for a successful outcome.

The primary practices that are essential to CST/MDT success in achieving a reduction in recidivism are based on four principles regarding the adult or juvenile who has sexually offended:

A. Effectively assess risk and criminogenic need, as well as overall strengths (also known as "protective factors"). Effective interventions should be closely matched to risk, need and responsivity factors;

B. Employ SMART, tailored supervision and treatment strategies;

C. Use incentives and graduated sanctions to respond promptly to observed behavior; and

D. Assist with the development of interests, activities and relationships that are incompatible with sexual offending rather than merely avoiding high-risk behaviors, which results in greater success in leading an offense-free life. Implement performance-driven personal management practices that promote and reward recidivism reduction.

It is also important to be sensitive to victim needs and issues with regard to the policy related to use of sexually stimulating materials. Ensuring that supervision and treatment planning efforts are individualized will help assist with this endeavor. For example, if an adult or juvenile who has offended sexually is allowed to utilize sexually stimulating materials, it is essential that the images do not represent a likeness of the victim. Victim representative (see Adult Standards Section 5.500 and Juvenile Standards Section 5.700) input should occur as well to ensure that the CST/MDT is making a balanced decision.

Polygraph Issues:

Polygraph exams should primarily focus on the use of sexually oriented or explicit materials while under supervision and in treatment by the adult or juvenile who has sexually offended, rather than attempting to identify the use of sexually stimulating materials. These questions may be asked in a variety of ways using terms such as pornography, pornographic, sexually explicit, and X-rated. Polygraph examiners should be aware of what sexually stimulating materials have been allowed by the CST/MDT for the individual adult or juvenile who has sexually offended. The CST/MDT should advise polygraph examiners more specifically what concerns there are when suggesting that maintenance or specific issue exams explore use of sexually oriented or explicit material, and indicate to the examiner if permission has been granted to the offender to have access to stimulating materials. Interviewing regarding both types of materials (sexually oriented or explicit, and sexually stimulating) during the polygraph exam may be useful for accountability purposes.

Community Supervision Team (CST)/Multi-Disciplinary Team (MDT) Guidance:

Sexually stimulating materials should be prohibited during the early phases of treatment and supervision for all adults and juveniles who have sexually offended. Once progress on treatment

engagement and supervision compliance has been documented via a thorough assessment, the CST/MDT may make the decision on how to regulate and monitor stimulating sexual materials. In making this decision, the CST/MDT should consider what materials would not contribute to the further development and reinforcement of abusive, deviant, and inappropriate sexual arousal/interest and patterns of behavior for the adult or juvenile who has sexually offended. As noted above, the CST/MDT in their assigned role under the Standards should be mindful of community and victim safety first. The use of sexually stimulating materials should only be allowed after a thorough review in advance and specific written permission being granted from the CST/MDT. If granted, the use of specific stimulating sexual materials should be reflected in the treatment contract and case plan, terms and conditions of supervision, and safety planning. The CST/MDT should specifically document the rationale for the decision to allow the use (e.g., promote healthy sexuality, an approved masturbation plan, etc.) of specific sexually stimulating materials for each adult or juvenile who has sexually offended based on the following criteria:

A. Risk as assessed through the use of static and dynamic risk assessment measures

B. Criminogenic needs as assessed in the treatment and supervision plan

C. Characteristics of the instant offense and pattern of offending as identified by self-report in the sexual history disclosure packet, and as verified by non-deceptive sexual history polygraph exams, where appropriate

D. Deviant sexual arousal/interest based upon assessment arousal/interest assessment, where appropriate. Materials related to the pattern of offending or that contribute to deviant sexual arousal/interest should always be prohibited.

E. Engagement in treatment and compliance with supervision, including progress and openness related to sexuality issues and activity, and reported use of sexually oriented or stimulating materials, as verified by monitoring polygraph and other forms of monitoring where appropriate. In addition, the presence or recurrence of denial of the facts of the underlying offense.

The process of approving the use of sexually stimulating materials is fluid in nature and should be discussed with the client throughout the supervision and treatment process, and continued monitoring to assure the goals of promoting healthy sexual and community safety is necessary. The CST/MDT should rescind approval for access to sexually stimulating materials as dictated by the behavior of or any regression in treatment or supervision by the adult or juvenile who has sexually offended.

The conditions of probation and parole as well as the treatment contract may currently contain language prohibiting possession or use of most of the materials pertinent to this appendix. The conditions of probation are essentially orders of the Court once a judge signs them and cannot be changed or amended without authority of the court. Conditions of parole are similar in nature to probation and must be approved by the Parole Board. Therefore, any modification must be approved by the judge or parole board. The treatment contract of each agency is probably the easiest to amend of all the documents, as it is signed by the adult or juvenile who has sexually offended at the beginning of treatment. Any approval of the use of sexually stimulating materials

must be reflected in a modification to the treatment contract and plan, and if allowable by order of the Court or Parole Board, reflected in the probation or parole file.

Healthy Sexuality:

Many treatment curriculums for adults and juveniles who have sexually offended include a component on the development of healthy sexuality. The following information is offered to approved treatment providers working with this population.

Sexual Expression

Human beings are sexual beings. Sexuality and sexual expression are integrally intertwined and inseparable from other fundamental human characteristics, specifically intimacy, interpersonal connectedness, belonging, and attachment. Healthy humans desire to be involved in relationships. Sexual expression is a part of intimate romantic relationships. Not everyone is capable of the reciprocity or other social skills that relationships entail, and often a sexual intimate relationship is not available to individuals for a number of reasons. However, therapy targets helping people move in the direction of being able to engage in reciprocal and mutual relationships.

Masturbation

Masturbation is often employed as a way to supplement sexual expression in a relationship or in lieu of being able to gratify sexual needs in a relationship. Masturbation (when not compulsive and done privately) is a natural and healthy practice to express sexuality and gratify or relieve sexual needs/tension. Masturbation can serve as a means of reducing sexual needs that could become expressed in less appropriate or more harmful ways. As people do masturbate, stimuli for masturbation need to be based on healthy themes, such as closeness, intimacy, mutuality, reciprocity, and safety. This does not rule out visual stimuli which are ubiquitous. Prohibiting stimulating materials is problematic and impossible. Instead it is a task of treatment to determine which materials are "inappropriate," by not reinforcing the values and principles stated herein (e.g., mutuality, reciprocity, safety, etc.). On the other hand, stimuli that reinforce these values are not problematic. It is not the goal of treatment to eliminate sexuality or sexual expression, rather to direct it to appropriate themes.

Teaching Healthy Sexuality

Treatment providers address healthy sexuality in a number of ways. One way is by discussing sexual needs, preferences and expression in an open nonjudgmental manner. This serves as *modeling* in that the client can observe a therapist discuss sexuality in a mature, open and non-defensive manner; the client learns to do the same. Sexual expression needs to be discussed in a treatment setting.

Sexual Diversity

Cultural, social and individual differences are accepted in healthy sexuality and one shows respect for these differences. As long as it is not harmful activity, a healthy attitude is open to

the fact that others have needs that are not like our own. Examples are represented in the G.L.B.T.Q. community; there should be no discrimination on the basis of orientation and preference when they are legal and not harmful to others.

Healthy Boundaries, Roles, and Safe Sex

Consent is quintessential to healthy sexual expression. Consent involves equality of the individuals to make informed decisions. People are always very different from one another but must be equal in their ability to consent to engage in sexual behavior with one another. Consent involves *communication in advance* of what will take place (sexual activity) between two individuals. It involves mutuality and reciprocity. Large disparities in power and influence are antithetical to these principles. Likewise, the needs and desires of both parties are negotiable and negotiated; an agreement is reached prior to the activity ensuing. Similarly, activities that are not permissible must be communicated and respected. Education related to issues of consent and barriers to consent including impairment due to alcohol or drug consumption, and the intellectual capacity of both parties should be addressed. Safe sexual practices are a requirement of healthy sexuality.

CONCLUSION:

This appendix has attempted to clarify the differences between sexually oriented or explicit materials from sexually stimulating materials. While the former is prohibited by terms and conditions of supervision and the treatment contract, the latter may be allowed at some point in treatment and supervision based upon the suggested criteria in this appendix. In addition, the exploration of concepts related to healthy sexuality are seen as critical for the therapeutic rehabilitation of the adult or juvenile who has sexually offended.

Appendix E
GUIDELINES FOR THE EVALUATION AND TREATMENT OF SEX OFFENDERS WITH A CURRENT NON-SEX CRIME

The Evaluation Guidelines and Intervention Options Matrix for Sexual Offenders Who Meet the Definition Based Upon a Current Non-Sex Crime and a History of Sex Crime Conviction or Adjudication (the Matrix) are to be utilized in the following circumstances:

- Per statute 16-11.7-102 (2) (a) (II) C.R.S., "A sex offender means any person who is convicted in the state of Colorado on or after January 1, 1994, of any criminal offense, if such person has previously been convicted of a sex offense as described in subsection (3) of this section in the state of Colorado, or if such person has previously been convicted any other jurisdiction of any offense that would constitute a sex offense as defined in subsection (3) of this section, or if such person has a history of any sex offense as defined in subsection (3) of this section."

The Matrix should also be used for any sex offenders convicted of Failure to Register.

All sex offenders in the state of Colorado "as part of the presentence or probation investigation (are) required pursuant to section 16-11-103, to submit to an evaluation for treatment, an evaluation for risk, procedures required for monitoring of behavior to protect the victims, and potential victims, and an identification developed pursuant to section 16-11.7-103 (4)." Further, all sex offenders in the state of Colorado are required, as part of any sentence to probation, commitment to the Department of Human Services, sentence to community corrections, incarceration with the Department of Corrections, placement on parole, or out-of-home placement to "undergo treatment to the extent appropriate to such offender based upon the recommendations of the evaluation and identified made pursuant to section 16-11.7-104…"[155] Finally, it is noted that sex offenders sentenced to community supervision (probation or parole) may be supervised by specialized sex offender supervision officers and subject to some or all of the specialized terms and conditions of supervision developed for sex offenders.[156]

MATRIX PROTOCOL

Who Should Do the Evaluation/Treatment?

The Sex Offender Management Board (SOMB) bulletin: Applicability of the Adult or Juvenile Standards for Individuals Meeting the Definition of a Sexual Offender (16-11.7-102), which is dated June 5, 2014, states as follows:

> Based on a number of recent inquiries, the staff of the Sex Offender Management Board (SOMB) is providing the information contained in this update as a clarification regarding the applicability of the Adult or Juvenile Standards given the age of the sexual offender (e.g., under or over age 18), the specific Court of record (e.g., Adult or Juvenile Court), and the specific referral offense

[155] See 16-11.7-105 C.R.S.

[156] See 18-1.3-1007 C.R.S., and Standard 5.620.

(e.g., a sexual offense or a non-sexual offense for those with a history of a sexual offense). All of these factors assist in determining whether the Adult or Juvenile Standards are applicable for a specific case.

The Juvenile Standards apply in all cases where the case is being handled by the Juvenile Court, regardless of the age of the person (under or over age 18) adjudicated for a sexual offense. As a result, the only approved treatment providers, evaluators, and polygraph examiners authorized to work with this population are those listed under the Juvenile Standards. However, the Adult Standards apply in cases where individuals under the age of 18 are transferred to the Adult Court and prosecuted as adults. In this latter case, treatment providers, evaluators, and polygraph examiners listed under the Adult Standards must be utilized.

Given the confusion regarding the set of applicable Standards and the unique needs of young adults ages 18-25 who may be under the purview of either the Juvenile or Adult Standards, the SOMB has provided written guidance for these cases in a Young Adult Modification Protocol, which may be found at http://dcj.somb.state.co.us/.

A related issue is the determination of the appropriate assessment for use with a juvenile under the age of 18 who was convicted as an adult, or the adult over the age of 18 who was adjudicated for a juvenile sex crime. Regardless of the specific Standards, Adult or Juvenile, applicable in the given circumstances, approved evaluators and treatment providers must utilize assessment instruments designed specifically for the population on which they were normed and validated. For example, it is not appropriate to use certain adult risk assessment instruments on a juvenile under age 18 who was convicted as an adult and is subject to the Adult Standards. Similarly, it is not appropriate to use certain adult risk assessment instruments on an adult over the age 18 who was adjudicated for a juvenile sex crime committed prior to age 18, or for an adult over age 18 convicted of a non-sex crime who has a history of a juvenile adjudication prior to age 18. For guidance related to the assessment of risk in the latter scenario (e.g., adults convicted of a non-sex offense with a history of a prior juvenile adjudication for a sex crime), see the Evaluation Guidelines and Interventions Option Matrix and the Young Adult Modification Protocol, which may be found at http://dcj.somb.state.co.us/.

This guidance is being offered to ensure that proper application of the Adult or Juvenile Standards occurs, and that risk assessment instruments are being used in a valid manner. Please direct any questions about the applicability of the Adult or Juvenile Standards, or specific assessment tools, to the Adult Standards Coordinator at (303) 239-4499, or the Juvenile Standards Coordinator at (303) 239-4197.

Therefore, in terms of evaluating or treating sex offenders with a history of a sex crime:

- If the current non-sex crime, including Failure to Register, occurred after age 18, and the offender is convicted as an adult, regardless of when the original sex crime occurred, an adult listed provider shall complete the evaluation and treatment and an adult supervision officer will supervise the case.

- If the current non-sex crime, including Failure to Register, occurred prior to age 18 and the offender is adjudicated as a juvenile, a juvenile listed provider shall complete the evaluation and treatment and a juvenile supervision officer will supervise the case.

However, in the specific circumstance where an adult is convicted of a non-sex crime, including Failure to Register, with a history of adjudication for a sex crime that occurred prior to age 18, the following recommendation is offered as a best practice. Ideally, the evaluator and treatment provider in this case would have both adult and juvenile listed provider status in order to account for the unique aspects of sexual offending related to juveniles. The SOMB does recognize that many providers do not have both listing statuses and such a provider may not be available in all areas. In lieu of using an adult and juvenile listed provider, the adult listed provider shall consult with a juvenile listed provider and document such consultation regarding the evaluation and treatment.

Multi-Disciplinary Collaboration

The listed evaluator and treatment provider working with a client with a history of a sex crime shall consult with the offender's prior Community Supervision Team (CST)/Multi-Disciplinary Team (MDT) members, including any prior adjunct treatment providers, from the time of the sex crime conviction or adjudication if available. The information obtained, or the unsuccessful steps taken to attempt to obtain the information, shall be documented in the evaluation and treatment plan.

When completing an evaluation on a client with a history of a sex crime, the listed evaluator shall collaborate with the Pre-Sentence Investigation (PSI) Officer and work towards consensus for specific treatment and supervision (i.e. per 16-11.7-104 (1) C.R.S., the procedures for monitoring of behavior to protect victims and potential victims) recommendations (e.g., are sex offense-specific treatment and the frequently addressed specialized terms and conditions of supervision indicated or not, and if so, what type of treatment and terms and conditions). Consistent recommendations across the PSI and evaluation will allow the court the opportunity to consider these recommendations when sentencing the client with a sex crime history.

When consistent recommendations are not possible, then the listed evaluator and the PSI Officer should both identify their specific recommendations and note the nature of the disagreement. Following the final decision by the Judge, it is hoped that the listed treatment provider and supervising officer will be able to effectively collaborate under the terms of judicial decision-making.

If the evaluation of a client with a history of a sex crime is completed prior to the entering of a plea, a release of information should be secured to release the evaluation to the PSI Officer. In addition, the evaluation must be updated following adjudication or conviction on the non-sex crime based upon the required collaboration with the PSI Officer noted above. If the original evaluator is unavailable to do such collaboration, a new evaluation that includes such collaboration must be conducted.

Training Requirement

Any listed evaluator or treatment provider who wishes to provide services to offenders with a history of a sex crime shall attend an SOMB required training on this population prior to beginning work with this population. The SOMB will make such training available on a regular basis.

Introduction to the Matrix

The following are guidelines for listed evaluators who are evaluating sexual offenders convicted of a non-sex crime (including Failure to Register) and have a history of a prior sex crime adult conviction or juvenile adjudication. Please note that the following guidelines are offered to assist listed evaluators in performing evaluations for this population and are not offered as a required protocol. Listed evaluators are free to continue to use professional discretion in evaluating this population within the requirements of the Colorado Sex Offender Management Board *Standards and Guidelines for the Assessment, Evaluation, Treatment and Behavioral Monitoring of Adult Sex Offenders* Section 2.000 (Standards For Sex Offense-Specific Evaluations). In addition to the following evaluation guidelines and intervention options, listed evaluators are encouraged to consider factors such as the nature of the original sex crime and the length of time that has passed since the sex crime occurred when assessing intervention needs.

The Evaluation Guidelines and Intervention Options for Sexual Offenders Who Meet the Definition Based Upon a Current Non-Sex Crime Conviction and a History of Sex Crime Conviction or Adjudication (the Matrix) is formatted in the following manner. For sexual offenders whose original sex crime adjudication (including deferred sentences and factual basis cases) occurred prior to age 18, even if the offender is now an adult, the first set of guidelines should be utilized. On the other hand, for sexual offenders whose original sex crime conviction (including direct file juveniles, deferred sentences, and factual basis cases) occurred after age 18 (except for direct file juvenile cases who are also included here), the second set of guidelines should be utilized. Please use the appropriate section of the Matrix for a given case.

As always in utilizing the Matrix, care should be given in application to females, persons with chronic mental illness, LGBT clients, certain ethnic groups, and persons with developmental, cognitive, and physical disabilities. Recommended guidelines and instruments may not be applicable to these populations, and the listed evaluator should use professional discretion with these populations.

<u>Evaluation Guidelines and Interventions Option Matrix for Sexual Offenders Who Meet the Definition Based Upon a Current Non-Sex Crime and A History of Sex Crime Conviction or Adjudication (Including Deferred Sentences and Factual Basis Cases) Prior to Age 18</u>:

There are five different intervention options (A, B, C, D, and E) for the Matrix. The listed evaluator should assess each consideration and then determine which option best fits the offender. A recommended intervention is then specified for each option. The options are not mutually exclusive and clinical judgment should be exercised to determine the best option given the evaluative review. Please note that a Quick Reference has been provided at the end of this appendix.

<u>Options for Sex Offense Adult Convictions</u>

Option A Considerations

- Successful completion of sex offense-specific treatment
- Non-violent index crime (no domestic violence)
- No current criminogenic needs as identified by current evaluation (utilizing clinical judgment and taking into account community safety issues)

- Index crime contains no components similar to original sex crime behavior and is non-sexual in nature
- Static risk factor from time of original sex crime conviction is low
- Low risk for sexual re-offense or general criminal re-offense (if actuarial risk assessments can be utilized) or the person presents with few dynamic risk factors (if actuarial risk assessments cannot be utilized)
- Failure to Register (FTR) – low level of intentionality to evade registration requirements

Option A Recommendations

- No specific treatment recommendations
- No additional terms and conditions for sex offender supervision

Option B Considerations

- Successful completion of sex offense-specific treatment
- Non-violent index crime (no domestic violence)
- Presence of current criminogenic needs as identified by current evaluation (utilizing clinical judgment and taking into account community safety issues)
- Index crime non-sexual in nature (details of the crime are not related or similar to details of the original sex offense)
- Static risk factor assessment from time of original sex crime conviction is low (if known)
- Low, moderate, or high risk factor for general criminal re-offense but low risk for sexual re-offense (if actuarial risk assessments can be utilized) or the person presents with few dynamic sexual risk factors (if actuarial risk assessments cannot be utilized)
- FTR – low level of intentionality to evade registration requirements

Option B Recommendations

- Non-sexual treatment needs (e.g., anger management, medical evaluation, or substance abuse)
- No additional terms and conditions for sex offender supervision

Option C1 and C2 Considerations (asterisked items are considerations for placement in Option C1)

- There is no documentation of successful completion of treatment.
- No completion of treatment, but the client has been in the community offense-free for an extended period of time (e.g., 10 years)[1]
- The non-sexual index offense is a violent crime/involves force (including, but not limited to, domestic violence)*
- The non-sexual index offense contains components similar to behavior in the original sex offense. (e.g., the original sex offense was burglarizing a woman's underwear from her apartment and the new offense is stealing underwear from the store)
- The client is determined to be a moderate or high risk for re-offense (if actuarial risk assessments can be utilized) or the person presents with a significant number of dynamic risk factors (if actuarial risk assessments cannot be utilized)
- The client is in Level Three Denial *Please note that denial alone is not a reason for automatic placement in Option C, D, or E and does not preclude placement in Option A or B*

- The client has deviant PPG or VT results*
- The client has an inability to demonstrate knowledge of treatment concepts either behaviorally (i.e. living a non-pro-social lifestyle) or verbally

Option C1 Recommendations

- All specialized terms and conditions for an adult sex offender, including the need to take a Child Contact Assessment (CCA) in order to determine contact with own children. Specific jurisdictions handling of Court orders concerning contact with children (e.g., Burns) should be taken into consideration.
- Additional assessment process to include:
  - Sex history disclosure process
  - Polygraph
  - Time limited treatment refresher work
  - Areas to assess:
    - Offense behavior chain including risk factors (red flags, triggers, etc.)
    - Pro-social relationship development (support system)
    - Support system development
    - Relapse prevention
    - Empathy development and victim impact
    - Coping skills
    - Problem solving
    - Mood Management
    - Boundaries
    - Healthy sexuality and intimate relationship development
    - Vocational skills/adaptive skills
- Assessment of deviant sexual arousal/interest, if present
- Listed provider should use modified written agreement outlining expectations
- For offenders in significant denial, attempt to overcome resistance to treatment and denial issues
- Domestic violence – assess to determine treatment needs (sex offense, domestic violence, combination of two and/or harm to child)
- Client can be referred to another Option at any time
- Treatment provider to prepare written discharge summary upon completion of Option C with updated recommendations

Option C2 Recommendations

- Selected specialized terms and conditions for an adult sex offender as recommended appropriate by the evaluator. Clients in this Option are not required to complete a CCA prior to contact with their own children unless they transition to Option C1, D, or E. Specific jurisdictions handling of Court orders concerning contact with children (e.g., Burns) should be taken into consideration.
- Additional assessment process to include:
  - Sex history disclosure process
  - Polygraph

- Time limited treatment refresher work
- Areas to assess:
  - Offense behavior chain including risk factors (red flags, triggers, etc.)
  - Pro-social relationship development (support system)
  - Support system development
  - Relapse prevention
  - Empathy development and victim impact
  - Coping skills
  - Problem solving
  - Mood Management
  - Boundaries
  - Healthy sexuality and intimate relationship development
  - Vocational skills/adaptive skills
- Assessment of deviant sexual arousal/interest, if present
- Listed provider should use modified written agreement outlining expectations
- For offenders in significant denial, attempt to overcome resistance to treatment and denial issues
- Domestic violence – assess to determine treatment needs (sex offense, domestic violence, combination of two and/or harm to child)
- Client can be referred to another Option at any time
- Treatment provider to prepare written discharge summary upon completion of Option C with updated recommendations

Option D Considerations

- Did not successfully complete sex offense-specific treatment *This factor alone may not predicate placement in Option D
- Index crime is sexual in nature (index crime has sexual motivation/dynamics, i.e. burglary involving stealing women's underwear)
- FTR – higher levels of intentionality to evade registration requirements
- Presence of deviant sexual arousal/interest during current evaluative review (per Plethysmograph assessment, VT assessment or offender self-report)
- Presence of pedophilia, psychopathy, sexual sadism, or Sexually Violent Predator status
- The client is determined to be a high risk for re-offense (if actuarial risk assessments can be utilized) or the person presents with a significant number of dynamic risk factors (if actuarial risk assessments cannot be utilized)

Option D Recommendations

- Additional terms and conditions for sex offense supervision including no contact with own children unless a Child Contact Assessment has been conducted
- Sex offense-specific/other treatment and intervention recommendations by listed evaluator, as applicable
- Assess for current treatment needs and address in treatment plan (only treat areas necessary)
- Treatment plan created upon potential length of sentence (include specific plans for sex history and maintenance polygraphs)

- Upon completion of Option D, a discharge summary outlining treatment plan completion and remaining areas not addressed based on sentence length limitations (not considered successful completion of SO specific treatment, but administrative completion)

Option E Considerations

- No motivation for treatment
- Refusal to participate in treatment
- No amenability to treatment
- Not treatable
- No motivation to change
- The client is determined to be a high risk for re-offense (if actuarial risk assessments can be utilized) or the person presents with a significant number of dynamic risk factors (if actuarial risk assessments cannot be utilized)
- Presence of pedophilia (exclusive type), psychopathy, sexual sadism, or Sexually Violent Predator status

Option E Recommendations

- Not appropriate for community based sex offense-specific treatment
- Not appropriate for community supervision and should be referred back to the court for possible modification of sentence

<u>Options for Sex Offense Juvenile Adjudications</u> (please note this section includes people who are currently juveniles with previous juvenile sex offense adjudication and people who are currently adults with previous juvenile sex offense adjudication)

Option A Considerations

- Successful completion of SO specific treatment
- Non-violent index crime (no domestic violence)
- No current criminogenic needs as identified by current evaluation (utilizing clinical judgment and taking into account community safety issues)
- Index crime contains no components similar to original sex crime behavior and is non-sexual in nature
- Low number of risk factors
- FTR – low level of intentionality to evade registration responsibility

Option A Recommendations

- No specific treatment recommendations
- No additional terms and conditions for sex offender supervision

Option B Considerations

- Successful completion of sex offense-specific treatment

- Non-violent index crime (no domestic violence)
- Presence of current criminogenic needs as identified by current evaluation (utilizing clinical judgment and taking into account community safety issues)
- Index crime non-sexual in nature (details of the crime are not related or similar to details of the original sex offense)
- Static risk factor assessment from time of original sex crime conviction is low (if known)
- Low, moderate or high risk factor for general criminal re-offense but low risk for sexual re-offense (if actuarial risk assessments can be utilized) or the person presents with few dynamic sexual risk factors (if actuarial risk assessments cannot be utilized)
- FTR – low level of intentionality to evade registration requirements

Option B Recommendations

- Non-sexual treatment needs (for example, anger management, medical evaluation or substance abuse)
- No additional terms and conditions for sex offender supervision

Option C1 and C2 Considerations (asterisked items are considerations for placement in Option C1)

- There is no documentation of successful completion of treatment.
- No completion of treatment, but the client has been in the community offense-free for an extended period of time (e.g., 10 years)
- The non-sexual index offense is a violent crime/involves force (including, but not limited to, domestic violence)*.
- The non-sexual index offense contains components similar to behavior in the original sex offense (e.g., the original sex offense was burglarizing a woman's underwear from her apartment and the new offense is stealing underwear from the store).
- The client is determined to be a moderate or high risk for re-offense (if actuarial risk assessments can be utilized) or the person presents with a significant number of dynamic risk factors (if actuarial risk assessments cannot be utilized)
- The client is in Level Three Denial *Please note that denial alone is not a reason for automatic placement in Option C, D, or E and does not preclude placement in Option A or B*
- The client has deviant PPG or VT results*.
- The client has an inability to demonstrate knowledge of treatment concepts either behaviorally (i.e. living a non-pro-social lifestyle) or verbally.

Option C1 Recommendations

- All specialized terms and conditions for an adult sex offender, including the need to take a Child Contact Assessment (CCA) in order to determine contact with own children. Specific jurisdictions handling of Court orders concerning contact with children (e.g., Burns) should be taken into consideration.
- Additional assessment process to include:
  - Sex history disclosure process
  - Polygraph
  - Time limited treatment refresher work
  - Areas to Assess

        - Offense behavior chain including risk factors (red flags, triggers, etc.)
        - Pro-social relationship development (support system)
        - Support system development
        - Relapse prevention
        - Empathy development and victim impact
        - Coping skills
        - Problem solving
        - Mood Management
        - Boundaries
        - Healthy sexuality and intimate relationship development
        - Vocational skills/adaptive skills
- Assessment of deviant sexual arousal/interest, if present
- Listed provider should use modified written agreement outlining expectations
- For offenders in significant denial, attempt to overcome resistance to treatment and denial issues
- Domestic violence – assess to determine treatment needs (sex offense, domestic violence, combination of two and/or harm to child)
- Client can be referred to another Option at any time
- Treatment provider to prepare written discharge summary upon completion of Option C with updated recommendations

Option C2 Recommendations

- Selected specialized terms and conditions for an adult sex offender as recommended appropriate by the evaluator. Clients in this Option are not required to complete a CCA prior to contact with their own children unless they transition to Option C1, D, or E. Specific jurisdictions handling of Court orders concerning contact with children (e.g., Burns) should be taken into consideration.
- Additional assessment process to include:
    - Sex history disclosure process
    - Polygraph
    - Time limited treatment refresher work
    - Areas to Assess:
        - Offense behavior chain including risk factors (red flags, triggers, etc.)
        - Pro-social relationship development (support system)
        - Support system development
        - Relapse prevention
        - Empathy development and victim impact
        - Coping skills
        - Problem solving
        - Mood Management
        - Boundaries
        - Healthy sexuality and intimate relationship development
        - Vocational skills/adaptive skills
- Assessment of deviant sexual arousal/interest, if present
- Listed provider should use modified written agreement outlining expectations

- For offenders in significant denial, attempt to overcome resistance to treatment and denial issues
- Domestic violence – assess to determine treatment needs (sex offense, domestic violence, combination of two and/or harm to child)
- Client can be referred to another Option at any time
- Treatment provider to prepare written discharge summary upon completion of Option C with updated recommendations

Option D Considerations

- Did not successfully complete sex offense-specific treatment *This factor alone may not predicate placement in Option D
- Index crime is sexual in nature (index crime has sexual motivation/dynamics, i.e. burglary involving stealing women's underwear)
- FTR – higher levels of intentionality to evade registration requirements
- Presence of deviant sexual arousal/interest during current evaluative review (per plethysmograph assessment, VT assessment or offender self-report)
- Presence of pedophilia, psychopathy, sexual sadism, or Sexually Violent Predator status
- The client is determined to be a high risk for re-offense (if actuarial risk assessments can be utilized) or the person presents with a significant number of dynamic risk factors (if actuarial risk assessments cannot be utilized)

Option D Recommendations

- Additional terms and conditions for SO supervision including no contact with own children unless a Child Contact Assessment has been conducted
- Sex offense-specific/other treatment and intervention recommendations by listed evaluator, as applicable
- Assess for current treatment needs and address in treatment plan (only treat areas necessary)
- Treatment plan created upon potential length of sentence (include specific plans for sex history and maintenance polygraphs)
- Upon completion of Option D, a discharge summary outlining treatment plan completion and remaining areas not addressed based on sentence length limitations (not considered successful completion of SO specific treatment, but administrative completion)

Option E Considerations

- No motivation for treatment
- Refusal to participate in treatment
- No amenability to treatment
- Not treatable
- No motivation to change
- The client is determined to be a high risk for re-offense (if actuarial risk assessments can be utilized) or the person presents with a significant number of dynamic risk factors (if actuarial risk assessments cannot be utilized)
- Presence of Pedophilia (Exclusive type), psychopathy, sexual sadism, or Sexually Violent Predator status

Option E Recommendations

- Not appropriate for community based sex offense-specific treatment
- Not appropriate for community supervision and should be referred back to the court for possible modification of sentence

MATRIX Quick Reference Guide

****Please note that this is a summary for people who are familiar working with MATRIX cases. This is not an exhaustive list, rather it is intended as a quick reference to inform mandatory clinical judgment. No one consideration mandates placement in any one Option[2]. Please refer to the full set of guidelines if you are new to MATRIX cases or for additional information. Additionally, specific jurisdictions handling of Court orders concerning contact with children (e.g., Burns) should be taken into consideration.****

The SOMB MATRIX protocol indicates five options related to recommendations in cases with referring non-sex charge (index crime) and previous sex offense conviction. These include the following:

- **Option A:** No sex offender treatment or terms and conditions recommended/required. No other treatment needs.

  Considerations for Option A:

  - Successful completion of treatment
  - No current significant criminogenic factors
  - Length of time since original sex offense
  - FTR is committed with a low intentionality
  - Non-deviant VT or PPG
  - Non-violent index crime

- **Option B:** No sex offender treatment or terms and conditions recommended/required, but other services recommended/required.

  Considerations for Option B:

  - Successful completion of treatment
  - Presence of current significant criminogenic factors
  - Length of time since original sex offense
  - Non-sexual treatment needs (own victimization, mental health concerns, cognitive concerns, etc.)
  - FTR is committed with a low intentionality
  - Non-deviant VT or PPG
  - Non-violent index crime

- **Option C:** Additional assessment period to assess client's working knowledge of sex offense treatment concepts, address dynamic risk factors, and complete sexual history polygraphs. This Option helps determine whether clients move to Option A, B, or D. Evaluators should determine if the client is appropriate for Option C1 or Option C2. Option C1 indicates that full terms and conditions of sex offender probation are appropriate, including no contact with the client's own children. Option C2 indicates that the evaluator should determine which terms and conditions are appropriate and which are not, including contact with client's own children.

Considerations for Option C1 and C2, asterisked items are considerations for placement in C1:

- No documentation of treatment completion
- Client reports they did not complete treatment
- Index offenses involves physical violence*
- High number of dynamic risk factors
- Deviant PPG or VT results*
- Level Three Denial (this does not mandate placement in Option C, D, or E, but should be considered)
- Inability to demonstrate treatment concepts behaviorally or verbally (special attention paid to issues related to victim empathy/impact)

- **Option D:** Sex offense-specific supervision terms and conditions and treatment required.

Considerations for Option D:

- Did not complete treatment
- FTR is committed with a high level of intentionality
- Deviant VT or PPG results
- Presence of pedophilia, psychopathy, sexual sadism, or Sexually Violent Predator designation, violent index offense

- **Option E:** Client is not appropriate for community-based treatment or supervision.

Conditions for Option E:

- No motivation for treatment
- Refusal to participate in treatment
- Not amenable to treatment
- High number of risk factors
- Deviant VT or PPG results
- Presence of pedophilia, psychopathy, sexual sadism, or Sexually Violent Predator designation, violent index

Appendix F
SEX OFFENSE-SPECIFIC INTAKE REVIEW FOR CLIENTS WHO HAVE BEEN IN PRIOR TREATMENT

Sex offense-specific Intake Review for Clients Who Have Been in Prior Treatment

The Colorado Sex Offender Management Board (SOMB) supports SOMB Listed Treatment Providers providing comprehensive intake assessments for clients seeking entry into a treatment program with a prior history of sex offense-specific (SOS) treatment. This document should be used as guidance in conjunction with the applicable SOMB Adult or Juvenile standards. The SOMB's purpose in developing this document is to ensure continuity of care via a thorough review of relevant prior treatment and supervision information to aid in the planning of treatment needs for the client. To this end, it is imperative that the Treatment Provider make every reasonable effort to identify and obtain past treatment records. In the absence of such records, it is the responsibility of the Treatment Provider to conduct a thorough and collaborative treatment review with the client to determine what treatment has been completed, what components of treatment need additional focus, and what components of treatment have not yet been completed. Through the completion of this review, a client's individual treatment needs can be determined. Clients should not be required to re-start treatment solely due to a change in Treatment Providers and the lack of available information from the prior Treatment Provider. On the other hand, mere completion of a treatment objective does not preclude the client from repeating such an objective if behavioral indicators suggest the need for additional treatment in this area.

The following information shall be reviewed collaboratively with the client to determine the starting point for the current treatment. It is recommended that this documented **be completed by the primary therapist** over the course of the first 2-3 sessions. This form may also be used for an on-going re-assessment of client treatment needs, as well as a final assessment at the time of discharge.

Client's Name: DOB:

Therapist completing intake: Date of intake:

Index Offense:

Past convictions / Adjudications:

Has the client previously received SOS treatment? ☐ Yes ☐ No
If yes, list previous providers:

Has the client signed releases to talk with previous treatment providers? ☐ Yes ☐ No

Length of time previously in treatment:

Does the client have any certificates of completion/documentation of treatment module completion?
☐ Yes ☐ No
If yes, list certificates/documentation:

Reason for discharge or transfer:

Have the following individuals been contacted for collateral information?
☐ Probation/Parole Officer ☐ Family ☐ Victim Therapist or DA's office ☐ Past Providers
☐ DHS Caseworker / DYC

What barriers or obstacles interfered with the client's successful engagement with the prior treatment, if any?

What factors aided the client in being successful in treatment? (What worked well?)

What are the client's strengths?

Have specialized assessments (Polygraph, PPG, ABEL/Affinity) been completed?
☐ Yes ☐ No
Identify and provide results:

What was the date of the last Sex offense-specific Evaluation?
Risk assessment results:
Results in terms of critical treatment needs:
Recommendations for treatment planning:

Current Risk Level:

Are there any specific conditions that have been previously set by the CST/MDT?
Provide details:

Are there any activities or special accommodations that have been previously approved by the CST/MDT?

Provide details:

Are there any approved safety plans in place at this time?

Provide details:

What recommendations have been made by previous treatment providers?

Which standards are applicable for the client? ☐ Adult ☐ Juvenile

For clients subject to Adult standards:

Yes	No	Partial	**Accountability / Empathy**
☐	☐	☐	Is the client is able to be accountable about their offense by openly discussing their offense without blame or minimization?
☐	☐	☐	Is the client able to discuss their full sexual history?
☐	☐	☐	Is the client able to identify and articulate the impact on their victims?
☐	☐	☐	Is the client able to articulate empathy for their victims?
☐	☐	☐	Does the client present with any level of denial?
☐	☐	☐	Is the client able to discuss and manage any deviant sexual urges or fantasies?
☐	☐	☐	Is the client able to discuss the clarification process and identify what steps they have taken?
Yes	No	Partial	**Treatment**
☐	☐	☐	Is the client able to identify their support system?
☐	☐	☐	Is the client able to educate their support system regarding their risk factors?
☐	☐	☐	Is the client able to discuss their thoughts, feelings and behaviors that facilitate sexual re-offense or other victimizing behaviors?
☐	☐	☐	Is the client able to identify and discuss adaptive and pro-social behaviors to prevent abusive behavior and are they able to articulate healthy sexual functioning?
☐	☐	☐	Is the client able to discuss personality traits and deficits related to their risk for re-offending?
☐	☐	☐	Is the client able to identify any deficits in their social and relationship skills?

☐	☐	☐	Has the client strengthened these skills?
☐	☐	☐	Is the client able to discuss a plan for preventing re-offense and can they discuss how they have shared this plan with their support system?
☐	☐	☐	Is the client able to discuss and demonstrate skills to manage issues of anger, power, and control?
Yes	No	Partial	**Additional Information**
☐	☐	☐	Has 5.7 criteria been met?
☐	☐	☐	Has a CCA been completed?
☐	☐	☐	Are there additional adjunct treatment needs? (i.e. substance abuse, suicidal ideation, mental health needs, cognitive needs or challenges, etc.): How have these needs been addressed in the past? How will these needs be addressed at this time?
☐	☐	☐	Has a relapse prevention plan or Personal Change Contract been completed?
☐	☐	☐	Is there a Qualified Approved Supervisor? (as defined in standard 5.771)
☐	☐	☐	Is there an Approved Community Support Person (as defined in standard 5.710) or COSA who has or is currently able to provide support to the client? (include any training or classes the person or group has completed)
☐	☐	☐	Are there documented provisions that have been granted to the client previously? (i.e. contact with children, access to internet, approved activities, etc.)

Upon completion of the intake review provide a brief narrative regarding how the above information was gathered and verified beyond solely client self-report. Include information about how the client is able to demonstrate internalization of treatment concepts.

Based upon the information gathered during the intake review the following recommendations are made regarding the current focus of treatment.

_____ _____

SOMB Treatment Provider - signature SOMB Treatment Provider - printed name

_____ _____

Client - signature Client - printed name

_____ _____

Supervisor - signature (where applicable) Supervisor - printed name

Appendix G
SOMB POSITION PAPER REGARDING A SEX OFFENDER'S CONTACT WITH HIS OR HER OWN CHILD

Colorado Sex Offender Management Board (SOMB)
Position Regarding A Sex Offender's Contact with His or Her Own Child
Approved March 18, 2016

Currently, in the State of Colorado, a person defined as a "sex offender" in C.R.S. §16-11.7-102 (2) and required to complete sex offense-specific treatment under the SOMB's *Adult Standards and Guidelines for the Assessment, Evaluation, Treatment and Behavioral Monitoring of Adult Sex Offenders* (herein referred to as *Standards & Guidelines*) is not allowed contact with his or her own child,[157] unless one of two conditions are met:

1. The offender meets the criteria for a Child Contact Assessment (CCA), completes the evaluation process with favorable recommendations, and the Community Supervision Team adopts those recommendations; or
2. The offender engages in treatment and meets the criteria as outlined in 5.700 of the *Adult Standards and Guidelines for the Assessment, Evaluation, Treatment and Behavioral Monitoring of Adult Sex Offenders* (herein referred to as *Standards & Guidelines*).

The recent Court ruling in the *United States vs. Burns*, 775 F.3d 1221 (10th Cir. 2014) impacts Colorado's current approach to parent-child contact and therefore necessitates Colorado re-evaluate its approach. In *Burns*, the Court ruled that a parent has a constitutional right to familial association. In part, "A father has a fundamental liberty interest in maintaining his familial relationship with his [child]." *Burns* at 1223, citing *United States v. Edgin*, 92 F.3d 1044, 1049 (10th Cir. 1996). The Court continued, stating that "When a court imposes a special condition that limits a fundamental right or liberty interest, the court must justify the condition with compelling circumstances."[158] A conviction, alone, may not meet the criteria for compelling evidence for restraining a parent's constitutional right to parental association.

In light of this recent ruling, lawyers, probation officers, evaluators and therapists, among others, must determine how to best assist the Judge in making informed decisions. Courts must balance a parent's constitutional right to parental association with concerns of posing undue risk to the children of sexual offenders.

In order to assist the Courts in determining whether or not compelling circumstances to limit such contact exist, it is now recommended that evaluators add information to the sex offense-specific evaluation discussing the risk factors that may impact the risk a client poses to his/her child(ren). The SOMB recognizes there are few empirically identified risk factors that predict a convicted sex offender's risk for sexually offending against his/her own child. The discussion should rely on the research supported evidence regarding risk of sexual re-offense and should include potential risk for the offender to victimize

[157] Per Section 5.710 of the *Standards and Guidelines*, an own minor child is defined as "a minor child with whom the offender has a parental role, including but not limited to, biological, adoptive, and step-child(ren)." In addition, per the *United States vs. White*, 782 F.3d 1118 (10th Circuit 2015), an emphasis is given to those who have a "custodial" relationship with their own child.
[158] Id.

across gender and age categories.[159] This section should explain how these factors may or may not translate to risk of a new sexual offense against a child. Protective factors are important and should be considered. The suggested risk factors that are consistently identified in research, and that may be relevant to identify and discuss in the evaluation, include, but are not limited to:

- Risk Level for sexual recidivism[160]
- Number of convictions for sexual offenses[161]
- Number of sexual offenses (does not have to be a conviction) involving minors[162]
- The nature of the relationship of the offender to the victim(s)[163]
- Number of victims[164]
- Age and gender[165]
- Intellectual and developmental disabilities of the victim and the offender[166]
- Age, gender and abuse history of the offender[167]

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- Sexual offense responsibility [168]
- Results of a sexual interest/sexual arousal assessment[169]
- Diagnosis of pedophilia[170]
- Psychopathy or psychopathology (via PCL-R, Millon Clinical Inventory, etc.)[171]
- Cognitive distortions related to child victims or children in general[172]
- Years sex offense free in the community[173]

Some of the above risk factors are also identified in other sections of the sex offense-specific evaluation. However, it may be helpful to summarize those factors specifically related to an offender's contact with his or her own child.

In addition, it is recognized that the necessary information to discuss each listed factor may not be available at the time of the sex offense-specific evaluation. In those circumstances, it is appropriate to note the limitations of the available information.

This information should be clearly identified in the sex offense-specific evaluation. Please note, evaluators are not required to make a recommendation either for or against such contact, unless the evaluator chooses to include such a recommendation, but rather to provide information to assist a judge in decision formulation.

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Appendix H
DISASTER EMERGENCY MANAGEMENT SAFETY PLAN

DISASTER EMERGENCY SAFETY PLAN (DESP)

___ Judicial District, Adult Probation Department, Parole Region, or Community Corrections Facility
And/or
_____ Law Enforcement Agency

Sex Offender Unit

Name: _____ Telephone Number: _____

Supervising Officer: _____ Telephone Number: _____

Treatment Provider: _____ Telephone Number: _____

Other Therapist: _____ Telephone Number: _____

In the event of a disaster (a natural or man-made event that negatively affects life, property, livelihood such as a fire, flood, weather event, etc.), I will implement the following Emergency Management Plan as developed with my supervising officer. I understand that all of the terms and conditions of registration and supervision, including no contact with children and victims, still remain in full force. I understand that my plan must include going to a safe location that does not violate my terms and conditions of supervision (e.g. no schools or other places where children, or my victim may be present), and that I am to remain accountable for all of my other safety plans and treatment requirements (e.g. treatment attendance, taking required psychotropic medication, checking in on schedule, etc.). Finally, I understand that a more comprehensive emergency risk management plan will be developed later with my treatment provider.

In the event of a disaster, I agree to keep in touch with my supervising officer and the other members of any community supervision team (CST) I may have. In addition, I agree to keep the following persons informed, on a daily basis, of my whereabouts, leaving good contact information with each of them.

In case of emergency, I will keep in daily contact with at least one of the following:

(1)
Name: _____

Address: _____

_____

Phone: (c) _____

(w) _____

(h) _____

(2)
Name: _____

Address: _____

_____

Phone: (c) _____

(w) _____

(h) _____

[This person should reside outside of the impacted area]
(3)
Name: _____ The following list will remain off limits.

Address: _____ _____

_____ _____

Phone: (c) _____ _____

(w) _____ _____

(h) _____ _____

The overriding purpose of this emergency plan is to keep me and the public safe. Compliance with this plan by keeping in touch with my supervising officer and community supervision team will help keep me in compliance with my legal obligations by following the directives of my supervisors.

In an emergency, were my home not available for me to reside in, I intend to stay temporarily at one of the following locations:

_____

_____

I understand that if I have no other place to go that is safe and legal, then I will report to the local shelter and disclose my registration status to the shelter staff and law enforcement at the time I enter. I will take responsibility for contacting law enforcement immediately upon arrival at any shelter. I agree to follow all law enforcement instructions regarding housing and notifying my supervisor of any instructions that I receive.

My supervisor's agency contact or on call supervisor's number is _____.

Signature _____ Supervising Officer_____

DATE: / / . Date: / / .

Keep a copy of this Disaster Emergency Safety Plan with your other important papers.

Appendix I
GUIDANCE TO SOMB LISTED PROVIDERS ON THE USE OF MEDICAL MARIJUANA, PRESCRIPTION MEDICATIONS AND OVER THE COUNTER MEDICATIONS BY SEXUAL OFFENDERS

Approved January 15, 2016

Recent legislation has impacted the use of medical marijuana by sexual offenders on probation. Probation officers are complying with this legislation.

House Bill (H.B.) - 15-1267

Pursuant to H.B. 15-1267, individuals on probation, including those convicted of a sex crime, are generally permitted to possess or use medical marijuana if they have a valid medical marijuana card. There are two exceptions to the individual being allowed to use medical marijuana:

- If the crime for which the probationer was convicted is a violation of Article 43.3 of Title 12, C.R.S. (Colorado Medical Marijuana Code), the probationer cannot use/possess medical marijuana. This is not discretionary on the part of the judge.

- The law provides that the court, on a discretionary basis, may prohibit use/possession if the "court determines, based on the assessment as required by section 18-1.3-209, a prohibition against the possession or use of medical marijuana is necessary and appropriate to accomplish the goals of sentencing as stated in 18-1-102.5." Probation officers are to provide the court with pertinent information regarding the assessment, and the court reaches a decision after considering the results of the assessment as well as the goals of sentencing.

Providers who have concerns about abuse/dependence may share those concerns with the probation officer, however, those concerns will not change the fact that a court's discretion relative to the use/possession of medical marijuana is extremely limited.

Guidance to SOMB Listed Providers On the Use of Medical Marijuana, Prescription Medications, and Over the Counter Medications by Sexual Offenders

In light of H.B. – 15-1267, the SOMB is offering the following guidance to SOMB Listed Providers. It is not uncommon for a client of therapeutic services to be under the care of a physician and be prescribed medication. This medication can be in the form of prescription narcotics for pain management, prescription psychotropic medication for mental health symptoms, or even medical marijuana. It is important for mental health professionals to consult with the client's medical provider to determine the effects of the medication, possible side effects, and potential impacts to the therapeutic process.

The Colorado Mental Health Practice Act (12-43-208 and 12-43-209) specifically prohibit a mental health professional from "engaging in the practice of medicine" or to "advise a client with reference to medical problems." The mental health professional should, however, assess during treatment sessions if a client's

decision-making and judgement are affected by medication use. A client cannot be impaired during treatment and needs to be able to focus, be present, participate, and track content of treatment sessions. The prescription of a medication or medical marijuana by a physician does not prohibit a SOMB Listed Provider from also determining as necessary whether the medication or medical marijuana use is being abused by the client. The various ethical codes of conduct, including the American Counseling Association, discuss the "inability of incapacitated adults to give consent." In these cases the mental health professional should discuss the concerns with the client and other members of the treatment team to determine the best course of action.

Specific Guidance Regarding Medical Marijuana and Clients in Treatment for a Sexual Offense

Obtain Information from the Probation Officer

SOMB listed providers, in conjunction with the Community Supervision Team (CST), or Multidisciplinary Team (MDT, should obtain information from the probation officer regarding the allowance or prohibition of medical marijuana use while under court supervision.

SOMB Listed Providers Agency Policies

Ethical standards allow mental health professions, including SOMB Listed Providers, to determine which clients they accept, or do not accept, into treatment, and whether their program has policies or protocols in place to address client impairment due to substance or medication use, including medical marijuana.

Confidentiality of the Marijuana Registry

It is important to keep in mind that per the State Court Administrator's Office, a sex offender's "status on the medical marijuana registry is not public information. It is a class 1 misdemeanor to release or make public confidential information from the marijuana registry. Therefore, if the information regarding a person's status is to be released, it is important to secure a signed release of information from the client before doing so, or place with communication with the court under confidential cover."[174]

Testing and Assessment Considerations

Medical marijuana usage by clients in sex offense-specific treatment may affect their polygraph results. Therefore, the use of medical marijuana by clients subject to polygraph assessment should be discussed with the polygraph examiner and prescribing physician. The CST/MDT should make a determination about the suitability of a client for assessment utilizing polygraph, plethysmograph, VRT, and alternative monitoring and accountability measures.

[174] Memorandum from the State Court Administrator's Office (DPS 09-01, March 5, 2009).

Appendix J
NOTICE OF DISCHARGE STATUS FORM

□COUNTY □DISTRICT COURT, _____ COUNTY, COLORADO _____ County Courthouse Courthouse Address:	
THE PEOPLE OF THE STATE OF COLORADO, Plaintiff v. _____, Defendant	♦ COURT USE ONLY ♦
	Case Number: (please indicate the case in which the client has been ordered to participate in offense-specific treatment) Division:
MOTION TO FILE THIS NOTICE AND ANY ATTACHMENTS UNDER SEAL & NOTICE OF DISCHARGE STATUS FROM SEX OFFENSE-SPECIFIC TREATMENT PROVIDER	

Motion to File Under Seal: The undersigned requests the Court accept this notice and any attachments under seal. This filing contains confidential mental health treatment information that should be kept private, subject to any release, in whole or in part, that may occur with the knowledge, approval, and supervision of this Court.

Notice: This notice is being provided to advise the Court that (name of client) _____ entered into sex offense-specific treatment on _____ (date) and was discharged on _____ (date) with the following status(es) (please check all applicable boxes):

□ having successfully completed treatment
□ discharged unsuccessfully from treatment
□ discharged prior to completing treatment but in good standing
□□other:_____ (provider *may* note another discharge status here, *e.g.,* "transferred to another provider," "client reached end of sentence," and/or provide additional documentation)

Name of Program: _____

Address: _____

Phone Number: _____ **Fax Number:** _____

Email Address: _____

I have / have not attached additional documentation concerning Mr./Ms. _____'s participation in offense-specific treatment.

_____

Signature of SOMB-Approved Provider

_____

Printed name of SOMB-Approved Provider

License # / credential (if applicable):

_____

Dated: _____

NOTE: PLEASE DETACH THIS PAGE BEFORE FILING THE FORM

INSTRUCTIONS TO THERAPISTS FOR DISCHARGE STATUS FORM:

At the time of discharge from treatment, ***print or type*** the information requested by the form and sign in the signature block. Please select all applicable boxes to indicate status at time of discharge. Where text is underlined, please **circle one** option, *e.g.*, **have / have not**.

The form is to be filed in the court and under the case number ("M" or "CR") where the client was ordered to register as a sex offender. The address for each County and District Court in Colorado is to be entered in the caption and is available under "Find a Court" at: http://www.courts.state.co.us/

This form may be filed with the court in person at the courthouse or submitted via U.S. Mail to the Clerk's Office at the court's mailing address. A Probation Officer may also assist you in properly filing this form with the court.

PURPOSE OF THIS DOCUMENT:

In Colorado, some clients will not become eligible or file a petition to be taken off the sex offender registry until many years or decades after their sentences have terminated. This form allows a therapist to share information with the court about a defendant's status at the time of termination from treatment and while authorizations remain in effect allowing the therapist to divulge this otherwise confidential information to the court.

Unlike most other records, court files are maintained forever. Consequently, by logging this information in the court record, it will remain available to clients and other parties to the case, in the court's discretion. Therapists are being asked to provide this documentation to ensure the client's involvement in treatment is part of the permanent court record and, if appropriate, may be considered by the court in future decision-making.

If the therapist would like to further expand on his/her description of the client's participation in treatment, s/he may attach a letter or report explaining his/her position more fully. Any documents received by the court under seal cannot be viewed by anyone else without subsequent court orders authorizing release.

Appendix K
INTERIM GENERAL MOVEMENT SAFETY PLAN

INTERIM GENERAL MOVEMENT SAFETY PLAN
Date: _____

NAME: _____ TELEPHONE NUMBER: _____

PAROLE OFFICER: _____ TELEPHONE NUMBER: _____

PROBATION OFFICER: _____ TELEPHONE NUMBER: _____

PROPOSED TREATMENT PROGRAM: _____

I am requesting permission to go to the following locations until I have been accepted into my treatment program and my General Movement Safety Plan is approved. Check all those that apply.

- ❑ Food: _____ (Location / Time Allowed / Initial)
- ❑ Transportation: _____ (Method / Restrictions / Initial)
- ❑ Cell Phone: _____ (Requirements & Restrictions)
- ❑ Laundry _____ (Location / Time Allowed / Initial)
- ❑ Haircut: _____ (Location / Time Allowed / Initial)
- ❑ Doctor: _____ (Location / Time Allowed / Initial)
- ❑ Mental Health Provider: _____ (Location / Time Allowed / Initial)
- ❑ Probation: _____ (Location / Time Allowed / Initial)
- ❑ Parole: _____ (Location / Time Allowed / Initial)
- ❑ Treatment Intake: _____ (Location / Time Allowed / Initial)
- ❑ Drug Monitoring: _____ (Location / Time Allowed / Initial)
- ❑ Banking: _____ (Location / Time Allowed / Initial)
- ❑ Job Search: _____ (Location / Time Allowed / Initial)
- ❑ Pharmacy: _____ (Location / Time Allowed / Initial)
- ❑ Computer Use Agreement: _____ (Location / Time Allowed / Initial)
- ❑ Community Re-entry Support: _____ (Location / Time Allowed / Initial)
- ❑ Other (Specify)

_____ (Location / Time Allowed / Initial)

A safety plan is only a theoretical plan for action while a positive decision is a validated plan of action.

Client signature:_____

Probation officer signature:_____

Parole officer signature:_____

Appendix L-1
THE USE OF PHALLOMETRY, VIEWING TIME, AND POLYGRAPHY TO SUPPORT INFORMATION-GATHERING FOR ASSESSMENTS

Taken From the ATSA Ethical Standards and Principles for the Management of Sexual Abusers, the Association for the Treatment of Sexual Abusers 2014, (PP. 26-28, and 75-78).

7.00 Members recognize that research–supported assessment methods such as phallometry and viewing time may be useful for (a) obtaining objective behavioral data about the client that may not be readily established through other assessment means; (b) exploring the reliability of client self–report; and (c) exploring potential changes, progress relative to treatment and other case management goals and objectives. Members appreciate that the polygraph for which reliability and validity questions remain may have utility in facilitating disclosure about sexual history, offense–specific behaviors, and/or compliance with treatment and other expectations.

7.01 Members obtain specific informed consent from clients prior to using phallometric, viewing time, and/or polygraph methods.

7.02 Members are familiar with the strengths and limitations of phallometric, viewing time, and polygraph methods (see Appendix B)[175] and note these issues when interpreting and communicating the findings from these methods.

7.03 Members take reasonable steps to obtain assurances that examiners utilizing phallometric, viewing time, and polygraph methods are appropriately trained in the use of such methods, use accepted methods, and adhere to applicable professional/discipline–specific standards or guidelines.

7.04 Members recognize that the findings from phallometric, viewing time, and polygraph methods are to be used in conjunction with other sources of assessment information, not as the single source of data for any assessment.

7.05 Members recognize that the results of phallometric, viewing time, and polygraph methods are not to be used as the sole criterion for the following:

- Estimating level of risk for recidivism;
- Making recommendations for release to the community from a correctional, institutional, or other non–community placement;
- Determining treatment completion; or
- Drawing conclusions regarding compliance with or violations of conditions of release or community placement.

7.06 Members appropriately limit phallometry to the following purposes:

- Assessing the client's relative sexual arousal and preferences regarding age and gender;

[175] Appendix B of *2014 ATSA Ethical Standards and Principles for the Management of Sexual Abusers, the Association for the Treatment of Sexual Abusers.*

- Evaluating the client's arousal responses to various levels of sexually intrusive or aggressive/coercive behaviors;
- Exploring the potential role of offense–related sexual arousal in the client's sexually abusive or at–risk behavior and developing accompanying treatment goals; and
- Monitoring the effectiveness of interventions involving the modification, management, and expression of both healthy and offense–related sexual arousal.

7.07 Members appropriately limit the use of viewing time measures to the following purposes:

- Assessing the client's sexual interests with respect to age and gender;
- Exploring the potential role of offense–related sexual interests in the client's sexually abusive or at–risk behavior and developing accompanying treatment goals; and
- Monitoring the effectiveness of interventions involving the modification, management, and expression of both normative and offense–related sexual interests.

7.08 Members appropriately limit use of the polygraph to the following purposes:

- Facilitating a client's disclosure of sexual history information, which may include sexually abusive or offense–related behaviors (generally disclosed in the interview portion of the examination);
- Eliciting from the client clarifying information regarding the instant/index offense;
- Exploring potential changes, progress, and/or compliance relative to treatment and other case management goals and objectives (through yes/no questions about adherence to specific treatment and other case management expectations); and/or
- Making collaborative case management decisions about a client with other partners and stakeholders based on the information gleaned from the examination and interview.

Polygraph testing involves a structured interview during which a trained examiner records several physiological responses of the examinee. Following this interview, the examiner reviews the charted record and forms opinions about whether the examinee was non–deceptive or attempting deception when answering each of the relevant questions. Many regions and jurisdictions do not utilize polygraphy for a variety of reasons, including empirical questions about its reliability and validity, yet in many other jurisdictions it is a widespread practice.

Post–conviction sex offender polygraph testing is a specialized form of general polygraph testing. Although all principles applicable to general polygraph testing also apply to post–conviction sex offender testing, its unique circumstances generate additional challenges. Using post–conviction sex offender testing responsibly requires members to have at least a rudimentary understanding of how the polygraph works, its advantages and limitations, and special considerations related to its integration into work with individuals who have engaged in sexually abusive behaviors. As with any instrument or procedure, members should be familiar with current literature and obtain appropriate training before using or interpreting polygraph results.

Post–conviction sex offender testing is intended to serve the following objectives:

A. Facilitate a client's disclosure of sexual history information, which may include sexually abusive or offense–related behaviors (generally disclosed in the interview portion of the examination);

B. Eliciting from the client clarifying information regarding the instant/index offense

C. Exploring potential changes, progress and/or compliance relative to treatment and other case management goals and objectives (through yes/no questions about adherence to specific treatment and other case management expectations); and/or

D. Making collaborative case management decisions about a client with other partners and stakeholders based on the information gleaned from the examination interview.

Some research indicates that the polygraph examination can lead to clients providing increased information regarding their sexually abusive behaviors; however, as has been mentioned, test validity and reliability often vary widely across studies. Examiner and examinee characteristics, treatment milieu, instrumentation, procedures, examination type, base rates of attempted deception in the population being tested, and other idiosyncratic factors can also affect reliability and validity. Therefore, it is important for providers to become informed about types of tests that produce the most accurate findings. As well, it is possible that some of the information obtained through post–conviction sex offender testing might be fictitious, representing an accommodation to pressure for disclosures. The third objective of post–conviction sex offender testing —to gauge enhanced supervision and treatment compliance — has received only limited empirical attention.

Members' primary purpose for collecting sexual history information is to further inform, as a complement to other assessment data, clinical interventions and other management strategies. The usefulness of post–conviction sex offender polygraph testing as a "clinical" tool is based on its potential to elicit historical information, thus arguably allowing psychosexual behavioral patterns to be more fully revealed, better understood, and therefore more effectively managed and changed.

The American Polygraph Association, The National Association of Polygraph Examiners, and other polygraph associations have developed standards for certifying polygraph examiners who work in the management and treatment of sexual abusers, as well as standards for administering sexual abuser tests. Some states also regulate post–conviction sex offender testing standards and procedures. Members are familiar with laws, state regulations, and association guidelines governing post–conviction sex offender testing where they practice. Members work with examiners who meet certificate requirements and adhere to procedures recommended by a relevant polygraphists' organization.

Four types of post–conviction polygraph exams are commonly performed with individuals who have engaged in sexually abusive behavior:

E. Instant/Index Offense Tests are designed to explore and clarify discrepancies between the client's and the official descriptions of the conviction offense(s).

F. Sexual History Disclosure Tests are designed to facilitate a client's disclosure of sexual history information, which may include sexually abusive or offense–related behaviors, to their treatment provider prior or subsequent to the polygraph examination itself.

G. Maintenance/Monitoring Tests are designed to explore potential changes, progress, and/or compliance relative to treatment, supervision, and other case management goals, objectives,

and expectations, based on specific yes/no questions pertaining to very specific and narrow expectations and goals that have been established.

H. Specific Issue Tests are generally designed using a yes/no format to explore a client's potential involvement in a specific prohibited behavior, such as unauthorized contact with a victim at a particular time.

Polygraph test accuracy is believed to be greatest when examiners focus on highly specified (i.e. single issue, narrow, and concrete) questions. Members cooperate with examiners in structuring tests that are responsive to program needs without unnecessarily compromising accuracy considerations.

Members must ensure that limits of confidentiality are fully disclosed to clients prior to polygraph testing, and that clients are afforded the opportunity for informed consent, specifically with respect to the ways in which the findings will be used and to whom the findings will be provided. Client disclosures of potentially incriminating information to mandated reporters can, lead to future prosecution. Members inform clients, in writing, of this potential dilemma and how it is addressed in their jurisdiction
and program.

There is very limited empirical research on the use of polygraph with clients who have developmental disabilities and clients with low/borderline IQs. Therefore, further caution is advised if members use polygraphy for assessment, treatment, and management processes with these clients.

As noted in the main body of this document, polygraphy is not used as the sole criterion for determining deviant sexual interests, estimating a client's risk for engaging in sexually abusive behavior, recommending whether a client be released to the community, or deciding whether a client has completed a treatment program or to change a client's treatment status. When the polygraph is utilized, findings are to be interpreted in conjunction with other relevant information to inform decision making.

Appendix L-2
APA MODEL POLICY FOR THE EVALUATION OF EXAMINEE SUITABILITY FOR POLYGRAPH TESTING

Model Policy for the Evaluation of Examinee Suitability for Polygraph Testing[176]

1. Statement of purpose. This Model Policy is intended to assist polygraph examiners, referring professionals, program managers, law enforcement agencies and governmental organizations to make better decisions regarding the suitability of potential polygraph examinees to undergo testing that will further the goal(s) for which the testing is being considered. Policies regarding the assessment of examinee suitability are intended to protect examinees from undergoing examinations for which there is no potential benefit to themselves or their communities, and to avoid expenditure of resources for examinations that may not contribute to the goals of an investigation, candidate screening, risk assessment or risk management. This Model Policy should assist field examiners to make more effective and expeditious judgments about whether or not to proceed with an examination when there are questions about the suitability of an examinee.

2. Scope of authority. Examiners should be responsible for knowing and adhering to all legal and regulatory requirements. In the case of any conflict between the Model Policy and any legal practice requirements, the legal regulations should prevail. Examiners who work in jurisdictions and programs without local regulations should refer to this Model Policy as a guide.

3. Goals of testing. Polygraph testing is a decision support tool intended to add incremental validity to investigative and evidentiary decisions, and to risk assessment and risk management activities. Polygraph testing and polygraph test results should not replace or supplant the need for professional decision making. Any or all of the following objectives should be considered a sufficient reason to complete polygraph testing:

   A. Increased disclosure of information;

   B. Increased deterrence of problems (e.g., non-compliance or unsuitable persons);

   C. Increased detection of involvement or non-involvement in problem behaviors or criminal activities.

4. Examinee suitability. Persons who are suitable to undergo polygraph testing should minimally meet the following requirements:

   A. Age 12 or older.

      1. Functional maturity should be considered more important than chronological age when assessing suitability for polygraph testing. This Model Policy recommends that testing of an examinee should only occur when the person's Mean Age Equivalence (MAE) or

[176] American Polygraph Association (2012). *Model Policy for the Evaluation of Examinee Suitability for Polygraph Testing.* [Electronic version] from http://www.polygraph.org.

Standard Age Score (SAS) is equivalent to that of a youth age 12 years or older, as determined through standardized psychometric testing (e.g., IQ testing, achievement and/or adaptive functioning), or when there is reasonable certainty the person is not functionally or developmentally impaired (e.g., developmental disorder, learning disorder, or serious emotional disturbance).

B. Adequate abstract thinking, as demonstrated by awareness of the context of the examination referral (i.e. reasons for the testing);

C. Insight into their own and others' motivation, as demonstrated by the ability to express basic reasons for being honest or dishonest and the basis for the concerns of the referring professional or retaining persons;

D. Possess a basic understanding of right from wrong, as demonstrated by an ability to verbalize potential reasons for being honest or dishonest, and the potential consequences for dishonesty or truthfulness;

E. Understand the difference between truth and lies, as demonstrated by the ability to recognize, describe or identify incidents, circumstances, or examples of lying and dishonesty;

F. Anticipate rewards and consequences for lying and behavior, an ability to verbalize potential rewards and consequences for honesty or dishonesty to the examination questions or other contexts; and

G. Maintain consistent orientation to date, time, and location, as demonstrated by independent functioning sufficient to transport oneself to the examination location at the scheduled date and time. (Examiners should rely on professional information sources to determine orientation or disorganized functioning when examinees are residing in or transported from institutional or secured settings.)

5. Unsuitability for polygraph. Examiners should not conduct polygraph examinations on individuals determined to be unsuitable. When available, examiners should consider psychological diagnostic information. Individuals deemed unsuitable for polygraph testing should not be tested until the identified conditions have improved, and when the individual is able to adequately attend to the examination context. Conditions that should preclude an examinee from suitability for polygraph testing include the following:

A. Psychosis (e.g., lack of contact with reality, including hallucinations or delusional thinking) or psychotic condition that is active, un-treated, or un-managed at the time of the examination;

B. Mean Age Equivalence (MAE) or Standard Age Score (SAS) is below 12 years, as determined through standardized psychometric testing (e.g., IQ testing, achievement and/or adaptive functioning);

C. Severe mental retardation or measured IQ less than 55, as determined through standardized psychometric testing (e.g., IQ testing, and/or adaptive functioning);

D. DSM Axis V Global Assessment of Functioning (GAF) score of 50 or less, (e.g., persons who require continuous observation or assistance due to psychiatric or developmental conditions);

E. Any DSM Axis I mental health condition to include a severity specifier of "severe" or "with psychotic features" (i.e. indicative of a high potential adverse outcome) for any disorder; acute serious injury or illness, involving acute pain or distress; or

F. Observable impairment due to the influence of prescribed or non-prescribed controlled substances including alcohol.

6. Special populations. Examiners should conduct all examinations in a manner that is sensitive to any medical, mental health or developmental issues that may affect the examinee's functioning or the quality of the examination data. There is no published research or theoretical rationale suggesting that any medical, mental health, or developmental issues would result in erroneous examination results for individuals who meet the normal functional requirements for polygraph examinees. Ethical professional and empirical practices suggest that the application of normative data and normative interpretation rules to exceptional individuals (i.e. persons whose functional characteristics are outside the normal range of individuals in an intended population or sample) should always be regarded with caution.

A. Medical. Persons with some acute or chronic medical/physical conditions may be regarded as marginally suitable for polygraph testing, at which times the test results should be accordingly qualified and viewed with caution. However, there is no published research or theoretical rationale suggesting that any medical conditions would interfere with the polygraph test or that polygraph testing would interfere with known medical conditions.

1. Except as precluded by law or regulations, examiners should note in the examination report any diagnosed acute or chronic medical condition. Medical conditions, including stable injuries, depending on their severity, do not necessarily preclude an individual from being suitable for polygraph testing. However, it may at times be advisable to delay polygraph testing until the prospective examinee's health has improved.

2. Examiners should defer to medical professionals when determining the suitability of prospective examinees that are pregnant. Examiners should require a statement or waiver from a physician, or other medical professional, attesting to the fact that the pregnancy is normal and uncomplicated with no expected reason that polygraph testing would interfere with the pregnancy. Examiners should delay polygraph testing of any individual determined to be experiencing a medically complicated or high-risk pregnancy.

B. Medications. Persons who require the administration of multiple prescription medications to manage the potentially overwhelming effects of a diagnosed medical or mental health condition may be regarded as marginally suitable for polygraph testing. Test results for these individuals should be accordingly qualified and viewed with caution.

1. There is no theoretical rationale or published research suggesting that any medications would result in erroneous polygraph examination results. Clinical commonsense suggests that persons who function optimally while taking prescription medications may produce polygraph examination data of optimal interpretable quality while taking medications as directed by a doctor. There is no way to predict the exact effects of medications for any

individual. Medication effects may vary with the types and numbers of medication, dosages, length of time on medications, in addition to the individual's physiology. Some increase in inconclusive results may occur from some medications, however, medications do not act differentially among the polygraph test questions, and no known increase in decision errors is expected from medication use.

2. Except as precluded by law or regulations, examiners should note in the examination report a list of the examinee's reported prescription medications, and any corresponding acute or general medical health conditions, including the absence of understanding of the reasons for a prescription medication.

3. Examiners should advise examinees who take prescriptions to take all prescription medications as prescribed by their medical or psychiatric provider.

C. Psychiatric. Persons who are actively psychotic should not undergo polygraph testing. However, individuals may be tested when their psychiatric conditions have stabilized. Individuals diagnosed with psychotic mental health disorders should be viewed as marginally suitable for polygraph testing. Test results for these persons should be reported as qualified and the test results should be viewed with caution.

1. Except as precluded by law or regulations, examiners should note in the examination report any examinee that reports being diagnosed with a serious mental health condition, including medically or age-related dementia/delirium, and the use of psychotropic medications. Psychiatric conditions do not necessarily preclude an individual from being tested; although it may be important to delay polygraph testing until the individual's psychiatric issues are stable or effectively managed.

2. Examiners should not test persons who require continuous observation or assistance until the individual's psychiatric and functional stability has improved.

D. Developmental. Persons with diagnosed developmental disorders should not be tested unless it can be reasonably expected that the goals of the program, investigation, agency, or individual can be met by the polygraph testing, and that the testing process will not jeopardize the health or safety of the examinee. These individuals should be viewed as marginally suitable for polygraph testing. Their test results should be accordingly qualified and viewed with caution.

1. Examiners should determine suitability on a case-by-case basis for prospective examinees that have diagnosed developmental disorders, such as serious impairment in cognition/memory, learning, language, communication, conceptual functioning, or temporal/organization deficits.

2. Persons whose functioning is profoundly limited (e.g., whose measured IQ is less than 55), should be regarded as unsuitable for polygraph testing.

Appendix L-3
PLETHYSMOGRAPH EXAMINATION AND VIEWING TIME

Taken From the ATSA Ethical Standards and Principles for the Management of Sexual Abusers, the Association for the Treatment of Sexual Abusers 2014 (PP. 70-75).

Phallometry

Phallometry is a specialized form of assessment used in treatment with individuals who have committed sexual offenses. Responsible use of phallometry results requires at least a rudimentary understanding of how phallometry works, and its advantages and limitations. As with any instrument or procedure, members are familiar with current literature and obtain appropriate training before using or interpreting phallometric testing results. Examiners receive training in phallometric testing in order to become knowledgeable about the technical aspects of the equipment and the appropriate protocols for conducting phallometric testing specific to the equipment being used. Examiners are also familiar with the research evidence on the reliability and validity of phallometric testing.

Phallometric testing using penile plethysmography involves measuring changes in penile circumference or volume in response to sexual and non–sexual stimuli. Circumferential measures (measuring changes in penile circumference) are much more common than volumetric measures (measuring changes in penile volume), which are used in only a few laboratories worldwide. However, there is good agreement between circumferential and volumetric measures once a minimal circumference response threshold is reached. Therefore, circumferential measures are the focus of this appendix.

Phallometric testing provides objective information about male sexual arousal and is therefore useful for identifying atypical sexual interests, increasing client disclosure, and measuring changes in sexual arousal patterns over the course of treatment.

Phallometric test results are not used as the sole criterion for determining atypical sexual interests, estimating risk for engaging in sexually abusive behavior, recommending that clients be released to the community, or deciding that clients have completed treatment programs. Phallometric test results are interpreted in conjunction with other relevant information (such as, the individual's offending behavior, use of fantasy, and pattern of masturbation) to determine risk and treatment needs. Phallometric test results are not to be used to draw conclusions about whether an individual has or has not committed a specific sexual crime. As well, there are limited data available regarding the use of the plethysmograph with clients who have developmental disabilities and clients with an acute major mental illness. Therefore, members need to exercise caution in using phallometry with these populations and in interpreting and reporting phallometric results.

Prior to testing, examiners screen clients for potentially confounding factors such as medical conditions, prescription and illegal drug use, recent sexual activity, and sexual dysfunction. Clients with active, communicable diseases, particularly sexually transmittable diseases, are not to be tested until their symptoms are in remission.

Specific informed consent for the testing procedure and release forms for reporting test results are obtained at the beginning of the initial appointment. Laboratories have a standard protocol for fitting gauges, presenting stimuli, recording data, and scoring.

Examiners use the appropriate stimulus set to assess sexual interests that are the subject of clinical concern. For example, examiners use a stimulus set with depictions of children and adults to test clients who have child victims or who are suspected of having a sexual interest in children. At a minimum, examiners have at least two examples of each stimulus category. Stimuli that are more explicit appear to produce better discrimination between individuals who sexually abuse and control subjects than less explicit stimuli. It is important to ensure that the stimuli are good quality and avoid any distracting elements.

Members are aware of the applicable legislation in their jurisdiction regarding the possession of sexually explicit materials. If permitted to use visual stimuli for testing of sexual interest in children, examiners use a set of pictures depicting males and females at different stages of physical development, ranging from very young, pre–pubertal children to physically mature adults. The use of neutral stimuli, such as pictures of landscapes without people present, may increase the validity of the assessment. The inclusion of neutral stimuli serves as a validity check because responses to sexual stimuli that are lower than responses to neutral stimuli might indicate faking attempts. Faking tactics include looking away from or not listening to stimuli. Audiotaped stimuli may also be used to assess sexual interest in children; if used, these stimuli clearly specify the age and sex of the depicted individuals.

For testing of sexual arousal to non–consenting sex and violence, examiners using audiotapes include stimuli describing consenting sex, rape, and sadistic violence. Stimuli depicting neutral, non–sexual interactions are also included. Stimuli can depict males or females, children, or adults.

The phallometric testing report includes a description of the method used for collecting data, the types of stimuli used, an account of the client's cooperation and behavior during testing, and a summary and description of the client's profile of responses. Client efforts to fake or other potential problems for the validity of the data or the interpretation of results are also reported.

The three most common means of scoring plethysmograph data are standardized scores, percentage of full erection, and millimeter of circumference change. Those using phallometric assessment are aware of the advantages and disadvantages of each scoring method. Research has found that standardized scores (e.g., z scores) increase discrimination between groups. Transforming raw scores to standardized scores for subjects who show little discrimination between stimuli can, however, magnify the size of small differences between stimuli. Raw scores, millimeter of circumference change, or scores converted to percentage of full erection may be clinically useful in the interpretation of results.

Deviance indices can be calculated by subtracting the mean peak response to non–deviant stimuli from the mean peak response to deviant stimuli. For example, a pedophilic index could be calculated by subtracting the mean peak response to stimuli depicting adults from the mean peak response to stimuli depicting prepubescent children. Thus, greater scores indicate greater sexual arousal to child stimuli. Because the sensitivity of phallometric testing is lower than its specificity, the presence of atypical/deviant sexual arousal is more informative than its absence. Results indicating no atypical/deviant sexual arousal may be a correct assessment or may indicate that a client's atypical/deviant sexual interests were not detected during testing.

Research indicates that initial phallometric assessment results are linked with recidivism. Repeated assessments can be helpful to monitor treatment progress and to provide information for risk management purposes.

Viewing Time Measures

Viewing time measures are a specialized form of assessment used with individuals who have engaged in sexually abusive behaviors. Using the results of viewing time measures responsibly requires members to have at least a rudimentary understanding of how viewing time measures work, as well as their advantages and limitations. As with any instrument or procedure, members should be familiar with current literature and obtain appropriate training before using or interpreting viewing time testing results. Currently, unobtrusively measured viewing time is primarily used to identify sexual interest in children. For instance, to test sexual interest in children, examiners have a set of pictures depicting males and females at different stages of development, ranging from very young children to physically mature adults. The relative amount of time clients spend looking at pictures of children (who are clothed, semi–clothed or nude, depending on the jurisdiction,) is compared to the time that the same adult spends looking at pictures of adults. Research suggests that, as a group, individuals who have engaged in sexually abusive behaviors against children look relatively longer at stimuli depicting children than adults. Unobtrusively measured viewing time correlates significantly with self–reported sexual interests and congruent patterns of phallometric responding among non–sexually abusive subjects. Little is known, however, about the value of retesting using viewing time as a measure of treatment progress.

As with any test, specific informed consent for the test procedure and release forms for reporting results are obtained prior to beginning testing. Examiners have a standardized protocol for presenting the stimuli, recording, and scoring. Examiners are familiar with the reliability and validity of the test. In particular, it is important that examiners know the degree to which the viewing time measure being used has been validated for the client population being assessed. Note that there is limited information specific to the use of viewing time with clients who have developmental disabilities. Currently this technology has primarily been used to identify sexual interest in gender and age. As well, there is limited information specific to the use of viewing time with clients with developmental disabilities.

The test report includes a description of the method used for collecting data, the types of stimuli used, an account of the client's cooperation and behavior during testing, and a summary and description of the client's responses. Client efforts to fake or other potential problems for the validity of the data or the interpretation of results are also included.

As noted in the main body of this document, viewing time is not to be used as the sole criterion for determining deviant sexual interests, estimating a client's risk for engaging in sexually abusive behavior, recommending whether a client be released to the community, or deciding whether a client has completed a treatment program. Viewing time test results are interpreted in conjunction with other relevant information (for example, the individual's offending behavior, use of fantasy, and pattern of masturbation) and are never to be used to make inferences about whether an individual has or has not committed a specific sexual crime.

Appendix M
FEMALE SEX OFFENDER RISK ASSESSMENT

Female Sex Offender Risk Assessment
White Paper
October 2013

Currently the field of sex offender management and treatment is lacking any validated/standardized risk assessment instrument for the female sex offender population. As a result, providers and other stakeholders working with this unique offender type do not have an approved method of accurately assessing risk. Further, it is counterproductive and prohibited for risk assessment instruments normed on the male population to be used on the female population. Given that research has shown that clinical judgment is the *least* accurate indicator of risk and that standardized risk instruments are the preferred measure of risk, this a substantial and concerning gap in the field.

Female sex offenders represent less than 10% of all known sex offenders.[177] With such a small offender population there are challenges in gathering data resulting in a lack of research.[178] In fact, the field of sex offender management is 20 years behind regarding female sex offenders in comparison to male offenders.[179] Given that recidivism amongst this group appears to be very low, (meta analyses from 2005 to 2010 indicate female sexual recidivism is between 1-3%) effectively discerning accurate risk factors is extremely challenging and has proven to be a barrier to developing a standardized risk assessment thus far.[180] The Sex Offender Management Board (SOMB) is working toward developing a risk assessment, but this task has proven arduous and will realistically take a long time due to the necessary numbers needed for data collection as well as collaboration with other states and possibly nations this project requires.

In the interim, the SOMB offers the following guidance to professionals working with this population. As new research emerges the SOMB will respond accordingly by incorporating updated information but until such time it is essential to utilize best practices. After a thorough review of current information from professional publications (books and peer reviewed journals by experts in the field) there appear to

[177] Cortoni, F., & Hanson, R.K. (2005). A review of the recidivism rates of adult female sexual offenders (Research Report 2005 No R-169). Ottawa, Ontario: Correctional Service of Canada, Research Branch; Cortoni, F., Hanson, R.K., & Coache, M.E. (2010). The recidivism rates of female sexual offenders are low : A meta-analysis. Sexual Abuse: A Journal of Research and Treatment, 22, 387-401; U.S. Department of Justice, Center for Effective Public Policy, Center for Sex Offender Management (2007). Female sex offenders. Retrieved from http://www.csom.org/pubs/female_sex_offenders_brief.pdf.

[178] Gannon, T. A., & Cortoni, F. (2010). Female sexual offenders: Theory, assessment, and treatment. Hoboken, NJ: John Wiley & Sons; Harris, D. A. (2010). Theories of female sexual offending. In T. A. Gannon & F. Cortoni (Eds.), Female Sexual Offending: Theory, Assessment, & Treatment. Hoboken, NJ: John Wiley & Sons; Lilly, J. R., Cullen, F. T., & Ball, R. A. (1995). Criminological theory: Context and consequences (2nd Ed.) Newbury Park, CA: Sage.

[179] Ford, H. & Cortoni, F. (2008). Sexual deviance in females: Assessment and treatment. In D. R. Laws & W. O'Donohue (Eds.), Sexual Deviance: Theory, Assessment, and Treatment Vol. 2, New York: Guilford Press; Gannon, T. A., & Cortoni, F. (2010). Female sexual offenders: Theory, assessment, and treatment. Hoboken, NJ: John Wiley & Sons;

[180] Cortoni, F., Hanson, R.K., & Coache, M.E. (2010). The recidivism rates of female sexual offenders are low : A meta-analysis. Sexual Abuse: A Journal of Research and Treatment, 22, 387-401; Cortoni, F., & Hanson, R.K. (2005). A review of the recidivism rates of adult female sexual offenders (Research Report 2005 No R-169). Ottawa, Ontario: Correctional Service of Canada, Research Branch.

be some indicators that can be helpful when appraising risk of female sex offenders.[181] The following list is not intended to be all encompassing or to be used as a risk assessment, rather, professionals should consider the following factors in conjunction with sound clinical judgment as they may potentially be related to risk for female sex offenders:

- Prior criminal history – i.e. anti-social orientation
- Prior child abuse offenses – criminal history, social services, self-report
- Denial or minimization of offending behavior
- Distorted cognitions about sexual offending/abuse – Multi Phasic Sexual Inventory II and/or Abel
- Intimacy deficits and problematic relationship(s) – Intimacy deficits can be defined as restrained capacity of an individual to exchange thoughts and feelings that are of personal significance with another individual who is highly valued. Problematic relationships can be relationships in which the individuals do not emotionally support one another, foster communication, or appropriately challenge one another. In addition, the individual may place a higher value on the relationship than his/her own personal worth. The relationship may contain unhealthy interaction, and does not effectively enhance the lives of the people involved. The individuals may not take responsibility for making their own lives or the relationship work.
- Use of sex to regulate emotional state or fulfill need for intimacy. This can be viewed as an individual who engages in sexual behaviors as a coping mechanism to improve mood, increase self-esteem, reduce stress, achieve emotional well-being, solve problems and/or to avoid negative emotional states. Using sex to fulfill a need for intimacy may be seen as an individual who engages in sexual behaviors to meet emotional needs, to achieve a superficial/distorted sense of connection, and/ or to achieve emotional fulfillment through physical sexual acts.
- Sexual gratification and instrumental goals such as revenge or humiliation
- Substance abuse
- Puts needs of co-offending partner above self and/or child(ren) and/or victim
- Evidence of deviant sexual interest – Viewing Time
- Impulsivity – This can be viewed as engaging in behavior without adequate thought, the tendency to act with less forethought than do most individuals of equal ability and knowledge, or a predisposition toward rapid, unplanned reactions to internal or external stimuli without regard to the negative consequences of these reactions.

[181] Clark , D., & Howden-Windall, J. (2000). A retrospective study of criminogenic factors in the female prison population. London : Her Majesty's Prison Service; Denov, M. S., & Cortoni, F. (2006). Adult female sexual offenders. In C. Hilarski & J. Wodarski (Eds.) Comprehensive mental health practices with sex offenders and their families (pp. 71-99). New York: Hawthorne Press; Cortoni, F., Anderson, D., & Bright, D. (2002). Locus of control, coping and sexual offenders. In B. A. Schwartz & C. Cellini (Eds.), The sex offender (Vol. 4). Kingston, NJ : Civic Research Institute; Gannon, T. A., & Cortoni, F. (2010). Female sexual offenders: Theory, assessment, and treatment. Hoboken, NJ: John Wiley & Sons; Gannon, T. A., Rose, M. R., & Ward, T. (2008). A descriptive model of the offense process for female sexual offenders. Sexual Abuse: A Journal of Research and Treatment, 20(3), 352-374.

- Documented presence of personality disorder (e.g. Borderline, which may impact emotional regulation, impulsivity and poor decision making).

It may benefit the clinician to focus on offender characteristics in conjunction with clinical judgment,[182] and to use the Level of Service Inventory Revised (LSI-R) to identify criminogenic risk and needs. Given that effective risk assessment is essential in evaluating, treating, and managing sex offenders, it may be tempting to utilize the plethora of standardized assessments available for male offenders. However, they are ***prohibited*** for use with female offenders.[183] This is because the assessments were validated on the male population and are empirically based on the specific relationship between risk factors and recidivism, which is null and void with females. In addition, these assessments may misrepresent risk in female offenders.

The Board would like to remind stakeholders that offenses involving female sex offenders have a lower reporting rate than those involving a male offender. In addition, there are female offenders who are dangerous and require a high level of treatment and supervision. While they are a unique population, the behavior is similar and should be treated equally (e.g. non-compliance, instability, resistance, risk characteristics). Often females in the criminal justice system are treated differently due to individual, professional, cultural and social biases. However, inequity and inconsistency in sentencing, supervision, treatment, etc. based solely on gender differences does an injustice to the offender and the system and places the community at risk. The SOMB continues to promote individualized assessment and intervention efforts for all offenders regardless of gender and encourages the use of risk, need, responsivity principles. Furthermore, the SOMB endorses gender responsive interventions and evaluation. The very nature of sexual offenses requires that public and victim safety remain at the forefront of decision-making.

[182] Especially for those who have expertise working with female sex offenders; see Eldridge, H., & Saradjian, J. (2000). Replacing the function of abusive behaviors for the offender: Remaking relapse prevention in working with women who sexually abuse children. Remaking relapse prevention with sex offenders: A sourcebook, 402-426; Matthews, J. K. (1998). An 11-year perspective of working with female sexual offenders. In W. L. Marshall, Y. M. Fernandez, S. M. Hudson, & T. Ward (Eds.), Sourcebook of treatment programs for sexual offenders (pp. 259-272). New York: Plenum Press.

[183] Gannon, T. A., & Cortoni, F. (2010). Female sexual offenders: Theory, assessment, and treatment. Hoboken, NJ: John Wiley & Sons.

Appendix N
RESEARCH SUPPORTING RESTRICTED CONTACT WITH CHILDREN

The following is a summary of the research that supports the statements listed below, which are found in 5.700 of these Standards.

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1. ***"The offense for which a person is convicted is not necessarily a reliable indicator of the offender's risk to children or victims."***

A. Knopp, F.H. (1984). *Retraining Adult Sex Offenders: Methods and Models*, Brandon, VT: Safer Society Press.

Gene Abel et. al. conducted a breakthrough study in 1983 which gave us information on the frequency and variety of sexual offending behaviors sex offenders have committed. He received a federal certificate of confidentiality to study sex offenders. Individuals in this study could admit to current offending behaviors without fear that the information would be reported to law enforcement. He studied 411 sex offenders and found that on average over a twelve year period each offender had attempted 581 crimes, completed 533 crimes, had 336 victims, and committed an average of 44 crimes a year. These crimes included hands off sex offenses such as exposing, peeping and obscene phone calls. Additionally, he found that 50.6% of the rapists involved in the study had also molested children.

B. Freeman-Longo, R., Blanchard, G. (1998). *Sexual Abuse in America: Epidemic of the 21st Century*. Brandon, VT: Safer Society Press.

In 1985, Rob Freeman-Longo reported on a group of 23 rapists and 30 child molesters involved in an institutional forensic mental health sex offender program. Arrest records indicated rapists had an average of 1.9 offenses each for a group total of 43 arrests for sex offenses. The 23 rapists as a group admitted committing a total of 5090 various incidents of sex offending behaviors, which included 319 child molestations and 178 rapes. Arrest records indicated child molesters had an average of 1.5 arrests each. While in treatment, the 30 child molesters as a group admitted 20,667 offenses which included 5891 sexual assaults on children and 213 rapes on adult women.

C. Ahlmeyer, S., Heil, P., McKee, B., and English, K. (2000). The Impact of Polygraphy on Admissions of Victims and Offenses of Adult Sex Offenders, *Sex Abuse: A Journal of Research and Treatment*, Vol. 12 (2).

The Colorado Department of Corrections Sex Offender Treatment Program has found similar patterns to those reported by Gene Abel with the sex offenders participating in treatment and polygraph assessment. The program collected data in 1998 on the number of known victims of the first 36 sex offenders to participate in two polygraph evaluations. On average, for each offender there were 2 known victims documented in official records. After the first polygraph exam inmates disclosed on average 165 victims per offender. By the second polygraph exam

the same inmates, on average, disclosed 184 victims per offender. These crimes included hands-on sex offenses such as rape and pedophilia as well as hands-off sex offenses such as exhibitionism, voyeurism and obscene phone calls. Approximately 80% of these offenders were still deceptive on their polygraph examinations, suggesting that even more offenses were committed.

D. English, K. (1998). Maximizing the Use of the Polygraph with Sex Offenders: Policy Development and Research Findings, Presentation at the Association for the Treatment of Sexual Abusers 17th Annual Research and Treatment Conference, Vancouver.

In 1998, Kim English analyzed a sample of 83 sex offenders who had participated in polygraph evaluations at the Colorado Department of Corrections. This sample included inmates and parolees. She determined that 48% of the offenders had crossed over in either age (36%) or the gender (25%) of the victims they offended against-- they had committed offenses with either victims of different ages (adults and children) or victims of different sexes (males and females). Again, 80% of this sample were still scoring deceptive on their polygraph evaluations.

E. Heil, P., Ahlmeyer, S., Simons, D. (2003). Crossover Sexual Offenses, *Sex Abuse* 15(4).

Between 1995 and 2001, crossover sexual offenses were analyzed in a larger sample of 223 incarcerated and 266 paroled sexual offenders who participated in polygraph evaluations at the Colorado Department of Corrections. *The majority of incarcerated offenders admitted to sexually assaulting both children and adults from multiple relationship types. In addition, there was a substantial increase in offenders admitting to sexually assaulting victims from both genders. In a group of incarcerated offenders who sexually assaulted children, the majority of offenders admitted to sexually assaulting both relatives and nonrelatives, and there was a substantial increase in the offenders admitting to assaulting both male and female children* (Heil, et al., 2003).

1. Ahlmeyer, S. (1999). Poster Presentation at the Association for the Treatment of Sexual Abusers 18th Annual Research and Treatment Conference, Lake Buena Vista, Florida 1999.

In 1999, Sean Ahlmeyer analyzed a larger sample of 143 inmates who participated in polygraph evaluations at the Colorado Department of Corrections. In this sample, 89 % of the inmates self-reported that they had crossed over in the type of the offenses they committed by either: committing offenses with victims of different ages (adults and children) and/or victims of different sexes (males and females) and/or victims from different types of relationships.

- It was determined that 71% of the total sample acknowledged crossing over in the age of the victims they assaulted.
- Of the offenders who were only known to have child victims in official records, 82% later admitted to also having adult victims.
- Of the offenders who were only known in official records to have adult victims, 50% later admitted to having child victims during the process of polygraph examination.
- It was determined that 51% of the sample acknowledged crossing over in the sex of the victims they assaulted.

- Of the offenders who were only known to have male victims in official records, 58% later admitted to having female victims.
- Of the offenders who were only known to have female victims, 22% later admitted to having male victims.
- It was determined that 86% of the sample acknowledged having victims in two or more of the following categories: relative, stranger, acquaintance, or position of trust.
- Of those offenders who were only known to have offended against non-relative victims, 62% admitted to also having victims who were relatives.

Again the majority of the individuals in this sample (82%) were still scoring deceptive on some areas of their polygraph evaluations, indicating that the percent of cross over may be higher than the numbers self-reported by these offenders.

F. Becker, J., and Coleman, E. (1987). "Incest". In *Handbook of Family Violence*, Van Hasselt, ed. New York, NY: Plenum Publishing.

In 1983, Abel et. al. studied incest offenders who had involved themselves sexually with female children. He found that 44% of these offenders had offended against unrelated female children, 11% had offended against unrelated male children, 18% had committed rapes, 18% had committed exhibitionism, 9% had engaged in voyeurism, 5% had engaged in frottage, 4% had engaged in sadism, and 21% had other paraphilias. In this study it was determined that 59% of the child molesters developed deviant sexual interest during adolescence.

G. Abel, G., Rouleau, J. (1990). "The Nature and Extent of Sexual Assault". In *Handbook of Sexual Assault,* Marshall, W., Laws, D., Barbaree, H., ed. New York, NY: Plenum Publishing.

In 1988, Abel et al. conducted an eight year longitudinal study of 561 male sexual assaulters who sought voluntary assessment and/or treatment at the University of Tennessee Center for the Health Sciences in Memphis and at the New York State Psychiatric Institute in New York City. The study collected information on the offenders self-reported patterns of deviant sexual behavior under a guarantee of confidentiality which was obtained under Federal Regulation 4110-88-M. After an extensive interview they diagnosed each offender and looked at the percentage of paraphiliacs (individual with a deviant sexual interest) who had multiple paraphilias (more than one type of deviant interest).

	Number	**Number of Paraphilias**				
Diagnosis	**of Subjects**	**1**	**2**	**3**	**4**	**5+**
Pedophilia (non-incest) female	224	15.2%	23.7%	19.2%	14.7%	27.2%
Pedophilia (non - incest) male	153	19.0%	26.8%	19.6%	12.4%	22.2%
Pedophilia (incest) female	159	28.3%	25.8%	17.0%	5.7%	23.3%
Pedophilia (incest) male	44	4.5%	15.9%	20.5%	18.2%	40.9%
Rape	126	27.0%	17.5%	19.0%	12.7%	23.8%
Exhibitionism	142	7.0%	20.4%	22.5%	15.5%	34.4%
Voyeurism	62	1.6%	9.7%	27.4%	14.5%	46.8%
Obscene phone calling	19	5.3%	5.3%	21.1%	21.1%	47.5%

Public Masturbations	17	5.9%	17.6%	0.0%	17.6%	58.8%

H. Office of Research and Statistics, Division of Criminal Justice, Colorado Department of Public Safety, March 2000.

The Colorado Division of Criminal Justice (2000), under a National Institute of Justice research grant, analyzed data from 180 sex offender case files in three states that had implemented the post-conviction polygraph to varying degrees (Texas, Oregon, and Wisconsin). The sample included both probation and parole cases. Their research found that polygraph combined with treatment significantly increases the known rate of offending and crossover in sex offenders. After treatment and polygraph, nearly 9 out of 10 sex offenders who were identified as having sex offenses against adults also admitted committing sex offenses against children. Based on a file review, 35 offenders were initially identified as having victims over the age of 18. Prior to treatment and polygraph only 18 (48.6%) of these offenders were identified as having victims under the age of 18. After treatment and polygraph 80 offenders admitted to victims over the age of 18. Seventy of these 80 offenders (87.5%) also admitted to committing a sex offense against someone under the age of 18. Sixty one (76.3%) of the 80 offenders admitted to having victims age thirteen and under.

I. Tanner, J. (1999). Incidence of Sex Offender Risk Behavior During Treatment, Research Project Final Report.

In 1998, Jim Tanner conducted a research study on the polygraph results of 128 sex offenders who were under supervision and participating in offense-specific treatment in the community. The sample consisted of 99 offenders with a current charge for a crime against a child and 29 offenders with a current charge for a crime against an adult. Each of the offenders had participated in one baseline and at least one maintenance polygraph examination. The study looked at the offender's behavior between the time period of the baseline polygraph and maintenance polygraph. Based on the polygraph examination results, 31% of the offenders had sexual contact with a minor during the maintenance polygraph time period. The percent of sex offenders with a current charge for a crime against a child who admitted to or was deceptive to sexual contact with a child was 35%. The percent of sex offenders with a current charge for a crime against an adult who admitted to or were deceptive to sexual contact with a child was 17%. Since the majority of the offenders with crimes against adults were not asked on the polygraph exam whether they had sexual contact with a child, the percent who had sexual contact with a child may be under represented.

In addition, 25% of the offenders in this study had unauthorized contact with a minor. Twelve percent of the offenders had forced someone to have sex since the baseline examination. Forty one percent were engaging in new sex offense behaviors. Overall, 86% of this sample were engaging in new high risk behaviors and/or new crimes at least 18 months into treatment. On average, each offender was engaging in 2.5 different high risk behaviors.

J. Hanson, R., Harris, A. (1998). Dynamic Predictors of Sexual Recidivism, Department of the Solicitor General Canada.

In 1997, Karl Hanson and Andrew Harris conducted research on dynamic predictors of sexual re-offense. The following factors were significantly associated with re-offense: General excuses/justifications/low victim empathy, sexual entitlement, attitudes tolerant of rape,

attitudes tolerant of child molesting, sees self as no risk, sexual risk factors (pornography, excessive masturbation, deviant sexual fantasies, preoccupation with sex), access to victims, and negative social influences.

K. Hindman, J. (1989). *Just Before Dawn*, Alexandria Association.

In her book, Just Before Dawn (1989), Jan Hindman cites research she conducted over 15 years involving 543 victims of child sexual abuse. She found that even in the most severe cases of sexual abuse, child victims frequently are asymptomatic. It may be years before symptoms are triggered in future developmental stages. Hindman's findings also indicate that ongoing demands for a relationship with the offender or his support system, without the benefit of significant intervention, contribute to severe and ongoing traumatic impact as the victim matures. "Sex offenders typically want to create certain elements in the sexually abusive scenario that will reduce their guilt and responsibility. Effort may be exerted to have the victim feel as though he/she has caused the offender to act inappropriately. While this attitude may help the offender rationalize the deed, it has a profound effect on the trauma bonding (continued demands for a relationship with the perpetrator or those significant to the perpetrator, interfering with the victim's capacity to resolve the abuse and feelings about the perpetrator) felt by the victim." "Even if the perpetrator was incapacitated, incarcerated or absent, the victim remained connected and in a trauma bond."

2. ***"An important aspect of ongoing risk assessment is measuring an offender's ability to comply with the requirements of treatment and supervision."***

A. Hanson, R.K., Harris, A. (1998). Dynamic Predictors of Sexual Recidivism. Department of the Solicitor General Canada. http://www.sgc.gc.ca

Karl Hanson and Andrew Harris (1998) conducted research on dynamic predictors of sexual recidivism. Data were collected for this study through interviews with supervising officers of approximately four hundred sex offenders and a review of the officers' case notes. The results indicated that both recidivists and non-recidivists were equally likely to attend sex offense-specific treatment programs; however, recidivists were more likely to have dropped-out of the treatment program. In addition, officers described the non-recidivists as more cooperative with supervision than the recidivists. Recidivists were also more often disengaged from treatment and community supervision and missed more scheduled appointments than the non-recidivists.

3. ***"A growing body of research indicates most sex offenders supervised by the criminal justice system have more extensive sex offending histories, including multiple victim and offense types, than is generally identified in their criminal justice records."***

A. Knopp, F.H. (1984). *Retraining Adult Sex Offenders: Methods and Models*, Brandon, VT: Safer Society Press.

Gene Abel et. al. conducted a breakthrough study in 1983 which gave us information on the frequency and variety of sexual offending behaviors sex offenders have committed. He received a federal certificate of confidentiality to study sex offenders. Individuals in this study could admit to current offending behaviors without fear that the information would be reported to law enforcement. He studied 411 sex offenders and found that on average over a

twelve year period each offender had attempted 581 crimes, completed 533 crimes, had 336 victims, and committed an average of 44 crimes a year. These crimes included hands off sex offenses such as exposing, peeping and obscene phone calls. Additionally, he found that 50.6% of the rapists involved in the study had also molested children.

B. Freeman-Longo, R., Blanchard, G. (1998). *Sexual Abuse in America: Epidemic of the 21st Century*. Brandon, VT: Safer Society Press.

In 1985, Rob Freeman-Longo reported on a group of 23 rapists and 30 child molesters involved in an institutional forensic mental health sex offender program. Arrest records indicated rapists had an average of 1.9 offenses each for a group total of 43 arrests for sex offenses. The 23 rapists as a group admitted committing a total of 5090 various incidents of sex offending behaviors which included 319 child molestations and 178 rapes. Arrest records indicated child molesters had an average of 1.5 arrests each. While in treatment, the 30 child molesters as a group admitted 20,667 offenses which included 5891 sexual assaults on children and 213 rapes on adult women.

C. Ahlmeyer, S., Heil, P., McKee, B., and English, K. (2000). The Impact of Polygraphy on Admissions of Victims and Offenses of Adult Sex Offenders, *Sex Abuse: A Journal of Research and Treatment*, Vol. 12 (2).

The Colorado Department of Corrections Sex Offender Treatment Program has found similar patterns to those reported by Gene Abel with the sex offenders participating in treatment and polygraph assessment. The program collected data in 1998 on the number of known victims of the first 36 sex offenders to participate in two polygraph evaluations. On average, for each offender there were 2 known victims documented in official records. After the first polygraph exam inmates disclosed on average 165 victims per offender. By the second polygraph exam the same inmates, on average, disclosed 184 victims per offender. These crimes included hands-on sex offenses such as rape and pedophilia as well as hands-off sex offenses such as exhibitionism, voyeurism and obscene phone calls. Approximately 80% of these offenders were still deceptive on their polygraph examinations, suggesting that even more offenses were committed.

D. English, K. (1998). Maximizing the Use of the Polygraph with Sex Offenders: Policy Development and Research Findings, Presentation at the Association for the Treatment of Sexual Abusers 17th Annual Research and Treatment Conference, Vancouver.

In 1998, Kim English analyzed a sample of 83 sex offenders who had participated in polygraph evaluations at the Colorado Department of Corrections. This sample included inmates and parolees. She determined that 48% of the offenders had crossed over in either age (36%) or the gender (25%) of the victims they offended against-- they had committed offenses with either victims of different ages (adults and children) or victims of different sexes (males and females). Again, 80% of this sample were still scoring deceptive on their polygraph evaluations.

E. Heil, P., Ahlmeyer, S., Simons, D. (2003). Crossover Sexual Offenses, *Sex Abuse* 15(4).

Between 1995 and 2001, crossover sexual offenses were analyzed in a larger sample of 223 incarcerated and 266 paroled sexual offenders who participated in polygraph evaluations at

the Colorado Department of Corrections. *The majority of incarcerated offenders admitted to sexually assaulting both children and adults from multiple relationship types. In addition, there was a substantial increase in offenders admitting to sexually assaulting victims from both genders. In a group of incarcerated offenders who sexually assaulted children, the majority of offenders admitted to sexually assaulting both relatives and nonrelatives, and there was a substantial increase in the offenders admitting to assaulting both male and female children* (Heil, et al., 2003).

1. Ahlmeyer, S. (1999). Poster Presentation at the Association for the Treatment of Sexual Abusers 18th Annual Research and Treatment Conference, Lake Buena Vista, Florida 1999.

   In 1999, Sean Ahlmeyer analyzed a larger sample of 143 inmates who participated in polygraph evaluations at the Colorado Department of Corrections. In this sample, 89 % of the inmates self-reported that they had crossed over in the type of the offenses they committed by either: committing offenses with either victims of different ages (adults and children) and/or victims of different sexes (males and females) and/or victims from different types of relationships.

   - It was determined that 71% of the total sample acknowledged crossing over in the age of the victims they assaulted.
   - Of the offenders who were only known in official records to have adult victims, 50% later admitted to having child victims during the process of polygraph examination.
   - It was determined that 51% of the sample acknowledged crossing over in the sex of the victims they assaulted
   - Of the offenders who were only known to have male victims in official records, 58% later admitted to having female victims.
   - Of the offenders who were only known to have female victims, 22% later admitted to having male victims.
   - It was determined that 86% of the sample acknowledged having victims in two or more of the following categories: relative, stranger, acquaintance, or position of trust.
   - Of those offenders who were only known to have offended against non-relative victims, 62% admitted to also having victims who were relatives.

   Again the majority of the individuals in this sample (82%) were still scoring deceptive on some areas of their polygraph evaluations, indicating that the percent of cross over may be higher than the numbers self-reported by these offenders.

F. Becker, J., and Coleman, E. (1987). "Incest". In *Handbook of Family Violence*, Van Hasselt, ed. New York, NY: Plenum Publishing.

   In 1983, Abel et. al. studied incest offenders who had involved themselves sexually with female children. He found that 44% of these offenders had offended against unrelated female children, 11% had offended against unrelated male children, 18% had committed rapes, 18% had committed exhibitionism, 9% had engaged in voyeurism, 5% had engaged in frottage, 4% had engaged in sadism, and 21% had other paraphilias. In this study it was determined that 59% of the child molesters developed deviant sexual interest during adolescence.

G. Abel, G., Rouleau, J. (1990). "The Nature and Extent of Sexual Assault". In *Handbook of Sexual Assault*, Marshall, W., Laws, D., Barbaree, H., ed. New York, NY: Plenum Publishing.

In 1988, Abel et al. conducted an eight year longitudinal study of 561 male sexual assaulters who sought voluntary assessment and/or treatment at the University of Tennessee Center for the Health Sciences in Memphis and at the New York State Psychiatric Institute in New York City. The study collected information on the offenders self-reported patterns of deviant sexual behavior under a guarantee of confidentiality which was obtained under Federal Regulation 4110-88-M. After an extensive interview they diagnosed each offender and looked at the percentage of paraphiliacs (individual with a deviant sexual interest) who had multiple paraphilias (more than one type of deviant interest).

	Number	**Number of Paraphilias**				
Diagnosis	**of Subjects**	**1**	**2**	**3**	**4**	**5+**
Pedophilia (non-incest) female	224	15.2%	23.7%	19.2%	14.7%	27.2%
Pedophilia (non-incest) male	153	19.0%	26.8%	19.6%	12.4%	22.2%
Pedophilia (incest) female	159	28.3%	25.8%	17.0%	5.7%	23.3%
Pedophilia (incest) male	44	4.5%	15.9%	20.5%	18.2%	40.9%
Rape	126	27.0%	17.5%	19.0%	12.7%	23.8%
Exhibitionism	142	7.0%	20.4%	22.5%	15.5%	34.4%
Voyeurism	62	1.6%	9.7%	27.4%	14.5%	46.8%
Obscene phone calling	19	5.3%	5.3%	21.1%	21.1%	47.5%
Public Masturbations	17	5.9%	17.6%	0.0%	17.6%	58.8%

H. Office of Research and Statistics, Division of Criminal Justice, Colorado Department of Public Safety, March 2000.

The Colorado Division of Criminal Justice (2000), under a National Institute of Justice research grant, analyzed data from 180 sex offender case files in three states that had implemented the post-conviction polygraph to varying degrees (Texas, Oregon, and Wisconsin). The sample included both probation and parole cases. Their research found that polygraph combined with treatment significantly increases the known rate of offending and crossover in sex offenders. After treatment and polygraph, nearly 9 out of 10 sex offenders who were identified as having sex offenses against adults also admitted committing sex offenses against children. Based on a file review, 35 offenders were initially identified as having victims over the age of 18. Prior to treatment and polygraph only 18 (48.6%) of these offenders were identified as having victims under the age of 18. After treatment and polygraph 80 offenders admitted to victims over the age of 18. Seventy of these 80 offenders (87.5%) also admitted to committing a sex offense against someone under the age of 18. Sixty one (76.3%) of the 80 offenders admitted to having victims age thirteen and under.

I. Weinrott, M. & Saylor, M. (1991). Self-Report of Crimes Committed by Sex Offenders, *Journal of Interpersonal Violence*, 6 (3) 286-300.

Data from a self-report survey regarding past criminal behavior was analyzed from over 90 institutionalized sex offenders. Included in this sample were both rapists and child molesters who had been mandated to receive specialized treatment. Results from this study showed both high rates and varieties of non-sexual offenses, and, high rates of previously undetected sexual aggression. In addition, the 99 sex offenders who completed the survey reported that nearly 20,000 non-sexual crimes were committed during the year prior to being institutionalized (rapists contributed to a disproportionate share).

4. ***"Research also indicates that children and victims are particularly vulnerable and are unlikely to report or re-report abuse."***

A. William Marshall has reported findings from an unpublished project conducted within child protective agencies in Ontario in the mid-1970's. The project was unsystematic in the sense that some, but not all, victims of incest over approximately a three year period were contacted. A child protective services caseworker located a number of children who had reported molestation by a relative. She found that many cases were recanted when the family did not believe the victim, or when the victim was believed but was poorly treated by family members. Once the children had been located, the caseworker asked the children if they would report the incident if they were molested again. Almost 100% answered "no". The reasons they gave included the following: Practically no one believes them when they tell or, if they do believe, they become hostile to the victim for getting the perpetrator in trouble and removing him from where he was needed; the child held him/herself responsible for the father's absence from the family; or the outcome almost always ended up being more devastating to the child than to the perpetrator. (Information presented at the Association for the Treatment of Sexual Abusers Annual Research and Treatment Conference; personal communication with William Marshall 11/6/98)

B. In 1995, Marshall reported that family reunification provides the following risks: Victims may not want the family to reunify, but may feel pressured into it; even after treatment, 80% of families separate within 5 years; there is an increased chance the victim will not report if victimized again; or the victim may get the impression that the family is important and that he/she is not. (Wisconsin Sex Offender Treatment Network, Inc. training tapes; personal communication with William Marshall 11/6/98)

C. Hanson, R.F., et al. (1999). Factors Related to the Reporting of Childhood Rape, *Child Abuse & Neglect*, 23 (6).

The National Women's Study surveyed a representative sample of 4009 adult women in the United States in 1990. They re-interviewed the women in 1991 and in 1992. During the survey 341 women identified that they had been the victim of a childhood rape prior to the age of 18. Rape was defined as any non-consensual sexual penetration of the victim's vagina, anus, or mouth by a perpetrator's penis, finger, tongue, or an object, that involved the use of force, the threat of force, or coercion. Only 44 (13%) of the women ever reported a childhood rape to authorities. Two hundred ninety seven (87%) of the women did not report any of their childhood rapes to authorities. In looking at the victims who did report the rape, a higher percent involved physical injury or life threat. In addition, reported cases were twice as likely to involve an offender who was a stranger to the victim. Unreported cases were more likely to involve an offender who was a relative or an acquaintance of the victim. This is similar to previous research which has found that victims are less likely to report the abuse when the

offender is a relative or acquaintance. (Arata, 1998; Ruback, 1993; Williams, 1984; Wyatt & Newcomb, 1990). Whether or not the rape was reported, one third of the victims of childhood rape met the criteria for PTSD-lifetime and one half met the criteria for Major Depression-lifetime.

D. (1992). Rape in America: A Report to the Nation, National Victim Center and Crime Victims Research and Treatment Center, Dept. of Psychiatry and Behavioral Sciences, Medical University of South Carolina.

Rape in America: a Report to the Nation, in 1992 reports findings of a phone survey of 4009 women across the United States. Based on the results of this survey, 1 out of 8 women are estimated to have been the victim of forcible rape sometime in their lifetime. It was determined that 78% of the rapes were committed by someone known to the victim. Only 16% of these rapes were ever reported to the police. Only 30% of the rapes resulted in the victim being physically injured. But, when compared to women who were never sexually assaulted, female sexual assault victims were 3.4 times more likely to have used marijuana; 5.3 times more likely to have used prescription drugs non-medically; 6.4 times more likely to have used hard drugs; 3 times more likely to have had a major episode of depression; 6.2 times more likely to have developed PTSD; 5.5 times more likely to have current PTSD; 4.1 times more likely to have contemplated suicide; and 13 times more likely to have attempted suicide. The majority of these women had not abused alcohol or drugs prior to their sexual assault.

E. Underwood, R., Patch, P., Cappelletty, G., Wolfe, R. (1999). Do Sexual Offenders Molest When Other Persons Are Present? A Preliminary Investigation, *Sexual Abuse: A Journal of Research and Treatment*, Vol. 11(3).

In 1999, Underwood, Patch, Cappelletty, and Wolfe reported on a sample of 113 child molesters. On average, each offender committed 88.6 offenses. Many of the offenders in the sample acknowledged molesting a child while a non-collaborating person was present. The following percentage of the sample engaged in the listed behaviors:

- Molested one child when another child was present - 54%; another adult was present - 23.9%; a child & adult were present - 14.2%
- Molested a child when they knew the other person was awake - 44.3%
- Molested a child when another child was in the same bed - 25.7%; when another adult was in the same bed - 12.4%; when another adult and child were in the same bed - 3.5%
- The child molesters listed the following reasons for molesting a child while a non-collaborating person is present: increased excitement - 77%; sense of mastery - 77%; compulsive sexual behavior - 75.2%; and stupidity -38.9%.

F. Hindman, J. (1989). *Just Before Dawn*, Alexandria Association.

In her book, Just Before Dawn (1989), Jan Hindman cites research she conducted over 15 years involving 543 victims of child sexual abuse. She found that even in the most severe cases of sexual abuse, child victims frequently are asymptomatic. It may be years before symptoms are triggered in future developmental stages. Hindman's findings also indicate that ongoing demands for a relationship with the offender or his support system, without the benefit of significant intervention, contribute to severe and ongoing traumatic impact as the

victim matures. "Sex offenders typically want to create certain elements in the sexually abusive scenario that will reduce their guilt and responsibility. Effort may be exerted to have the victim feel as though he/she has caused the offender to act inappropriately. While this attitude may help the offender rationalize the deed, it has a profound effect on the trauma bonding (continued demands for a relationship with the perpetrator or those significant to the perpetrator, interfering with the victim's capacity to resolve the abuse and feelings about the perpetrator) felt by the victim." "Even if the perpetrator was incapacitated, incarcerated or absent, the victim remained connected and in a trauma bond."

G. Colorado Coalition Against Sexual Assault, http://www.ccasa.org/statistics.cfm

"Twenty-four percent (1 in 4) of Colorado women and 6% (1 in 17) Colorado men have experienced a completed or attempted sexual assault in their lifetime. This equates to over 11,000 women and men each year experiencing a sexual assault in Colorado (*Sexual Assault in Colorado: Results of a 1998 Statewide Survey. 1998. Colorado Department of Public Health and Environment and Colorado Coalition Against Sexual Assault).* One thousand seven hundred ninety-four (1,794) rapes were reported to Colorado law enforcement in 1997. If compared to the 1998 Statewide Survey, these reports constitute only 16% of sexual assaults."

H. Cardarelli, A. (1998). Child Sexual Abuse: Factors in Family Reporting, NIJ Reports, No. 209, May/June.

Data involving 156 sexually abused children who were treated at a Family Crisis program associated with Tuft's New England Medical Center in Boston were analyzed. Sixty-two percent of the sample chose not to report the abuse to the police. Of the individuals who did report the abuse, very few were the victims (they were mostly parents or primary caretakers).

5. ***"It is important to recognize that treatment under unsafe conditions is not beneficial to the offender or others in the treatment program and undermines treatment program integrity."***

A. *Quinsey, V.L., Harris, G.T., Rice, M.E., Cormier, C.A. (1998).* Violent Offenders: Appraising and Managing Risk. *American Psychological Association, 55-72.*

Quinsey, Harris, Rice, and Cormier (1998) reported on numerous studies on clinical judgment in regard to prediction of violence. His overall conclusion to these studies was that "clinical intuition, experience, and training at least as traditionally conceived are not helpful in either prediction or treatment delivery. Although discouraging, this conclusion is not nihilistic. Training, in the sense of knowing the empirical literature and relevant scientific and statistical techniques, must improve the selection of appropriate treatments, treatment program planning, and evaluation."

Articles/Professional Opinions that support this statement:

1. *O'Connell, M.A., E. Leberg, Donaldson, C.R. (1990).* Working with Sex Offenders: Guidelines for Therapist Selection. *Newbury Park, CA: Sage Publications, pp 13-16, 52-53, 94-96, 101-103.*

2. *(2000). Community Supervision of the Sex Offender: An Overview of Current and Promising Practices. Center for Sex Offender Management, January, 2000.*

3. *Salter, A. (1988).* Treating Child Sex Offenders & Victims, *Newbury Park, CA: Sage Publications, pp.84 – 86.*

4. *Scott, L. (1997). "Community Management of Sex Offenders". In* The Sex Offender, Vol II, *Schwartz, B., Cellini, H., eds., Kingston, NJ: Civic Research Institute, p.16-2 through 16-5.*

5. *Freeman-Longo, R., Knopp, F. (1992). State of the Art Sex Offender Treatment: Outcome and Issues,* Annals of Sex Research, *Vol. 5 (3).*

6. *(1997). "Ethical Standards & Principles for the Management of Sexual Abusers" ATSA, p.11, 2.02*

7. *Kercher, G., Long, L. (1998)* Supervision & Treatment of Sex Offenders, *Huntsville, TX: Sam Houston Press, pp47-49, & 123-126.*

8. *Cumming, G., Buell, M. (1997).* Supervision of the Sex Offender, *Brandon, VT: Safer Society Press, pp 91-92.*

6. ***"Some offenders have a history of persistent arousal to minors. Although they may be able to meet 5.742 criteria, because of the likelihood that proximity to children will trigger or increase this arousal, the team shall frequently reassess the offender's ability to maintain a reduced level of arousal. The team shall terminate an offender's approval for contact with minors if there is behavior or other evidence to indicate arousal to minors cannot be managed."***

A. Davis, G., Williams, L., Yokley, J. (1996). An Evaluation of Court-Ordered Contact Between Child Molesters and Children: Polygraph Examination as a Child Protective Service. Paper presented at 15th Annual ATSA Conference, November, 1996.

   In a 1996 study by Gary Davis, Laura Williams and James Yokley, 142 child molesters were polygraphed to determine if they were having deviant fantasies and masturbating while thinking about a known minor. Only 3% of offenders who were not permitted contact with children were having deviant fantasies and masturbating while thinking about a known minor. Of the child sex offenders who were permitted supervised contact with children, 59.5% were having deviant fantasies and masturbating while thinking about a known minor.

B. In 1999, the Sex Offender Treatment and Monitoring Program at the Colorado Department of Corrections compiled polygraph testing responses to questions regarding contact with children in the prison visiting room. The study involved a sample of 36 offenders who were polygraphed while participating in the second phase of the Sex Offender Treatment and Monitoring Program. The sex offenders were asked whether they had ever masturbated to thoughts of a known child they had seen in the prison visiting room. Eight offenders (22%) denied masturbating to thoughts of a known child and were non-deceptive on the polygraph exam. Sixteen offenders (44%) admitted to or were deceptive to questions on the polygraph exam, which would indicate the offender had masturbated to thoughts of known child they had seen in the visiting room. Twelve offenders (33%) were deceptive to other questions on

the polygraph test and as a result it could not be determined whether they had masturbated to thoughts of a child seen in the visiting room.

Appendix O
COMPUTER USE AGREEMENT FOR SEX OFFENDERS

Computer Use Agreement for Sex Offenders

Client: _____ Supervising Officer/Designee: _____

By signing below, the above named client indicates (s)he understands (s)he has the right to refuse consent to the items contained herein and that the client voluntarily agrees to be compliant with the following conditions:

_____ Client shall provide a complete and accurate inventory of all computers, computer-related equipment, and communications devices and services on an inventory form provided by the Probation Department. The client agrees to ensure that all information on the inventory is complete, accurate and current at all times and that they will not use or access any electronic storage or communication device or service not reported on the inventory form and specifically approved for use by the Probation Department.

_____ Client shall obtain prior approval from the Supervising Officer/Designee to engage in the following activities:

_____Web browsing (including but not limited to surfing).
_____Email (all email accounts must have prior approval).
_____Interpersonal communication (including but not limited to chatting, texting and instant messaging).
_____Producing web content (including but not limited to a web site, MySpace and other social networking site pages, YouTube, Podcasting, blogging, vlogging).
_____Participating in social networking activities
_____Internet related telephone communication (including but not limited to using Voice Over Internet Protocol).
_____File sharing by any method (including, but not limited to Peer to Peer, Internet Relay Chat, attachments to emails, iTunes).

_____ Client shall not use the computer for any purpose which might further sexual activity. Such use includes, but is not limited to, possession or viewing of material that is sexual in nature.

_____ Client shall be prohibited from possessing or viewing certain materials related to, or part of, the grooming cycle for his/her crime. Such materials include, but are not limited to, the following:

_____ Images of your victim.
_____ Stories or images related to your crime or similar crimes.
_____ Images which depict individuals similar to your victims (e.g. children).
_____ Stories written about or for individuals similar to your victim.
_____ Materials focused on the culture of your victim (e.g. children's shows or web sites).

_____ Client shall be prohibited from using any form of encryption, cryptography, steganography, compression, password protected files and/or other method that might limit access to, or change the appearance of, data and/or images without prior written approval from the Supervising Officer/Designee. If, for work purposes, password protection is required on any system or files used by Client, the password shall be provided to the Supervising Officer/Designee upon request.

_____ Client shall be prohibited from avoiding the creation of, or altering or destroying records of computer use without Supervising Officer/Designee's approval. This includes, but is not limited to, deleting or removing browser history data regardless of its age, emptying the Recycler, the possession of software or items designed to boot into or utilize RAM kernels, alter or wipe computer media, defeat forensic software, or block monitoring software. This also includes a prohibition against restoring a computer to a previous state or the reinstallation of operating systems.

_____ Client consents to unannounced examination by Supervising Officer/Designee of any and all computer(s) and/or devices(s) to which Client has access for the limited purpose of detecting content prohibited by this document, conditions of probation, or court order. This consent to examine includes access to all data and/or images stored on any storage media (including but not limited to cell phones, iPods, PDA's, removable media, thumb drives, camera cards, game consoles, CDs, DVDs) whether installed within a device or removable and separate from the actual device.

_____ Client shall allow the installation of monitoring software and periodic examination of their computer at their own expense to insure compliance with the conditions of probation and this agreement. The client has no expectations of privacy regarding computer use or information stored on the computer if monitoring software is installed and understands and agrees that information gathered by said monitoring software may be used against him/her in any subsequent administrative or legal proceeding.

_____ That the conditions of usage may be modified by the Probation Department or their designee as needed and agrees to abide by all modifications of usage. The client has the right to refuse to abide by modifications of these conditions, but understands that their access to computers and communications devices may be revoked if they fail to comply with all conditions imposed by the Probation Department or their designee.

_____ Client specifically agrees to be responsible for all data, images and material on the computer and voluntarily consents to announced or unannounced searches by the Supervising Officer/Designee to verify compliance with these special conditions of supervision. The Client understands and agrees that his/her computer, related equipment, communication, and storage devices are subject to seizure by Supervising Officer/Designee if, during a search, any evidence of a violation or any evidence of a new crime is detected.

_____	_____	_____	_____
Client's Signature	Date	Supervising Officer's Signature	Date

Appendix P
DIGITAL TECHNOLOGY USE FACTORS

Digital Technology Use Factors
Which Indicate Increased Sex Offender Investment
In Digital Sexual Content

Jim Tanner, Ph.D.
KBSolutions Inc.
www.kbsolutions.com
lists@kbsolutions.com

I have been conducting forensic examinations of convicted sex offenders' digital devices since 1998. I worked as a cybercrime analyst for and with various state level probation departments during this period. My work environment was unique in that the offenders were convicted and on probation. I worked live on the offender's devices, in the offender's home or office environment and with the offender present. During my examinations I talked with the offender, discussed his/her cyber behavior and asked questions about what I was finding. This afforded me a fuller understanding of their cyber-sexual behavior than I would have obtained working on the device in a forensic lab or simply talking to an offender in absence of the device itself.

Based on more than 1,300 examinations of offenders' digital devices, I found 14 factors which indicate an offender has an investment in digital sexual content that is beyond the norm for convicted sex offenders. This investment often leads to resistance to containment/treatment and a higher probability of recidivism. While some of these factors may be benign for the public at large, they become important when found in the technology use of individuals charged with or convicted of sex crimes. It is when one's behavior draws the attention of law enforcement that the factors below become significant.

When considering the digital behavior of sex offenders, one should seek to understand the big picture of the offender's technology use and how it relates to sexual behavior (also see www.kbsolutions.com/beyond.pdf and www.kbsolutions.com/PornContraband.pdf). As offenders engage in more of the factors, their investment in cyber-sexual content increases. It has been my experience that increased investment in cyber-sexual content also leads to an increase in resistance to containment and treatment.

The elements described in the remainder of this paper are listed in no particular order. The reader should not assume any priority based on location within the list.

The 14 Factors:

1. Surfing more than 10 hours a week of sexual content.
2. High ratio of sexual sites to general surfing, regardless of number of hours.
3. Saved versus cached material. As the ratio of saved to cached goes up, so does the risk.
4. Any cataloging of sexual content.
5. Low ratio of "Splash Page" to "Inside Site" images.
6. Membership in adult sites or organizations promoting sexual behavior.
7. Nude pictures of the offender on the offender's devices.
8. Pictures with sexual content taken by, created by, or altered by the offender.
9. Erotic literature written by the offender.
10. Trophy materials stored on the offender's devices.
11. User group or Peer to Peer activity seeking sexually explicit materials.
12. "Red Flag" Themes, if they have a significant number of images/files:
13. Internet grooming or solicitation of minors using any medium.
14. Use of technology for sexual content which indicates a more heavily invested approach:

Each of these factors are explained in the pages that follow. I believe a complete psycho-sexual evaluation cannot be obtained without both a polygraph and a digital technology examination. It is my intention that this paper serve as a checklist to evaluators, containment/treatment teams, and forensic examiners when considering the digital behavior of sex offenders.

As technology advances, changes will undoubtedly occur in the number and types of indicators related to cyber-sexual investment. I will endeavor to keep this paper updated as technology changes. This paper, in its most recent form will always be available at www.kbsolutions.com/KBS14Factors.pdf.

Factor 1: Surfing more than 10 hours a week of sexual content.

Addiction to cyber-sex is a concern for those charged with or convicted of sex crimes. There is no hard and fast rule as to what constitutes a threshold of addiction. Each individual's pattern of sexual content use must be compared to their pattern of general (non-sexual) technology use.

During my examinations I found that offenders who used digital sexual content more than 10 hours a week also reported higher incidence of intrusive sexual thoughts, deviant sexual ideation, and feeling like they were 'addicted' to technology use. Using technology more than 10 hours to obtain sexual content indicates enhanced investment in digital sexual content.

Factor 2: High ratio of sexual sites to general surfing, regardless of number of hours.

Regardless of the total number of hours spent on the Internet (or using technology), the ratio of sexual content to non-sexual content is an important indicator of investment in digital sex. Calculating the percentage of digital sexual activity to non-sexual digital activity gives the treatment team valuable information concerning investment. An offender who views sexual content 80 hours of 100 hours of technology use is different than the offender who views sexual content10 hours of 100 hours technology use. Similarly, an offender who views sexual content 8 of 10 hours of technology use is different than the offender who views sexual content 1 of 10 hours of technology use.

The higher the percentage (ratio) of sexual content to general technology use, the higher the investment in digital sexual content.

Factor 3: Saved versus cached material.

Cached: When browsing the Internet, all browsers automatically write the contents of the sites visited to the local hard drive in a special folder called a 'cache'. This content is automatically stored by the browser and is not a 'purposeful download' of the material. Its presence on the storage media simply indicates the offender visited the site and/or viewed the material. Cached material should be considered differently than material that is saved by the offender.

Saved: When using a browser the User can right-click on the content and save it to the local hard drive. This "Save As" function is built into all major operating systems. The User can place the content (picture, video, etc.) anywhere on the storage media, can name the folder it is placed in, and can change the name of the content being stored. This "Save As" function requires human interaction; it is not automatic. Thus, when something has been 'saved' it indicates the content is of special significance to the offender.

The percent of saved material (offender took action) to cached material (offender simply viewed the material), is an indication of the investment the offender has to

digital sexual content. The higher the proportion of saved material, the greater the investment.

Additionally, evaluators and treatment team members should pay attention to the themes contained in the saved material. Saved material indicates special interest on the part of the offender.

Factor 4: Cataloging of sexual content.

Related to saving material is cataloging material. As indicated above, when a User saves material, they can create and name folders, rename content, and save the material in any organizational structure that makes sense to the offender. When offenders begin to organize saved material into categories they have become 'collectors'. Often the names of the folders are elucidating for evaluators and treatment teams. For example, folders named 'blondes, 'girls 13', or 'outdoors' give us an insight to the offender's cognitive structure.

Further, keeping sexual content (saving it outside the cache) indicates an offender's unwillingness to part with the material. They don't want to lose it, they want to keep it and use it again in the future. Organizing and cataloging the saved material is a major step further into the investment in sexual content. The organization and cataloging of material is done primarily for ease of access and focus. It is faster and easier for an offender to find specific content if they have it organized and cataloged.

Cataloging behavior indicates a substantial increase to the investment in digital sexual content.

Factor 5: Low ratio of "Splash Page" to "Inside Site" images.

Splash Page: When visiting a website, the first page that displays is the 'home' or 'splash' page. This page is the portal that is comes up when entering the top level domain URL into a browser (e.g. www.youtube.com). The splash page on adult sites is an advertisement. Splash pages generally contain several smaller images designed to entreat the User into clicking deeper into the web site. The economics of web site management dictate that images on the splash page be limited in size. Smaller images load faster and take up less room on the screen. The goal of the site's splash page is to get the User to 'drill down' by clicking on items to go deeper into the site. Due to size limitations, splash page images are generally of lower quality and splash videos short in length.

Inside Site: Material located on pages other than the splash page are accessible only by User action.

Once a User clicks through or drills down into a site, the images are larger (full sized), higher quality, and the videos generally longer. Drilling down into a site indicates the offender has more interest in the material.

The extent to which an offender skims across splash pages versus drills down into site content is an indicator of investment in digital content. This is

related to the Pace element of the TRAPS model of assessing sex offender's computer use (www.kbsolutions.com/beyond.pdf).

A thorough examination of URL histories indicates whether content was contained on a splash page or was deeper inside the site. However, a quick rule of thumb is to consider the size of the image on the media. Images smaller than 10kb are generally splash page content. Images between 10kb and 20kb could be either splash page or inside site material. Images larger than 20kb are generally found inside the site (the offender drilled down into the site to view it). The average splash page can have between 5 and 20 images. Pages located deeper in the site have fewer images (often only 1 image per page). Thus, even a 80:20 ratio of splash to inside can indicate significant drilling down behavior on the part of the offender.

Offenders found to have frequently drilled down into many sites (e.g. have a low ratio of splash page to inside site materials) demonstrate a higher investment in digital sexual content. Evaluators and treatment teams should also pay particular attention to the themes of the content viewed from inside sites - it is of interest to the offender.

Factor 6: Membership in adult sites or organizations promoting sexual behavior.

Adult web sites make money by selling memberships. The average adult site will give away 10-20 images as loss leaders to encourage visitors to purchase membership in the site. This is analogous to your local grocery store putting green beans on sale for 10 cents a can to get you into the store. The logic of loss leaders is that once in the store, you will also purchase other items at full price.

Adult sites work on the same principle. By giving away 10-20 images or short video clips free, they are betting the visitor will become interested in seeing the remainder of the site's content and be willing to purchase a membership to have access to the thousands of images/videos.

There are many adult sites available on the web. Because of the sheer number of sites in existence, there are literally tens of thousands of images and videos available free on the web. One could view sexual content for months, if not years, and never have to pay for any content. Thus, when an offender decides to pay money to purchase membership in a site, it is an indication of an increased investment (literally and figuratively) in sexual content.

Concomitantly, when an offender joins groups which promote sexual behavior (e.g. adultfriendfinder, squirt, alt, etc.), they are signifying an increased investment in and identification with sexual content. The type and focus of member groups should be carefully examined by the treatment team.

I caution the reader that I am not talking about behavior between non-offender consenting adults. Membership in adult sites or sexually focused groups for non-offenders is not at issue here. It is when one's behavior draws the attention of law enforcement that membership in such sites and groups becomes significant.

Factor 7: Nude pictures of the offender on the offender's devices.

It is my experience that approximately 25% of the offenders whose devices I examined had pictures of themselves nude on their devices. When images of the offender are found on their devices, it should raise the question "...what are they doing with the pictures?" Are they sharing them? With whom are they sharing?

Having nude pictures of themselves indicates an increased investment in defining themselves as a sexual object. The more graphic the images, the greater the investment in the offender seeing himself/herself primarily as a sexual object. This focus in self-definition is reflective of a resistance to containment and treatment.

It is important to note that I am not talking images commonly found among those participating in "sexting" behavior that is becoming more common among young people. I'm talking about images contained on the digital devices of individuals charged with or convicted of sex crimes, not adolescent 'felony stupid' behavior. Nor am I talking about behavior of or between non-offender consenting adults. It is when one's behavior draws the attention of law enforcement that the possession of self-erotic images becomes significant.

Factor 8: Pictures with sexual content taken by, created by, or altered by the offender.

Images or videos do not have to contain the offender to be significant. If the offender has used their digital equipment to create sexual images or videos of others it again raises the question of what they are doing with them. The offender is a producer of adult material rather than just a consumer. This indicates an increased investment in digital sexual content. The created material might include artwork (digital or scanned) that the offender created.

It is also important to note whether the offender has altered digital sexual content. Altering would include cropping, editing, retouching, and morphing content. Other than removing copyright notices, any alteration of an image indicates increased investment in the digital content.

Again, I caution the reader that I am not talking about behavior of or between non-offender consenting adults. It is when one's behavior draws the attention of law enforcement that the manipulation of digital content becomes significant.

Factor 9: Erotic literature written by the offender.

In the same vein as creating or altering images or videos, offenders who produce erotic literature are demonstrating an increased investment in sexual content. Adult ("erotic") stories abound on the Internet and in print. Some of the topics contained in erotic literature are illegal when found in images/videos (e.g. sex with children). For example, in June of 2010 there were 21,488 stories on literotica about incest and 9,787 stories about non-consensual sex (rape). Offenders who have shifted their focus in stimuli from images to text are often doing so to avoid prosecution. While the creation of such prose may be protected by the 1st Amendment, it should be of concern when the prose is created by sex offenders.

The act of creative writing takes more imagery and focus than is commonly found among amateurs who produce sexual images/videos. Therefore, it is of concern when we find evidence that a sex offender has been producing written erotica.

Again, I caution the reader that I am not talking about behavior of or between non-offender consenting adults. It is when one's behavior draws the attention of law enforcement that the creation of written erotic content becomes significant. The presence of the material indicates an increased investment in sexual content.

If offender-produced erotica is discovered, the content of the material should be of great interest to the treatment team.

Factor 10: Trophy materials stored on the offender's devices.

Offenders often make the news, articles/stories are often available in digital formats. In about 10% of the digital devices I examined, I found offenders saving articles, clippings, and/or video news stories about themselves. These articles constitute "trophy materials" and indicate the offender has not fully grasped the magnitude of their behavior.

Additionally, when victims are family members it is not uncommon to find pictures of the victim on the offender's digital devices. Sometimes this possession is inadvertent or unintentional post-conviction, often it is purposive. Examining the last access dates of images helps the treatment team determine whether the image should be considered trophy material or not (if viewed and kept after being told to remove images of the victim, it clearly constitutes trophy material).

If the local jurisdiction has web accessible sex offender registries, I find that approximately 10% of offenders will visit the registry and search for themselves and others within their community. When questioned about this behavior offenders often tell me that it makes them feel less deviant to know others have done what they did. Looking themselves up may be curiosity, but surveying the registry for others constitutes behavior that indicates more than curiosity, it is a form of trophy activity.

The presence of trophy materials on the digital devices of sex offenders indicates a greater investment in their behavior.

Factor 11: Usegroup or Peer to Peer activity seeking sexually explicit materials.

Usegroups: Decades ago bulletin boards (Usegroups) were the primary source of sexual content. There are many Usegroups still in existence that appear to specialize in sexual content. The last time I counted (2008) 3.7% of all Usegroups focused on sexual content. There were 1,600 Usegroups dedicated to sexual content in 2008. Usegroup materials are primarily advertisements for adult sites and amateurs posting images. Downloading from Usegroups is time consuming (even when automated) and generally requires unpacking the content. Moreover, when downloading from a Usegroup, one does not know what they are getting. Hence, it is risky behavior. Few sex offenders will download from Usegroups (less than

2% in my experience). When you find an offender who continues to use this approach to gaining content, it indicates a heavy investment in sexual content.

Peer to Peer (P2P): P2P has blossomed in the past decade. Currently most of the exploitation of children material is passed via P2P. Sex offenders who are active in P2P are generally interested in receiving or distributing child pornography. In my experience offenders who are not interested in child pornography are not involved in P2P activities to any great extent. Finding P2P activity, especially high levels of P2P activity, on an offender's digital devices indicates an increased investment in sexual content, and more specifically an increased investment in illegal sexual content.

Factor 12: "Red Flag" Themes, if they have a significant number of images/files

As indicated in the TRAPS model (www.kbsolutions.com/beyond.pdf), digital devices yield information about an offender's themes of interest. Categories of images are not themes until there is a consistent pattern found within the digital device. As a general rule of thumb, I do not consider something a theme unless I find more than 30-50 indications of interest (i.e. 30-50 pictures or videos, 15-20 searches for the same or similar topics, etc.). These themes are often unrelated to the behavior resulting in the precipitating offense. Knowing the offender's themes of interest substantially advances the job of containment and treatment.

More importantly when certain "Red Flag" themes are discovered, it signifies increased investment in illegal sexual behavior. The most common Red Flag themes I have found are (in order):

A. Bestiality
B. Exhibitionism
C. Voyeurism
D. Non-Consensual
E. Minors/Children

A particularly important theme, Snuff materials (victim is killed), is rare but always significant.

Presence of any Red Flag theme indicates increased investment in sexual content.

Factor 13: Internet grooming or solicitation of minors using any medium.

At the federal level a high proportion of cases involve child pornography or Internet grooming/solicitation of minors. These crimes are heinous. Fortunately (or unfortunately, I'm not sure which), at the state and local level this is not the case. Only a small percentage of state level sex offenders are involved with child pornography or Internet solicitation/grooming of minors. Most state level offenders generate victims from a position of trust. Family, relatives, students, members of congregations, etc. are the common victim pool.

Most sex offenses are prosecuted at the state and local level. The sheer number of victims generated by state level sexual offenses is staggering. As a result, most offenders nationwide generate victims through a position of trust. My comments should not be construed to minimize the horrendous carnage visited upon children by federal level offenders. Nor are they intended to diminish the efforts or value of national efforts to catch Internet offenders. My intent is to point out that the vast number of victims are not groomed via digital technology.

Soliciting through digital devices is, then, "outlier" behavior. It violates the standard MO of sex offenders. Sex offenders groom the victim's environment as well as the victim. Internet solicitation and grooming violates this normal approach. It is impossible to groom the victim's environment over the Internet. Moreover, it is not possible to ensure who, exactly, your victim is. Offenders who solicit and groom over the Internet often recognize that it may be a cop they are grooming (has anyone not seen at least one episode of To Catch A Predator?). There are two kinds of individuals who will solicit or groom over the internet:

A. The offender who is so stupid they don't know it could be a cop on the other end. This stupidity makes them dangerous. They could (and probably would) try anything.

B. The offender who understands it may be a cop on the other end, but whose drive to get a victim outweighs their instinct for self-survival. These offenders generally ask "... are you a cop?" This overriding drive to get a victim makes them dangerous.

Offenders who solicit or groom through digital devices are high risk and should be treated as such.

When an offender's digital devices indicate they were used to initiate contact with, solicit, and/or groom minors, it is an indication that the offender has a significant investment in digital sexual content. If the presenting charge does not involve solicitation or grooming via digital devices, the presence of it on their devices should immediately raise the level of containment for any offender.

Factor 14: Use of technology for sexual content which indicates a more heavily invested approach

There are a few technologies which are not generally associated with sexual content. If an offender is found to have used these technologies to further sexual interests, it indicates an increased investment in digital sexual content and a concomitant increase in resistance to containment and treatment. These technologies are:

A. IRC/IM (Chat/Instant Messaging).
B. SMS/MMS (Texting - risk is determined by level of use and age of correspondents)

Appendix Q
BACKGROUND INVESTIGATIONS FOR APPROVED SUPERVISORS

Background Investigations for Approved Supervisors
Adult Standards – Sex Offender Management Board
February 2015

Approved Supervisor: a person who can supervise an adult offender's contact with a specified minor child or children. This person is an individual who has met the criteria described in the Standards, has been approved by the CST (Community Supervision Team) and has signed the contract.

In 2011 the Sex Offender Management Board (SOMB) revised Adult Standards and Guidelines, including Section 5.770 (Approved Supervisor) and 5.775 (1) (Approved Supervisor Duties and Responsibilities). Since that time, the SOMB has been made aware of several implementation challenges related to citizens attempting to obtain criminal history records for the purposes of becoming an approved supervisor. The SOMB has made several policy revisions to attempt to address this issue and improve the policy; however, these efforts have not significantly improved the ability of citizens to obtain criminal history records in a timely manner. The current policy approved by the SOMB is for potential approved supervisors to obtain their own criminal history information online through the FBI (Federal Bureau of Investigation), and then subsequently every three years online through CBI (Colorado Bureau of Investigation), at the discretion of the community supervision team (CST). However, the FBI process for a criminal history has demonstrated to take a long time (up to 6 months) to produce results. This is causing significant delays for offenders in obtaining appropriate approved supervisors. The SOMB continues to believe that a national criminal history check is appropriate, given that CBI checks do not include non-Colorado criminal history, even if it is time-consuming and more costly than the CBI criminal history check, but also recognizes the importance of expediency in approving supervisors.

Given the above concerns, the SOMB is again modifying its policy related to criminal history checks for approved supervisors to allow for a more expedited approval process. Citizens interested in being approved supervisors may be tentatively approved by the CST based upon a favorable (according to 5.772) CBI online criminal history check alone or verification of an approved support person through the Department of Corrections, provided that he/she also submits to an FBI online criminal history check. If subsequent results from the FBI indicate a problem, the approved supervisor status could then be removed pursuant to the requirements in the Standards and according to the discretion of the CST. This solution would allow offenders to have approved supervisors much sooner, but would add a cost (approximately $8.00). It is still acceptable for those citizens not wishing to pay the extra money to submit only the FBI online criminal history check and wait for the results as is stated in the current policy.

The hope is that this change in the current policy will maintain community and victim safety, while still supporting the needs of the offender for positive support via an approved supervisor.

Appendix R
PAROLE GUIDELINES FOR DISCRETIONARY RELEASE ON DETERMINATE-SENTENCED SEX OFFENDERS

These guidelines are designed to inform the Parole Board of information regarding progress in treatment, or criteria information for those not currently in treatment, for determinate-sentenced sexual offenders. Those offenders who have demonstrated treatment progress or meet certain criteria may be better suited for consideration of discretionary parole. These guidelines may be considered as a component in the decision-making process of the Parole Board among other components considered (e.g. lack of mandatory parole, Code of Penal Discipline/institutional behavior, risk assessment, victim input, etc.).

1. In treatment at the Department of Corrections

    A. Use the same treatment criteria as the indeterminate sentence offenders based on the standard format

        1. *Meets the criteria for successful progress in treatment in prison*, or
        2. *Does not meet the criteria for successful progress in treatment in prison*

2. Not in treatment at the Department of Corrections

    A. Not on wait list for treatment (Signified by a "D" designation)

        1. *Lack of recommendation for discretionary parole*

    B. On wait list for treatment (Signified by a "R" designation)

        1. Not designated Sexually Violent Predator (SVP), and
        2. No history of prior sex crime conviction or adjudication (1 sex crime conviction), and
        3. No history of parole or community corrections revocation during the current sentence to the Department of Corrections, and
        4. Does not have a "P" designation signifying a treatment placement refusal or failure.

        No objection to recommendation for discretionary parole

    C. On wait list for treatment

        1. Designated a SVP, or
        2. Have 2 or more sex crime convictions or adjudications, including factual basis, or
        3. History of parole or community corrections revocation during the current sentence to the Department of Corrections, or
        4. On the waitlist with a "P" designation signifying a treatment placement refusal or failure

        Objection to recommendation for discretionary parole

Appendix S
LIFETIME SUPERVISION CRITERIA

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INTRODUCTION

In 1998, the Colorado General Assembly passed legislation directing the Sex Offender Management Board (hereafter SOMB), in collaboration with the Department of Corrections, the Judicial Branch and the Parole Board to establish the criteria by and the manner in which a sex offender who is subject to lifetime supervision may demonstrate that he or she would not pose an undue threat to the community if released on parole or to a lower level of supervision while on parole or probation or if discharged from parole or probation and the methods of determining whether a sex offender has successfully progressed in treatment (Section 18-1.3-1009 C.R.S.). The court and the parole board may use these Criteria to assist in making decisions concerning release of a sex offender, reduction of the level of supervision for a sex offender, and discharge of a sex offender.

Supervising parole and probation officers and treatment providers should utilize these Criteria in making recommendations to the court and or the parole board regarding release, reduction in levels of supervision and discharge of sex offenders.

These Criteria do not stand alone. They are based on the Guiding Principles of the *Standards and Guidelines for the Assessment, Evaluation, Treatment and Behavioral Monitoring of Adult Sex Offenders* (hereafter, *Standards*). Treatment for sex offenders under lifetime supervision must be consistent with the existing *Standards*.

Progress in treatment relies on consistent reduction/management of dynamic risk factors based on ongoing assessments of the client's overall risk profile and treatment needs. A comprehensive evaluation of risk factors and treatment needs relies on accurate identification of static and dynamic risk factors. It's important to consider a client's overall risk profile, as well as, singular risk factors that are elevated to a level that may create an undue risk to the community. The accuracy of risk and need assessments is impacted by the client's level of openness and honesty during treatment and evaluation processes. CST's should work collaboratively to share information relevant to informing risk factors and treatment needs. Results of assessments should not stand alone and all clinical indicators should be used to inform a client's risk to the community. A client's overall risk profile can inform decisions to determine levels of supervision.

The intent of the lifetime supervision of sex offender is to reduce risk to the community. Although these Criteria are written in a format that indicates what individuals must do to be released, moved to lower levels of supervision, discharged or to demonstrate successful progress in treatment, this does not imply that any or all individuals on lifetime supervision will be able to meet criteria for any of these reductions in levels of supervision or complete treatment. Progress in treatment and assessment regarding whether or not these criteria are met must be measured by behavior that indicates lessened risk, not by any passage of time. In some cases there may be overlap among the Criteria. This is a natural outcome of the community supervision team structure and the interplay between the team members.

For the purposes of these criteria, successful progress in treatment is a process that involves a reduction of supervision levels that coincide with the clients' ability to reduce risk by effectively managing identified risk factors. Clients should understand that many risk factors are not fully eliminated but require ongoing management and the ability to actively and consistently employ intervention strategies.

Just as a client can progress through the levels of treatment and supervision, he/she can regress or be revoked for certain behaviors. If an individual is consistently failing to meet criteria for progression, the

team should evaluate whether the current level of care and supervision is intensive enough to manage the current level of risk.

Like the original *Standards*, these criteria are consistent with current research and best practices known today.

ADDITIONAL GUIDING PRINCIPLES FOR WORKING WITH SEX OFFENDERS ON LIFETIME SUPERVISION

These Guiding Principles serve as a part of the philosophical foundation of these Criteria. They are not to be used alone. They are intended to be used in conjunction with the Guiding Principles in the *Standards and Guidelines for the Assessment, Evaluation, Treatment and Behavioral Monitoring of Adult Sex Offenders,* located in the front section of this publication.

LS1. Because of the long term nature of the work with sex offenders on lifetime supervision, and the concomitant risks to supervising officers and treatment providers, there is greater risk of complacency and inaccurate risk assessment. Supervising officers, treatment providers and their employing agencies should take steps to ensure the following:

- Adequate clinical and administrative supervision;
- Regular case audits;
- Critical incident debriefings;
- Support for trauma reactions;
- Methods for transferring cases as needed; and
- Adequate self-care.

LS 1.000
CRITERIA FOR RELEASE FROM PRISON TO PAROLE

1.010 In order to demonstrate that the sex offender would not pose an undue threat to the community if released from prison to parole, he or she must meet the criteria in each of the following areas of focus:

A. Criminal Behavior Past and Present

1. The offender acknowledges and takes full responsibility for the crime of conviction.

2. The offender has adequate plans to address components of the crime(s) that pose current risk as identified in the mental health sex offense-specific evaluation, treatment plan or relapse prevention plan. Such components may be, but are not limited to:

- Initial charge versus the conviction or plea
- Facts and circumstances of the crime
- Premeditation, grooming or predatory behavior
- Nature of the crime was incidental to another crime or was spontaneous
- The use of threats, violence or weapons
- Age of victim(s) or the presence of any mental or physical disability in the victim(s)
- Any conviction other than the instant offense for a violent crime per CRS 16-11-309

B. Sentence Failures

1. The offender acknowledges reasons for sentence failures (which could include, but are not limited to deferred prosecutions or judgments, probation, community correction, or parole), as verified by official record, and has made progress in addressing those reasons or demonstrates the presence of a plan that addresses those issues.

C. Participation in Programs

1. Required participation in the Sex Offender Treatment and Management Program (SOTMP). SOTMP program staff report offender compliance with recommended program plan and sufficient progress in treatment;

2. Demonstrated participation in all recommended programs. Positive participation and recommendations from staff of each program (based on program compliance) or a clearly established plan to obtain recommended programming in the community where placement in the community does not pose an undue risk;

3. If the offender is placed in community corrections, he or she has demonstrated positive participation and progress as indicated by recommendation from Community Corrections staff and SOMB approved sex offense-specific treatment provider.

D. Code of Penal Discipline Rules Convictions, Escapes or Absconds

Discussion: Non-compliance with rules in a highly structured environment like DOC is highly related to risk of re-offense.

1. No COPD rules convictions in the last 12 months.

2. No drug violations and demonstrates all clean UAs for the last 12 months.

3. No sexual violations in DOC for a minimum period of the last 2 years.

E. Classification Level Changes

1. The offender has had no increase in classification level in the last 12 months.

F. Risk Assessment

1. The offender has completed the SOTMP evaluation (in adherence to SOMB *Standards and Guidelines* and including the administration of the DCJ Sex Offender Risk Scale) and has a recommendation from the SOTMP program staff, which is based on the evaluation, for release to parole.

G. Victim Input (Pursuant to 17-22.5-404 (2) (a) (I) this may include the victim or a relative of the victim)

1. The offender has had no contact with the victim, other than therapeutically approved contact. (Contact means any kind of communication either direct or indirect by the offender with the victim and includes but is not limited to physical proximity, written correspondence, electronic, telephone or through third parties.)

2. The offender is not engaging in victim blaming.

3. The offender is not engaging in harassment, manipulation or coercion of the victim.

4. Offender has demonstrated support for the victim's recovery, minimally at the level of no contact, as verified by SOTMP staff.

H. Age of Offender at Offense vs Date of Parole Hearing

1. The offender demonstrates the emotional maturity necessary to predict a successful release to parole.

I. Parole Plan

1. The offender's Parole plan minimally includes the following:

- No undue level of risk is indicated in any part of the parole plan or recommendations from any DOC staff.
- The offender has an appropriate plan to safely transition back to the community.
- The home living situation is free from former and potential victims.
- The offender has appropriate employment plans with lack of access to potential victims.

- The offender has access to and demonstrates willingness to participate in sex offense-specific treatment and other recommended treatment if released on Parole.
- The appropriate level of supervision and containment is available where the offender plans to live.
- The offender has a realistic plan to pay restitution based on a his or her ability to pay.

J. Honesty

1. The offender demonstrates truthful, complete and non-evasive answers to all questions posed by the parole board members.

LS 2.000
CRITERIA FOR REDUCTION IN LEVEL OF SUPERVISION WHILE ON PAROLE AND DISCHARGE FROM PAROLE

2.010 In order to demonstrate that the sex offender would not pose an undue threat to the community if placed on a lower level of supervision while on parole, he or she must meet the reduction in supervision criteria in each of the following areas of focus; in order to demonstrate that he or she would not pose an undue threat to the community if discharged from parole, he or she must meet the discharge criteria in each of the following areas of focus:

A. Community Supervision Team Staffing

Reduced Supervision: The team considers all information below and other appropriate information to make any determination regarding movement to lower levels of supervision. All team members must agree to the reduction in the level of supervision.

No exceptions will be made for reduction in supervision from level 1 (maximum). Any exception made to the requirements for movement from levels other than level 1 must be made by a consensus of the community supervision team and the parole board. In such a case, reasons for movement to a lower level of supervision when criteria are not met must be documented as well as any resulting potential risk to the community.

Discharge: In any case when an offender is being considered for recommendation of discharge from lifetime supervision, the offender must demonstrate that he or she would not pose an undue threat to the community if allowed to live in the community without supervision. The team considers all information below and other appropriate information to make any determination regarding discharge from lifetime supervision. All team members must agree to the discharge from supervision.

The supervising officer will document what criteria are met or not met at any consideration of reduction in level of supervision or discharge and the decision of the community supervision team.

Discussion: If an offender is consistently failing to meet criteria for progression, the team should evaluate whether the current level of supervision is intensive enough to adequately contain the offender. In such cases, regression to a higher level of supervision should be considered.

B. Polygraphs

Reduced Supervision: The offender must complete at least two consecutive non-deceptive polygraph examinations before moving to the next lower level of supervision. The examinations must be the two most recent exams each time.

Discharge: The offender must have completed a non-deceptive baseline (sex history) polygraph examination and complete at least two consecutive non-deceptive polygraph examinations for each of the three levels of supervision before discharge.

Any exception made to the requirements for movement from level to level or for discharge must be made by a consensus of the community supervision team. In such a case, reasons for movement when criteria are not met must be documented as well as any resulting potential risk to the community.

C. Progress in Treatment

Reduced Supervision: The sex offender's monthly reports are consistently indicating the following (consistency is defined as 6 months or longer):

- Regular attendance with no un-excused absences in the last 6 months.
- Active participation.
- Progression with the established treatment guidelines.
- Payment.
- The offender acknowledges and takes full responsibility for crime of conviction.
- Completion of a non-deceptive polygraph regarding the offender's sex history.
- The treatment provider reports that any other denial issues are being consistently and adequately addressed in treatment.
- The offender understands the offense cycle.
- The offender has and is utilizing an appropriate relapse prevention plan.
- No unsuccessful terminations.
- Full compliance with established treatment guidelines.
- Full compliance with recommended medications.

Discharge: For discharge from parole, the treatment provider must be reporting successful termination of treatment or successful progress in treatment to date and actively recommending discharge from parole. (Successful completion indicates active, consistent practice of a treatment aftercare program. Successful progress indicates an active plan to continue in treatment.)

D. Employment

Immediately upon release, providing there are no medical, mental or physical problems, the sex offender shall actively seek appropriate full time employment or enroll in an appropriate vocational training program, with consent of supervising officer. Appropriate employment limits contact with victims and potential victims and allows the supervising officer to consistently locate the offender.

Reduced Supervision: The offender must demonstrate of job stability, longevity and appropriate usage. In addition, a positive evaluation or progress report (written or verbal) is required from the immediate work supervisor.

An exception may be made if the sex offender becomes unemployed for reasons beyond his or her control. Any exception must be agreed to by a consensus of the community supervision team. In such a case, reasons for movement when criteria are not met must be documented as well as any resulting potential risk to the community.

Discharge: The sex offender's employment record shall reflect the ability to seek and maintain appropriate long-term employment with no periods of willful unemployment during the past 5 years.

E. Relationships

Relationships developed in the community shall be appropriate and of positive benefit to the sex offender. The safety of the community shall be considered a priority in all relationships. Appropriate relationships limit contact with all victims and potential victims and include an awareness of the offender's criminal history.

Reduced Supervision: Consideration for progression to a lower level of supervision will be based on the sex offender's ability to articulate the status and benefits of any relationships. The offender shall have had no unauthorized contact with victims or minors in the last 6 months.

Consideration for progression to level 2 (medium) will be based on the offender identifying an appropriate community support person who is willing to participate in offense-specific education.

In a situation where the offender cohabits with or is in an intimate relationship, the co-habitor or significant other must be supportive of treatment, not supportive of the offenders' denial, and be willing to participate in treatment and sex offense-specific education as needed. Significant other(s) and co-habitors, should also be able to articulate the status and benefits of relationship, demonstrate an awareness of the sex offender's criminal history including the current offense and have knowledge and awareness of the sex offender's risk to children and potential victims.

Exceptions may be made and documented when the offender is residing in a residential facility or hospital and it would be inappropriate to disclose the offender's history to all other residents. In such cases, the safety of the other residents shall be the determining factor regarding disclosure, not the offender's desire for confidentiality. In no case is it appropriate to keep any information regarding the offender and his or her history from staff of any facility in which they are being treated or in which they reside.

Discharge: The sex offender shall have demonstrated, over the course of supervision, the ability to maintain age appropriate, professional and personal relationships that are non-criminal. The sex offender shall demonstrate an understanding of how positive relationships in the community have influenced non-criminal behavior and thinking.

F. Sex Offender Registration

Each sex offender, domestic or interstate, if required by statute to register, shall upon becoming a temporary or permanent resident, register with the law enforcement agency within the jurisdiction where the offender's residence is located.

Reduced Supervision: Consideration for progression to a lower level of supervision will be based on consistent compliance with re-registration requirements, advising law enforcement of current residence, appropriately notifying original jurisdiction and timely filing of a change of residency card with law enforcement when moving to a new jurisdiction.

Progression to a lower level of supervision will not be considered if sex offender is not in compliance with state registration laws.

Discharge: The sex offender must currently be registered and have been in compliance with sex offender registration laws for the (5) five consecutive years immediately preceding consideration for discharge.

G. Leisure Activities:

Immediately upon release, leisure activities engaged in or developed within the community shall be appropriate, legitimate, legal and of benefit to the sex offender. Appropriate leisure activities limit contact with victims and potential victims and allow the supervising officer to consistently locate the offender.

Reduced Supervision: Consideration for progression to a lower level of supervision will be based on sex offenders' ability to identify appropriate leisure activities and the benefit of each activity. In addition, the offender must be able to articulate how the relapse prevention plan is used when engaging in leisure activities.

Discharge: To be considered for discharge, the sex offender must have demonstrated the ability to participate in appropriate, legitimate and legal leisure activities from which he/she has benefited. In addition, the offender must have demonstrated consistent use of a relapse prevention plan as needed during leisure activities.

H. Compliance with Conditions of Supervision

On a regular basis, the sex offender demonstrates compliance with all conditions of supervision.

Reduced Supervision: Consideration for progression to a lower level of supervision will be based on the sex offender's attitude, progress, participation and consistent compliance with all conditions of supervision.

The sex offender will not be considered for progression to a lower level of supervision if not actively in compliance with all offense-specific conditions of supervision, or if the offender has a pending summons or complaint for any parole violation(s).

Discharge: To be considered for discharge sex offender must be in compliance with all conditions of supervision including successful discharge from treatment and active participation in an aftercare program.

LS 3.000
CRITERIA FOR REDUCTION IN LEVEL OF SUPERVISION WHILE ON PROBATION AND DISCHARGE FROM PROBATION

3.010 In order to demonstrate that the sex offender would not pose an undue threat to the community if placed on a lower level of supervision while on probation, he or she must meet the reduction in supervision criteria in each of the following areas of focus (For the purpose of these Criteria, reduction in level of supervision while on probation means movement from Sex Offender Intensive Supervision Probation to Regular Probation). For criteria that refer to reduction in levels of supervision while on Sex Offender Intensive Supervision Probation, please refer to the *Sex Offender Intensive Supervision (SOISP) Guidelines and Standards* published by the Colorado Judicial Branch, Office of Probation Services.

In order to demonstrate that the sex offender would not pose an undue threat to the community if discharged from probation, he or she must meet the discharge criteria in each of the following areas of focus:

A. Compliance with the Treatment Contract to the Treatment Provider's Satisfaction

Reduced Supervision: The treatment provider is indicating a recommendation for reduced supervision based on the following indicators of progress in treatment:

- Regular attendance and active participation in sex offense-specific treatment.
- Demonstrates increased internal motivation for treatment.
- The offender admits to committing the offense and acknowledges sexual assault intent.
- The offender demonstrates understanding and use of a written offense cycle.
- Completion of a written relapse prevention plan and demonstrated ability to use it.
- The offender appropriately confronts others in group treatment.
- Completion of non-deceptive maintenance polygraph examinations at least every 6 months.
- Completion of all homework assignments and evidence of an attempt to do a quality job.
- No violations of the treatment contract.
- A reduction in attempts to Asplit@ team members.
- Demonstrates increased awareness of victim impact and the development of victim empathy.
- Verification that the offender is using techniques, such as covert sensitization, to interrupt deviant arousal.

- Non-deceptive disclosure polygraph. (Any exception to this criteria must be consistent with the requirements in the SOMB *Standards and Guidelines* located in the front section of this publication.)

- Demonstrates ability to recognize and correct thinking errors.
- Demonstrated the ability to express anger appropriately and without aggression.
- Full and consistent compliance with any medication requirements.

Discharge: For discharge from probation, the treatment provider must be reporting successful termination of treatment or successful progress in treatment to date and actively recommending discharge from probation. (Successful completion indicates active, consistent practice of a treatment aftercare program. Successful progress indicates an active plan to continue in treatment.)

B. Consistency Between Words and Behavior

Reduced Supervision:

- The offender can identify inconsistencies in his or her words and behavior and makes attempts to correct them.
- Evidence of consistency in what is said to the members of the community supervision team.

Discharge: The offender consistently displays consistency between his or her words and behavior in all areas of his life.

C. Appropriate Relationships and Community Support

Reduced Supervision: The offender recognizes and terminates inappropriate relationships. The offender has establishment of some appropriate social relationships and community support. This may include a community chaperone if deemed necessary by the community supervision team. In a situation where the offender cohabits with or is in an intimate relationship, the co-habitor or significant other must be supportive of treatment, not supportive of the offenders' denial, and be willing to participate in treatment and sex offense-specific education as needed. Significant other(s) and cohabiters should also be able to articulate the status and benefits of relationship demonstrate an awareness of the sex offender's criminal history including the current offense and have knowledge and awareness of the sex offender's risk to children and potential victims.

Exceptions may be made and documented when the offender is residing in a residential facility or hospital and it would be inappropriate to disclose the offender's history to all other residents. In such cases, the safety of the other residents shall be the determining factor regarding disclosure, not the offender's desire for confidentiality. In no case is it appropriate to keep any information regarding the offender and his or her history from staff of any facility in which they are being treated or in which they reside.

Discharge: The sex offender shall have demonstrated, over the course of supervision, the ability to maintain age appropriate, professional and

personal relationships that are non-criminal. The sex offender shall demonstrate an understanding of how positive relationships in the community have influenced non-criminal behavior and thinking.

D. Stable and Safe Residence

Reduced Supervision: The offender shall maintain a stable and safe residence. A safe residence is one that limits the offender's contact with victims, potential victims and minors and where any co-habitors are aware of the offender's criminal history including the current offense and have knowledge and awareness of the sex offender's risk to children and potential victims.

Discharge: The offender shall have demonstrated, over the course of supervision the ability to maintain a stable and safe residence.

E. Stable and Safe Employment

Reduced Supervision: The offender shall demonstrate the ability to maintain stable and safe employment. Safe employment limits contact with victims and potential victims and allows the supervising officer to consistently locate the offender.

Discharge: The offender's employment record shall reflect the ability to maintain stable and safe employment with no periods of willful unemployment during the past 5 years.

F. Substance Abuse Treatment

This criteria applies only to those offenders who are recommended for substance abuse treatment.

Reduced Supervision: The offender has entered into a recommended substance abuse treatment program and is making and maintaining consistent progress in the program.

The offender has not used drugs or alcohol for at least 6 months prior to any reduction in level of supervision.

Discharge: The offender has completed any recommended substance abuse program and is actively and consistently involved in any recommended aftercare or maintenance programs.

G. Leisure Activities

Leisure activities engaged in or developed within the community shall be appropriate, legitimate, legal and of benefit to the sex offender. Appropriate leisure activities limit contact with victims and potential victims and allow the supervising officer to consistently locate the offender.

Reduced Supervision: Consideration for progression to a lower level of supervision will be based on sex offenders' ability to identify appropriate leisure activities and the benefit of each activity. In addition, the offender must be able to articulate how the relapse prevention plan is used when engaging in leisure activities.

Discharge: To be considered for discharge, the sex offender must have demonstrated the ability to participate in appropriate, legitimate and legal leisure activities from which he has benefited. In addition, the offender must have demonstrated consistent use of a relapse prevention plan as needed during leisure activities

H. Compliance with Conditions of Supervision

Reduced Supervision: Consideration for progression to a lower level of supervision will be based on the sex offender's attitude, progress, participation and consistent compliance with all conditions of supervision including but not limited to the following:

- Keeps probation and other related appointments and is generally on time.
- Is open to discussing the offense and treatment progress.
- The offender does not try to control the probation officer or content of visits.
- No technical violations within the last 6 months of probation related to the offense cycle.
- No alcohol or drug use at least 6 months preceding a supervision reduction.
- No unauthorized contact with the victim(s) or with minors.
- Full compliance with requirements for registration and DNA Genetic Marker collection.
- Consistent payment of restitution and fines imposed by the court.
- Any community complaints regarding the offender have been adequately addressed to the treatment team's satisfaction.

I. Community Supervision Team Staffing

Reduced Supervision: The team considers all information above and other appropriate information to make any determination regarding movement to a lower level of supervision. All team members must agree to the reduction in the level of supervision.

Discharge: In any case when an offender is being considered for recommendation of discharge from lifetime supervision, the offender must demonstrate that he or she would not pose an undue threat to the community if allowed to live in the community without supervision. The team considers all information below and other appropriate information to make any determination regarding discharge from lifetime supervision. All team members must agree to the discharge from supervision.

The supervising officer will document what criteria are met or not met at any consideration of reduction in level of supervision or discharge and the decision of the community supervision team.

Discussion: If an offender is consistently failing to meet criteria for progression, the team should evaluate whether the current level of supervision is intensive enough to adequately contain the offender. In such cases, regression to a higher level of supervision, or revocation, should be considered.

LS 4.000
CRITERIA FOR SUCCESSFUL PROGRESS IN TREATMENT IN PRISON: SEX OFFENDER TREATMENT AND MONITORING PROGRAM, COLORADO DEPARTMENT OF CORRECTIONS (CDOC)

4.100 Criteria for Successful Progress in Sex offense-specific Treatment

4.110 In order to demonstrate successful progress in treatment, the offender must meet the progress criteria in each of the following areas of focus; in order to meet the criteria for successful completion of treatment, the offender must meet all of the progress and completion criteria in each of the following areas of focus.

For the purposes of these criteria, successful progress in treatment indicates an active plan to continue treatment and supervision; successful completion of treatment indicates active, consistent participation in a treatment aftercare program, containment and monitoring to manage lifelong risk.

A. Relapse Prevention Criteria

1. Reduction in Denial

Progress:

- The offender discloses all victim(s) and sexual offending behavior in detail.
- The offender's account must reasonably match or surpass the victim(s) accounts.
- The offender recognizes and admits the purposes of their sexually assaultive/offending behavior including sexual gratification, deviant sexual arousal and power and control.
- The offender completes non-deceptive polygraph examination(s) regarding sexual history.

Completion:

- The offender has met all progress criteria and continues to complete non-deceptive polygraph examinations.
- The offender no longer uses denial of responsibility in any arena of his or her life as a primary coping mechanism.

2. Decreased deviant sexual urges, arousal, and fantasies:

Progress:

- The offender demonstrates knowledge of his or her historical offense and relapse cycles including awareness of thoughts, emotions and behaviors that could facilitate sexual re-offenses or other assaultive behaviors.
- The offender demonstrates knowledge of his or her cognitive distortions and is working to correct them.

- The offender has developed and implemented a plan to alter his or her lifestyle to limit their ability to plan or groom potential victims and has developed skills to interrupt fantasies and inappropriate masturbatory behaviors and utilizes them.
- The offender has developed a comprehensive relapse prevention plan.
- Is, and consistently has been, in compliance with all recommended prescribed psychiatric medications used to reduce arousal or manage behaviors related to risk.
- The offender can identify objectification and inappropriate sexual gratification in relationships and is developing skills to address them.

Completion:

- The offender demonstrates control over arousal or interest through Plethysmograph or Abel Screen Aimprovement@.
- The offender consistently completes non-deceptive polygraphs regarding planning behavior or masturbation to arousal and fantasies.
- The offender consistently demonstrates self-motivated use of the relapse prevention plan and has distributed written copies of the plan to any co-habitors or significant others.
- The offender consistently demonstrates self-motivated use of a plan for identifying and correcting cognitive distortions.
- The offender demonstrates the development and maintenance of appropriate adult relationships. Appropriate relationships value the quality of the relationship over sexual gratification.
- The offender demonstrates an ongoing commitment to and active engagement in treatment or an aftercare treatment program, containment and monitoring to manage lifelong risk.

Discussion: Demonstrating improvement on these measures does not necessarily indicate reduced risk or that the offender will utilize his or her ability to control arousal or interest appropriately.

B. Environment Management Criteria

Progress:

- The offender demonstrates willing, active and knowledgeable participation in the treatment process and/or a milieu or residential treatment setting.
- The offender demonstrates the ability to identify anti-social behaviors and is working toward pro-social skills to replace them.
- The offender has disengaged from relationships that support his or her denial, minimization, and resistance to treatment.
- The offender is engaged in relationships which are supportive of treatment, and the people engaged in relationships with the offender demonstrate awareness of the sex offender's criminal history including the current offense and of the sex offender's risk to children and potential victims. These people actively assist in limiting the offender's contact with children and potential victims. Additionally, those who are in either in intimate relationships with the offender or are co-habiting with the offender are willing to participate in treatment and sex offense-specific education as needed.

- The offender's support system has been given permission by the offender to question and confront the offender about his or her behavior and to report their concerns to the community supervision team and law enforcement authorities when appropriate.
- The offender has demonstrated consistent and full compliance with all conditions of supervision and the treatment contract.
- The offender has demonstrated consistent ability to avoid high risk environments.

Completion:

- The offender demonstrates willing and active participation in only pro-social behaviors.

C. Community & Victim Responsiveness Criteria

Progress:

- The offender acknowledges the full impact of his or her sexually assaultive and offending behavior.
- The offender understands that the protection of victims and potential victims from unsafe and or unwanted contact with the offender outweighs the needs or desires of the offender.
- The offender changes his or her behavior to prevent unsafe or unwanted contact with victims or potential victims.
- The offender has started to pay restitution and has a realistic plan to continue.
- The offender has demonstrated consistent compliance with all registration, notification, HIV testing and DNA testing requirements and has an active plan to continue.

Completion:

- The offender has successfully completed victim clarification with his or her victims and secondary victims or victim surrogates when victim needs or desires indicate non- participation.
- The offender demonstrates the capacity, knowledge, willingness and ability to empathize.

Discussion: It should be noted that it can be dangerous to attempt empathy work with those offenders who may not have the capacity to develop real empathy (such as psychopaths and sadists). These offenders may utilize information about others= pain as a means to learn how to harm victims more effectively.

D. Offender Criteria

Progress:

- The offender recognizes and acknowledges his or her lifelong risk.
- The offender does not project blame for his or her offending behavior.
- The offender does not present himself or herself as entitled or as a victim.
- The offender has identified cognitive distortions and has demonstrated a consistent ability to change them.

- The offender has been able to demonstrate a primarily positive attitude toward supervision and treatment.
- The offender has identified problems with stress management, social skills and anger management and is developing pro social skills to address them.
- The offender can identify his or her unhealthy attitudes and behavior regarding sex roles and sexuality and is working to change them.
- The offender can identify his or her misuse of power and control and is working to eliminate it.

Completion:

- The offender consistently maintains a positive attitude toward supervision and treatment.
- The offender is committed to permanently altering his or her lifestyle to reduce and control his or her lifelong risk.
- The offender does not project blame or minimize personal responsibility.
- The offender assumes full and appropriate responsibility for his or her actions.
- The offender demonstrates primarily non-distorted thinking.
- The offender has accepted and is actively and consistently working to address any diagnosed personality disorders.
- The offender has addressed in treatment and demonstrated the ability to practice ongoing self-care regarding: 1) previous trauma, 2) social skills, 3) stress management, 4) anger management, and 5) independent living skills.
- The offender has consistently demonstrated realistic and healthy attitudes and behavior about sexuality and sex roles.
- The offender has addressed power and control issues in treatment and has consistently demonstrated an ability to engage with others without abusing power and control.
- The offender has willingly engaged in risk assessment and physiological monitoring and has an active plan to continue.
- The offender has developed a positive life purpose which is internally oriented, value driven and not outcome dependent.

E. Co-morbidity and Adjunctive Issues

Progress:

- The offender is addressing any domestic violence history with appropriate domestic violence treatment and has not engaged in domestic violence.
- The offender is addressing drug and alcohol problems in treatment and is maintaining abstinence of recommended.
- The offender is addressing any psychiatric conditions in treatment and is in compliance with all recommended medications.

Completion:

- The offender has not committed any new incidents of domestic violence, has addressed domestic violence in treatment and demonstrates a commitment to continue domestic violence treatment as needed.

- The offender demonstrates an ongoing commitment to participate in recommended substance abuse treatment and maintenance programs.
- The offender has addressed any psychiatric conditions in treatment and demonstrates an ongoing commitment to participate in recommended treatment, maintenance and medication programs.

4.210 Sex offender treatment in the prison setting is preliminary to continued treatment and supervision in the community post release from prison. Since sex offenders who participate in treatment in the prison setting cannot complete treatment in prison, the Sex Offender Treatment and Monitoring Program has developed criteria for offenders to receive a recommendation for release to parole. In accordance with the Risk, Need, Responsivity Model the SOTMP has developed two risk based criteria formats. Sex offenders participating in the Sex Offender Treatment and Monitoring Program (SOTMP) must meet all of the following criteria to receive a recommendation for release to parole from the SOTMP staff.

A. Low to Low-Moderate Risk Category

1. Participates and actively engages in recommended level of sex offense-specific treatment.

2. Complete a disclosure of his or her offense related sexual history relevant to identified risk areas as verified through either the sexual history polygraph[184] process, or other clinical indicators[185].

3. Client will develop a plan to manage ongoing risk factors and treatment needs specific to recommended level of treatment.

4. Client will present an approved risk management plan through SOTMP disclosure session.

5. Demonstrate management of identified risk areas as verified by clinical indicators[186].

6. Must be compliant with any CDOC psychiatric recommendations for medication which may enhance his or her ability to benefit from sex offense-specific treatment.

7. Client does not display attitudes, behaviors or risk factors that present an undue risk to the community. Examples may include, but are not limited to, high degrees of traits associated with psychopathy, sadism, and static and dynamic factors or responsivity needs elevated to an unmanageable level.

B. Moderate to Moderate High to High Risk Category

1. Participates and actively engages in recommended level of sex offense-specific treatment as evidenced by a measured reduction in dynamic risk.

[184] Polygraph examination results will not be used in isolation to exclude someone from meeting criteria without additional evidence that indicates high risk behaviors.

[185], [169] Clinical indicators can be anything that provides information about a client's overall clinical presentation, which may include but is not limited to interviews, quality of treatment participating, polygraph examination results, scores on dynamic risk assessments, psychological evaluation, behavioral observations, and collateral reports.

2. Complete a disclosure of his or her offense related sexual history relevant to identified risk areas as verified through either the sexual history polygraph[187] process, or other clinical indicators[188].

3. Complete a comprehensive, written plan to manage ongoing risk areas and treatment needs. The plan must be approved by the SOTMP team.

4. Have an approved support person or system who has participated in SOTMP Family Support Education. The support person/system will receive an approved copy of the client's written plan to manage on-going risk areas and treatment needs through their participation in an SOTMP therapist facilitated disclosure session.

5. Demonstrate management of identified risk areas as verified by clinical indicators[189].

6. Must be compliant with any CDOC psychiatric recommendations for medication which may enhance his or her ability to benefit from sex offense-specific treatment.

7. Client does not display attitudes, behaviors or risk factors that present an undue risk to the community. Examples may include, but are not limited to, high degrees of traits associated with psychopathy, sadism and dynamic factors or responsivity needs elevated to an unmanageable level.

[187] Polygraph examination results will not be used in isolation to exclude someone from meeting criteria without additional evidence that indicates high risk behaviors.

[188, 172] Clinical indicators can be anything that provides information about a client's overall clinical presentation, which may include but is not limited to interviews, quality of treatment participating, polygraph examination results, scores on dynamic risk assessments, psychological evaluation, behavioral observations, and collateral reports.