COLORADO SEX OFFENDER MANAGEMENT BOARD

STANDARDS AND GUIDELINES FOR THE EVALUATION, ASSESSMENT, TREATMENT AND SUPERVISION OF JUVENILES WHO HAVE COMMITTED SEXUAL OFFENSES

Colorado Department of Public Safety
Division of Criminal Justice
Office of Domestic Violence &
Sex Offender Management

700 Kipling Street, Suite 3000
Denver, CO 80215
(303) 239-4442
website: http://dcj.somb.state.co.us/

These Standards and Guidelines continue to be revised. As the Board approves revisions, they will be uploaded into this on-line Standards and Guidelines document. When only certain standards of a section have been revised, those standards are highlighted so the changes are easily identifiable. Updates will be frequent and you are encouraged to access this document when seeking SOMB guidance. This electronic document supersedes previously printed versions.

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INTRODUCTION *December 2014*

In 1992, the Colorado General Assembly passed legislation (section 16-11.7-101 through section 16-11.7-107, C.R.S.) that created the 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 (hereafter Board) in 1998 to more accurately reflect the duties assigned to the Board. The Standards and Guidelines (hereafter Standards) were originally drafted by the Board over a period of two years and were first published in January 1996. The Standards and Guidelines were designed to establish a basis for systematic management and treatment of adult sex offenders.

In 2000, The Colorado General Assembly amended and passed legislation (section 16-11.7-103, C.R.S.) that required the Sex Offender Management Board to develop and prescribe a standardized set of procedures for the evaluation and identification of juvenile sex offenders. The legislative mandate to the Board was to develop and implement methods of intervention for juvenile sex offenders, recognizing the need for standards and guidelines specific to these youth. These Standards continue to hold public safety as a priority, specifically the physical and psychological safety of victims and potential victims.

These Standards are required for juveniles who are placed on probation or parole, committed to the State Department of Human Services, placed in the custody of the County Department of Human Services, or those in out-of-home placement for sexual offending or abusive behavior. Juveniles who have received deferred adjudications and those whose charges include an underlying factual basis of a sexual offense are also subject to these Standards. However, many juveniles with developmental/intellectual disabilities who have committed a sexual offense are either found incompetent to stand trial, or are not charged with offenses; instead their case opens on a Dependency and Neglect (D&N) Petition and/or prior to or in lieu of prosecution and may receive services provided by the Department of Human Services (DHS).

The Board also recommends that these Standards and Guidelines be utilized with juveniles and families who are seeking intervention regarding sexually abusive behavior that has been disclosed through self-report or evaluation. Following a comprehensive evaluation, such juveniles who have been adjudicated for non-sexual offenses, placed on diversion or those who are the subject of a dependency and neglect order may be included in the same programs as those developed for juveniles adjudicated for sexual offending behavior.

In contrast to legislation and policy regarding adult sex offenders, the "no cure model" should not, as a general rule, be applied to juveniles who commit sexual offenses.[1,2] Due to developmental and contextual considerations, the identification of individual differences among juveniles who commit sexual offenses is a more accurate method than the "no cure model" for identifying risk and supporting the goal of victim and community safety. It is the intention of the Board that each juvenile, to whom these Standards apply, has an individualized evaluation from which a comprehensive treatment and supervision plan will be developed.

[1] Association for the Treatment of Sexual Abusers (2012). *Adolescents Who Have Engaged in Sexually Abusive Behavior: Effective Policies and Practices*. Beaverton, OR: Association for the Treatment of Sexual Abusers.

[2] Becker, J.V. (1998). What we know about the characteristics and treatment of adolescents who have committed sexual offenses. *Child Maltreatment, 3 (4),* 317-329.

An overarching objective of these Standards is to empower the multidisciplinary team (MDT) to have discretionary influence over the course of treatment and management within the limitations of these Standards. This discretionary influence is vital to properly apply these Standards to the wide range of developmental and case specific considerations.

Sex offense specific treatment is a developing field. The Board will remain current on the emerging research and literature and will modify these Standards and Guidelines based on an improved understanding of the issues. The Board must also make decisions and recommendations in the absence of clear research findings. Such decisions will, therefore, be directed by the Guiding Principles outlined in the beginning of these Standards, the governing mandate with the priority of public safety and attention to commonly accepted standards of care.

The *Standards* 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 Evaluation, Assessment, Treatment and Supervision of Juveniles Who Have Committed Sexual Offenses.* The guiding principles of the *Standards* serve as the philosophical foundation for this document.

The *DD/ID Standards* intend to better address the specific needs, risk and best interests of juveniles with developmental/intellectual disabilities who have committed a sexual offense. They are based in best practices known today for managing and treating juveniles with developmental/intellectual disabilities who have committed a sexual offense. To the extent possible, the SOMB has based these *Standards* on the current research in the field, although it is limited. Materials from knowledgeable professional organizations have also been used to direct the *Standards*. These *Standards* are based on all of the above and also on research related to juveniles with developmental/intellectual disabilities in general.

GUIDING PRINCIPLES *Revised December 2015*

PRINCIPLE #1:
The highest priority of these Standards and Guidelines is to maximize community safety through the effective delivery of quality evaluation, treatment and management of juveniles who commit sexual offenses.

PRINCIPLE #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, as well as social, family, economic, and spiritual harm. 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. 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. Professionals working with sexual offenders should be alert to how offenders' behaviors may inflict further harm on persons they have previously victimized.

PRINCIPLE #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 supervision of juveniles who have committed sexual offenses.

When assessing the needs of a juvenile who has committed a sexual offense community safety must be achieved. In the event of a conflict between the two, the MDT shall determine how to meet the needs of the juvenile in a manner that does not compromise or negatively impact community safety.

PRINCIPLE #4:
Safety, protection, developmental growth and the psychological wellbeing of victims and potential victims is a priority for the Multidisciplinary Team (MDT).

Victims have the right to safety, to be informed and to provide input to the MDT.

PRINCIPLE #5:
Offense-specific treatment must address all types of abusive behaviors and not just the legally-defined delinquent behavior(s) for which they were adjudicated.

PRINCIPLE #6:
Treatment and supervision decisions should be informed by a comprehensive evaluation and ongoing assessments.

The evaluation and ongoing assessment of juveniles who have committed sexual offenses is a process. Ongoing assessment must constantly consider changes in the juvenile, family and community in order to make decisions concerning restrictions, intensity of supervision, placement, treatment and opportunities for positive growth and development of juveniles.

PRINCIPLE #7:
Risk assessment of juveniles who have committed sexual offenses should be based on an empirically supported protocol.

The risk assessment protocol, including the selection of instruments, should be tailored to the unique characteristics of the juvenile. A juvenile's level of risk should not be based solely on the sexual offense(s).

PRINCIPLE #8:
A multidisciplinary team will be convened, and is responsible for the evaluation, treatment, care and supervision of juveniles who commit sexual offenses.

The adoption of these standards and guidelines significantly improves public safety outcomes when all agencies and parties are working cooperatively and collaboratively.

PRINCIPLE #9:
Treatment and supervision decisions should be guided by available research and best practice.

Research with this population continues to emerge, leading to changes of these Guiding Principles and Standards. In the absence of research, decisions should be made cautiously and in accordance with best practices to minimize unintended consequences.

PRINCIPLE #10:
Treatment and supervision should be individualized and responsive based on the juvenile's risks and needs.

Juveniles who commit sexual offenses vary in ways such as; age, development, gender, culture, background, strengths, protective factors, pattern(s) of offending and numbers of victims.

PRINCIPLE #11:
Evaluation, ongoing assessment, treatment and behavioral monitoring of juveniles who have committed sexual offenses should be non-discriminatory, humane and bound by the professional code of ethics and law.

Professionals responsible for the evaluation, assessment, treatment and behavioral monitoring of juveniles who have committed sexual offenses must not discriminate based on race, religion, gender, sexual orientation, disability or socio-economic status. Juveniles who have committed sexual offenses and their families shall be treated with dignity and respect by all members of the multidisciplinary team.

PRINCIPLE #12:
Assessment of the degree of progress in treatment is based on the juvenile's application of relevant changes in their daily functioning.

Treatment should include measurable outcomes that will demonstrate progress and successful completion of treatment.

PRINCIPLE #13:
Treatment should be holistic and enhance overall health and protective factors.

Many juveniles who commit sexual offenses have multiple problems and areas of risk. Research indicates that juveniles are at greater risk for non-sexual re-offenses than for sexual re-offenses[3,4]. Assessment and treatment must address areas of strengths, risks and deficits to increase the juvenile's abilities to be successful and to decrease the risks of further abusive or criminal behaviors. Treatment plans should specifically address the risks of further sexual offending, other risks that might jeopardize safety and successful pro-social functioning. Treatment plans should also reinforce developmental and environmental assets.

PRINCIPLE #14
Assessment, treatment and supervision should be viewed through an ecological framework of Development.

Assessment and intervention with a juvenile who has committed a sexual offense recognizes the nature of adolescent development and the dependence on and influence by social-ecological factors, including family, peer group, community and school. This focus seeks to decrease risk factors and increase protective factors in the juvenile's ecology.

PRINCIPLE #15:
Family members/Primary Caregivers should be considered an integral part of evaluation, assessment, treatment and supervision.

The families'/primary caregivers' abilities to provide informed supervision and support positive changes are critical to reducing risk of re-offense.

Cooperative involvement with family members/primary caregivers enhances juvenile's prognosis in treatment. Family members/primary caregivers possess invaluable information about the juvenile who has committed a sexual offense. Family members can be an important part of the juvenile's support system through the course of treatment and supervision.

Conversely, non-cooperative family members may impede the juvenile's progress. It is expected that the MDT will work with the family/primary caregiver to help them support the juvenile through cooperative involvement.

PRINCIPLE #16:
Treatment and supervision decisions regarding juveniles who have committed sexual offenses should minimize caregiver disruption and maximize exposure to positive peer and adult role models.

As juveniles move through the continuum of services emphasis should be given to maintaining positive and consistent relationships. Research indicates that association with delinquent peers[5],

[3]Hagen, M.P. & Gust-Brey, K.L. (2000). A Ten-Year Longitudinal Study of Adolescent Perpetrators of Sexual Assault Against Children. *Journal of Offender Rehabilitation, 13(1/2),* 117-126.

[4] Weinrott, M.R. (1996). *Juvenile Sexual Aggression: A Critical Review*. (Center Paper 005). Boulder, CO: Center for the Study and Prevention of Violence.

[5] Prentky, R., Harris, B., Frizzell, K., and Righthand, S. (2000). An actuarial procedure for assessing risk in juvenile sex offenders. *Sexual Abuse: A Journal of Research and Treatment, 12 (2),* 71-93.

the absence of pro-social adult role models, and the disruption of caregiver relationships increase the risk of delinquent development.[6]

PRINCIPLE #17:
A continuum of care for treatment and supervision options should be available and utilized as needed.

Decisions about level of care and supervision are informed by the youth's risk and need, taking into consideration the least restrictive environment while prioritizing community safety. Adjustments in the level of treatment and supervision should be made based on changes in risk and need, and continuity of services across these levels of care should be ensured. Whenever possible, priority should be given to the juveniles residing with their families or within the community in which their family resides

PRINCIPLE #18:
For juveniles who have been removed from the home family reunification can only occur after careful consideration of all the potential risks.

The ability of parents to provide informed supervision in the home must be assessed in relation to the particular risks of the juvenile. Reunification of the juvenile with the family should occur only after the parents/primary caregivers can demonstrate the ability to provide protection and support of the victim(s) and other children in the home, as well as address the needs and risks of the juvenile.

PRINCIPLE #19:
Juveniles shall not be labeled as if their sexual offending behavior defines them.

It is imperative in understanding, treating and intervening with juveniles who commit sexual offenses to consider their sexual behavior in the context of the many formative aspects of their personal development. As juveniles grow and develop their behavior patterns and self-image constantly change. Research suggests that most juveniles will not go on to offend sexually as adults. (INSERT CITATION)Because Identity formation is a significant developmental task during adolescence, labeling juveniles based solely on sexual offending behavior may cause potential damage to long-term pro-social development.

PRINCIPLE #20:
Successful completion of treatment and supervision depends upon a juvenile's willingness and ability to cooperate. Accordingly, members of the MDT should employ practices designed to maximize the juvenile's participation and accountability.

[6] Bagley & Shewehuk-Dann (1991), Miner, Siekart, & Ackland (1997), and Morenz & Becker (1995) as cited in Righthand, S., & Welch, C. (2001) *Juveniles who have Sexually Offended: A Review of the Professional Literature*, Office of Juvenile Justice and Delinquency Prevention.

DEFINITIONS *December 2014*

ACCOUNTABILITY
Quality of being responsible for one's conduct: being responsible for causes, motives, actions and outcomes.

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." "Adjudication" means a determination by the court that is 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.

AFTERCARE
Commences at the point when the team approves completion of primary treatment and readiness for accountability through a less restricted supervision plan. Aftercare requires continued input by the members of the multidisciplinary team.

AFTERCARE PLAN
Developed by the multidisciplinary team prior to the juvenile's completion of treatment; addresses strengths, risks and deficits relative to the release/completion and follow-up stage of treatment and supervision.

AMENABILITY TO TREATMENT
A sincere willingness, even if minimal, to participate in treatment to address changes in thoughts, feelings and behaviors.

ASSESSMENTS
Standardized measurements, developed and normed for juvenile populations, used to test various levels of functioning, including: cognitive, neuropsychological, psychiatric, psychological (DSM Axis II), memory and learning, social and emotional, social stability, family dynamics, academic, vocational/career, sexual, accountability and offense characteristics and, level of risk.

BOARD
Colorado Sex Offender Management Board.

CAREGIVERS
Parents or other adults who have a custodial responsibility to care for the juvenile. Caregiving is broadly defined as providing the nurturance, guidance, protection and supervision that promotes normal growth and development and supports competent functioning.

CAREGIVER STABILITY
Consistency of a caregiver's relationship with the juvenile across the continuum of care.

COERCION
Exploitation of authority. Use of pressure through actions such as bribes, threats or intimidation to gain cooperation or compliance.

COMMITMENT
A statutory process by which a person is placed in the custody of a public or private agency, i.e. committed to the State Department of Human Services.

COMMUNITY CENTERED BOARD (CCB)
A private non-profit corporation that provides case management services to an individual with a developmental/intellectual disability. 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 these 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
When a juvenile is residing in any unlocked location (home, foster placement, RTC placement, etc.) he/she is considered to be under community supervision. The multidisciplinary team, when in place, supervises the juvenile and often, there is a probation or parole officer assigned to the case. When the multidisciplinary team has not been developed yet, the custodial agency and/or Department of Human Services caseworker is generally the supervising agent.

COMPLETE CASE RECORD
A working file which includes the PSI, initial evaluations, all ongoing assessments, all case plans, all interventions and sanctions and contact information of all professionals, parents/guardians and others identified as significant in a juvenile's case.

CONSENT
Agreement including all of the following: 1) understanding what is proposed, based on age, maturity, developmental level, functioning and experience; 2) knowledge of societal standards for what is being proposed; 3) awareness of potential consequences and alternatives; 4) assumption that agreement or disagreement will be respected equally; 5) voluntary decision; and 6) mental competence.

CONSENSUS
An opinion or position reached by a group as a whole; an idea or opinion that is shared by all the people in a group.

CONTACT
Any verbal, physical or electronic communication, that may be indirect or direct, between a juvenile who has committed a sexual offense and a victim or potential victim.

Purposeful: a planned experience with an identified potential outcome

Incidental: unplanned or accidental; by chance

CONTINUUM OF CARE AND SERVICES
The various levels and locations of care, based on the juvenile's individual needs and level of risk; include treatment intensity and approach, and restrictiveness of setting. For the purpose of these Standards, the continuum is not uni-directional.

COURT APPOINTED SPECIAL ADVOCATE (CASA)
CASA volunteers are appointed to gather information in child abuse and neglect cases and speak to the court on behalf of the needs of the children.

DEPENDENCY AND NEGLECT
A civil court finding that a juvenile is in need of care and/or protection beyond that which the parent is, or has been, able or willing to provide. Dependency and neglect cases are often referred to as "D&N" cases. Such cases may result in court ordered treatment for parents, children and families, without any family member having been charged, convicted or adjudicated for a crime. Court orders may include directives for the juvenile to participate in sex offense specific treatment, or directives regarding familial participation in the juvenile's treatment. At times these orders are put in place to ensure residential treatment for juveniles.

DEVELOPMENTAL COMPETENCY
Having the acquired skills for optimal human functioning at each developmental stage.

DEVELOPMENTAL/INTELLECTUAL DISABILITY (DD/ID)
A condition manifested before age 22 which constitutes a substantial disability to the affected individual and is attributable to an impairment in general intellectual functioning 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 diagnosed with mental retardation.

DEVELOPMENTAL/INTELLECTUAL DISABILITY (DD/ID) PROVIDER LIST
The list published by the SOMB, identifying treatment providers, evaluators, and polygraph examiners who meet the criteria set forth in the *Standards* (refer to Section 4.000).

DIVISION OF DEVELOPMENTAL DISABILITIES
A section within the Colorado Department of Human Services Office of Adult Health and Rehabilitation Services, responsible for the administration of state sponsored activities and funding for developmental disabilities for the State of Colorado.

DEVIANCE
Significant departure from the norms of society; behavior which is not normative, differing from an established standard.

DIRECT CLINICAL CONTACT
Includes intake, face-to-face therapy, case/treatment staffing with the juvenile, treatment plan review with the juvenile, crisis management, and milieu intervention.

DYADIC THERAPY
Two people engaged in a therapeutic setting facilitated by a provider.

DYNAMIC RISK FACTORS
For the purpose of these Standards, dynamic risk factors are considered changeable and must be addressed in sex offense specific treatment. The juvenile is held accountable and responsible for managing dynamic risk factors that are not based in the environment.

EMPATHIC RECOGNITION
Noticing signs/cues of emotions and/or needs and accurately assessing their meaning.

EMPATHY
The act of noticing, interpreting and responding to the affective cues of oneself and others.

EVALUATION
The scope of various assessments and information gathered collaterally constitutes an evaluation. The systematic collection and analysis of the data is used to make treatment and supervision decisions. Evaluations, as a whole, are not likely to be ongoing since the subsequent assessments can be done on an as-needed basis. Evaluations are required by these Standards prior to sentencing and by section 16-11.7-104, C.R.S.

GROOMING
Subversive actions perpetrated to gain access and trust of the victim and the victim's support system. Training the victim and victim's support system to lower their guard. Behaviors are victim specific and include such things as: relationship building through shared interests or activities; development of a sense of *specialness* within the victim; shared secrets before sexual victimization.

GUARDIAN AD LITEM (GAL)
The person appointed by the court to look out for the best interests of the child during the course of legal proceedings.

GUIDELINE
A principle by which judgments to determine a policy or course of action is made. Guidelines are identified by the terms, "should," "may," and in some cases, "it is recommended…"

IMPOSITION OF LEGAL DISABILITY (ILD)
A determination made in a court of law that an individual 18 years or older 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/intellectual 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/intellectual 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.).

INCOMPETENT TO PROCEED (ITP)
The defendant is suffering 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.).

INDIVIDUALIZED EDUCATION PLAN (IEP)
The Individual Education Program Plan (IEP) is a written plan/program developed by the school's special education team with input from the parents and specifies the student's academic goals and the method to obtain these goals. The plan also identifies transition arrangements. The law expects school districts to bring together parents, students, general educators and special educators to make important educational decisions with consensus from the team for students with an IEP and those decisions will be reflected in the documentation.

INFORMED ASSENT[7]

Juveniles give assent, whereas adults give consent. Assent means compliance; 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 juveniles who have committed sexual offenses 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 means 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.

INFORMED SUPERVISION

Specific to these Standards, informed supervision is the ongoing, daily supervision of a juvenile who has committed a sexual offense by an adult who:

A. Is aware of the juvenile's history of sexually offending behavior

B. Does not deny or minimize the juvenile's responsibility for, or the seriousness of sexual offending

C. Can define all types of abusive behaviors and can recognize abusive behaviors in daily functioning

D. Is aware of the laws relevant to juvenile sexual behaviors

E. Is aware of the dynamic patterns (cycle) associated with abusive behaviors and is able to recognize such patterns in daily functioning

F. Understands the conditions of community supervision and treatment

G. Can design, implement and monitor safety plans for daily activities

H. Is able to hold the juvenile accountable for behavior

I. Has the skills to intervene in and interrupt high risk patterns

J. Can share accurate observations of daily functioning

K. Communicates regularly with members of the multidisciplinary team

[7] 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 juvenile who has committed a sexual offense and his/her parent/guardian. No attempt has been made to include full legal definitions of these terms.

INTERDISCIPLINARY TEAM (IDT)
A group of people convened by a community centered board (CCB) which shall include the person with a developmental/intellectual disability receiving services, the parent or 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.).

MASTURBATORY SATIATION
Repetition of masturbation paired with specific erotic cues until non-arousal to these cues is achieved.

MILIEU THERAPY
A residential or day treatment setting where employees interact with juveniles in a therapeutic manner regarding day-to-day living; may or may not include on-site sex offense specific treatment.

NEEDS
Issues to be addressed therapeutically or by specific intervention through the treatment and supervision plan.

ON-SITE TREATMENT
Treatment provided in a therapeutic milieu, residential or day-treatment setting which is specifically not an outpatient program.

OVERALL HEALTH
Consists of personal and ecological aspects of a juvenile's life including: physical, emotional, intellectual, social, relational, spiritual, educational and vocational aspects.

PARAPHILIAS
A psychosexual disorder in which the subject has recurrent, intense, sexually arousing fantasies, urges and/or thoughts that usually involve humans, but may also include non-human objects or animals.

POTENTIAL VICTIM
A vulnerable person whom the juvenile objectifies, fantasizes about and makes plans to harm. Animals have been harmed by juveniles who sexually offend and must be considered potential victims.

PROVIDER LIST
Roster of suppliers of specific services generated by the Sex Offender Management Board following the applicant's acceptance by the Application Review Committee.

RELAPSE PREVENTION
An element of treatment designed to address behaviors, thoughts, feelings and fantasies that were present in the juvenile's instant offense, abuse cycle and consequently, part of the relapse cycle. Relapse prevention is directly related to community safety. Risk assessment must be used to develop safety plans and determine level of supervision.

RECIDIVISM
Return to offending behavior after some period of abstinence or restraint. A term used in literature and research which may be measured by: re-offenses that are self-reported; convicted offenses; or, by other measures. The definition must be carefully identified especially when comparing recidivism rates as an outcome of specific therapeutic interventions.

SAFETY PLANNING
Recognition/acknowledgement of daily/circumstantial/dynamic risks; and purposeful planning of preventive interventions which the juvenile and/or others can use to moderate risk in current situations.

SECONDARY VICTIM
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 OFFENSE
The following definition is based on statute. For the purpose of this document, a sex offense is:

A. Sexual Assault;
B. Sexual Assault in the first, second or third degree as it existed prior to July 1, 2000;
C. Unlawful Sexual Contact;
D. Sexual Assault on a child;
E. Sexual Assault on a child by one in a position of trust;
F. Sexual Assault on a client by a psychotherapist;
G. Enticement of a child;
H. Incest;
I. Aggravated Incest;
J. Trafficking in children;
K. Sexual Exploitation of a child;
L. Procurement of a child for sexual exploitation;
M. Indecent Exposure;
N. Soliciting for child prostitution;
O. Pandering of a child;
P. Procurement of a child;
Q. Keeping a place of child prostitution;
R. Pimping of a child;
S. Inducement of child prostitution;
T. Patronizing a prostituted child, or;
U. Internet luring of a child;
V. Internet Sexual Exploitation of a child;
W. Criminal Attempt, Conspiracy, or Solicitation to commit any of the above offenses.

SEX OFFENSE SPECIFIC TREATMENT
A comprehensive set of planned therapeutic experiences and interventions to reduce the risk of further sexual offending and abusive behavior by the juvenile. Treatment focuses on the situations, thoughts, feelings and behaviors that have preceded and followed past offending (abusive cycles) and promotes changes in each area relevant to the risk of continued abusive, offending and/or sexually deviant behaviors. Due to the heterogeneity of the population of juveniles who commit sexual offenses, treatment is provided on the basis of individualized evaluation and assessment. Treatment is designed to stop sexual offending and abusive behavior, while increasing the juvenile's ability to function as a healthy, pro-social member of the community. Progress in treatment is measured by the achievement of change rather than the passage of time. Treatment may include adjunct therapies to address the unique needs of individual juveniles, yet always includes offense specific services by listed sex offense specific providers.

SEXUAL ABUSE CYCLE
A theoretical model of understanding the sequence of thoughts, feelings, behaviors and events within which sexual offending and abusive behavior occur. Also referred to as "offense cycle," or "offense chain."

SEXUAL PARAPHILIAS/SEXUAL DEVIANCE
Sexual paraphilias/sexual deviance means a sub-class 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.

Paraphiliac 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 acts" (DSM-IV-TR, pages 566-567).

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.

SOMB
SOMB means the Colorado Sex Offender Management Board.

SPECIAL POPULATIONS
Persons subjected to federally mandated protections and accommodations under the *Americans with Disabilities Act (1990), Section 504 of the Rehabilitation Act (1973) or* who were subjected to the *Education of all Handicapped Act (1975),* and all subsequent *Individuals with Disabilities Education Act (1990)* and *Individuals with Disabilities Education Act (2004)* are clearly identified as special populations according to these legislative guidelines.

STANDARD
Criteria set for usage or practices; a rule or basis of comparison in measuring or judging. Standards are identified by directive wording such as "shall," "must," or "will".

STATIC RISK FACTORS
For the purposes of these Standards, static risk factors refer to those characteristics that are set, are unchangeable by the juvenile and may be environmental, or based upon other observable or diagnosable factors.

SUPERVISING OFFICER/AGENT
A professional in the employ of the probation, parole or state/county department of human services who is the primary supervisor of the juvenile and who maintains the complete case record.

TERMINATION
Removal from or stopping sex offense specific treatment due to 1) completion; 2) lack of participation; 3) increased risk; 4) re-offense; or, 5) cessation of mandated sex offense specific treatment without completion (without accomplishing treatment goals).

THERAPEUTIC CARE
Intervention and nurturance, beyond normal parenting, which address treatment goals. Remediation of special needs and/or developmental/intellectual deficits identified in the individualized evaluation which focuses on increasing juveniles' potential and competencies for successful, normative functioning. Standards for therapeutic care apply to care in both in- and out-of-home living settings, yet such care may also be provided by parents who are active participants in the treatment process.

THERAPEUTIC CAREGIVERS
Responsible for implementing interventions to address goals to be accomplished in a therapeutic care setting.

THERAPEUTIC MILIEU
The setting in which caregivers provide therapeutic care in out-of-home, residential and day-treatment environments.

TRANSITION POINTS
Planned movement from one level of care to another.

VICTIM REPRESENTATIVE
A person who advocates for and/or brings the perspective of the victim to the multi-disciplinary team. This person acts in the best interest of the victim, gives a voice to the victim and ensures that the needs or concerns of the victim are being heard and addressed. The victim representative keeps the victim informed and involved in the supervision and management of the juvenile who has committed a sexual offense.

ABBREVIATIONS

- Child Placement Agency (CPA)
- Department of Human Services (DHS) – For the purpose of these Standards, DHS is generally intended as a reference to county departments.
- Division of Youth Corrections (DYC)
- Multidisciplinary Team (MDT)
- Sex Offender Management Board (SOMB)

1.000
PRESENTENCE INVESTIGATIONS OF JUVENILES WHO HAVE COMMITTED SEXUAL OFFENSES *December 2014*

1.100 Each juvenile 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, including those which statutorily allow for the waiver of the presentence investigation.

Discussion: The purpose of the presentence investigation is to provide the court with verified and relevant information which it may utilize in making sentencing decisions. The evaluation establishes a baseline of information about the juvenile's risk, protective factors, amenability to treatment and treatment needs.

1.110 The presentence investigation report, including the results of the sex offense specific evaluation, shall become part of the permanent record and complete case record and shall follow the juvenile throughout the time the juvenile is under the jurisdiction of the juvenile justice system.

1.200 In cases of adjudication, including plea agreements and deferred adjudications for a non-sexual offense, if the instant offense has an underlying factual basis of unlawful sexual behavior, the juvenile's case should be assigned to an investigating officer who has completed training specific to juvenile sexual offending.

Discussion: While it is preferable that charges and plea agreements reflect the sexual nature of the offense, some cases will proceed through the system without being identified primarily as a sexual offense. However, this does not eliminate the need for the juvenile to be evaluated on sexual offense information or the factual basis of the case.

1.300 Probation officers investigating juveniles during the presentence stage should have successfully completed recommended sex offense specific training (Section 5.140).

1.400 A presentence investigation (PSI) report shall address all the criteria pursuant to section 19-2-905, C.R.S.

1.500 Based on the information gathered, the presentence investigation report should make recommendations concerning a juvenile's amenability to treatment and suitability for community supervision.

1.600 When referring a juvenile for a sex offense specific evaluation, presentence investigators should send the following information to the evaluator, as part of the referral packet:[8]

A. Police reports

B. Victim Impact Statement

C. Child protection reports

D. Juvenile justice/criminal history

E. School records

F. Pertinent medical history

G. Relevant family history

H. Any available risk assessment materials

I. Prior evaluations and treatment reports (e.g. psychiatric and psychological)

J. Results from objective measurements, if available

K. Prior supervision records, when available

L. Any other information requested by the evaluator

1.700 Evaluations received by the presentence investigator that have been performed prior to an admission of guilt by the juvenile may not meet the requirements of these Standards.

It is the responsibility of the PSI writer to ensure all areas of information gathering and testing required by these Standards in Section 2.000 have been covered in such a way that the sex offense specific evaluation is comprehensive. The investigating officer must inform the court if an evaluation submitted to the court does not meet the SOMB Standards. The officer must then provide recommendations to resolve the outstanding issues so that the evaluation meets the requirements described in these Standards.

1.800 During the presentence investigation, the investigating officer should provide the juvenile and the parent/legal guardian(s) with a copy of the disclosure/advisement form, appropriate releases of information and request signatures on these forms.

[8] Marshall, W.L. (1999). Current Status of North American Assessment and Treatment Programs for Sexual Offenders. *Journal of Interpersonal Violence. 14(3)*, 221-239.

2.000
EVALUATION AND ONGOING ASSESSMENT OF JUVENILES WHO HAVE COMMITTED SEXUAL OFFENSES

December 2014

Evaluations are conducted to identify levels of risk and specific risk factors that require attention in treatment and supervision, and to assist the court in determining the most appropriate sentence for juveniles. Due to the importance of the information to subsequent sentencing, supervision, treatment and behavioral monitoring, each juvenile who has committed a sexual offense shall receive a thorough assessment and evaluation that examines the interaction of the juvenile's mental health, social/systemic functioning, family and environmental functioning, and offending behaviors. Sex offense specific evaluations are not intended to supplant more comprehensive psychological or neuropsychological evaluations. Evaluators have an ethical responsibility to conduct evaluations in a comprehensive and factual manner regardless of the juvenile's status within the criminal justice system.

DD/ID
Evaluators who provide evaluations to juveniles with developmental/intellectual disabilities who have committed sexual offenses shall be SOMB approved with a specialty in the evaluation of juveniles with a developmental/intellectual disabilities who have committed sexual offenses in accordance with the qualifications required pursuant to Standards, section 4.000 DD/ID.

2.100 The evaluation of juveniles who have committed sexual offenses shall be comprehensive.[9] Recommendations for intervention shall be included in the summary and the evaluation shall be provided in written form to the referring agent. The evaluation of juveniles who have committed sexual offenses has the following purposes:

A. To assess overall risk to the community;

B. To provide protection for victims and potential victims;

C. To provide written clinical assessment of a juvenile's strengths, risks and needs;

D. To identify and document treatment and developmental/cognitive needs;

E. To determine amenability for treatment;

F. To identify individual differences, potential barriers to treatment, and static and dynamic risk factors;

G. To make recommendations for the management and supervision of the juvenile;

H. To provide information which can help identify the type and intensity of community based treatment, or the need for a more restrictive setting.

Evaluation reports more than 6 months old should be regarded with caution.

[9] Quinsey, V.L., Harris, G.T., Rice, M.E., and Cormier, C.A. (1998). *Violent Offenders: Appraising and Managing Risk*. American Psychological Association, 55-72.

Discussion: Risk assessments are time limited.[10] *The assessment of risk by the MDT should be ongoing, and especially following significant social, environmental, familial, sexual, affective, physical, or psychological change. It should be noted that this does not necessarily require a comprehensive evaluation but rather an ongoing assessment by the MDT.*

2.200 Recommendations regarding intervention shall be based on a juvenile's level of risk and needs rather than on resources currently or locally available. When resources are less than optimal this information shall be documented and an alternative recommendation must be made.

2.210 There are two identified phases of evaluation and assessment. Evaluators shall comply with these Standards at each phase:

1. Pre-trial: Information and/or assessments compiled before an admission of guilt is considered the least reliable and incomplete. Evaluations conducted prior to an admission of guilt may not meet the requirements of the presentence investigation and may not meet the conditions of these *Standards*.

If the juvenile is admitting to the sexual behavior, there is an order of the court, or a voluntary request by the juvenile with the consent of the parent/guardian, evaluators may perform evaluations prior to, or in the absence of, filing of charges or adjudications. Such referrals for evaluation should be made only after the juvenile and parent/guardian have had the opportunity to consult with legal counsel concerning consequences, supervision and treatment expectations. Evaluations are an aid to the court and should focus on placement and treatment recommendations. It is not the role of the evaluator to establish innocence or guilt, or make a recommendation related to the legal disposition in a presentence evaluation. Recommendations should include the ideal level of supervision and placement and outline the options that are realistic and available.

Discussion: Law enforcement officers and human services caseworkers are called upon to make decisions concerning the placement of juveniles pending an investigation. The assessments made at this juncture should evaluate the level of risk posed by the juvenile by remaining in the home and in the community. Answers to the following questions inform decisions:

A. Is the victim(s) in the home?

B. What was the level of intrusiveness of the sexual behavior?

C. Did the juvenile use force, threats, intimidation, coercion, or weapons during the alleged offense?

D. Are the juvenile's parent/guardians minimizing or denying the seriousness of the alleged offense?

E. Can the parent/guardian be reasonably expected to provide supervision in the home and the community as outlined in the Informed Supervision Protocol, at minimum?

F. Does the juvenile have access to other vulnerable persons?

[10] Prentky, R. and Righthand, S. (2003). *The Juvenile Sex Offender Assessment Protocol II (J-SOAP II).*

G. What is the juvenile's history of delinquent or sexual offending behavior?

Discussion: It is important to note that for youth who deny involvement in the referring offense throughout the evaluation process, the following components will be incomplete: a sexual evaluation, assessment of risk, awareness of victim impact, external relapse prevention systems including informed supervision and amenability to treatment. Participation in a pre-plea evaluation does not preclude the juvenile's right for the process and results of the evaluation should not be used as a substitute for court proceedings.

2. Presentence and post-adjudication: (dangerousness/risk, placement and amenability to treatment) A comprehensive evaluation, performed by a listed evaluator, is mandated by these *Standards*, and shall be completed post-disposition and presentence. This evaluation shall determine the juvenile's strengths, risks, and needs related to areas addressed in Section 2.40 of these *Standards*.

2.300 The evaluator shall be sensitive to any cultural, language, ethnic, developmental, sexual orientation, gender, gender identification, medical and/or educational issues that may arise during the evaluation. The evaluator shall meet the requirements set forth in Section 4.000. Evaluators shall select evaluation procedures relevant to the individual circumstances of the case and commensurate with their level of training and expertise.

2.400 Each stage of an evaluation shall address strengths, risks and needs in the following areas:

A. Cognitive functioning;

B. Personality, mental disorders, mental health;

C. Social/developmental history;

D. Developmental competence;

E. Current individual functioning;

F. Current family functioning;

G. Sexual evaluation;

H. Delinquency and conduct/behavioral issues;

I. Assessment of risk;

J. Community risks and protective factors;

K. Awareness of victim impact;

L. External relapse prevention systems including informed supervision;

M. Amenability to treatment.

Evaluation methods may include the use of clinical procedures, screening level tests, observational data, advanced psychometric measurements and special testing measures.

Please see the areas of evaluation matrix contained in this section.

2.500 Evaluation methodologies shall include:

A. Examination of juvenile justice information and/or department of human services reports;

B. Details of the offense/factual basis and any victim statements including a description of harm done to the victim;

C. Examination of collateral information including information regarding the juvenile's history of sexual offending and/or abusive behavior;

D. A sex offense specific risk assessment protocol;

E. Use of multiple assessment instruments and techniques;

F. Structured clinical interviews including sexual history;

G. Integration of information from collateral sources;

H. Standardized psychological testing if clinically indicated.

2.500 DD/ID

A. Evaluators shall also address the level of functioning and neuropsychological concerns for juveniles with developmental/intellectual disabilities who have committed sexual offenses and make appropriate recommendations regarding treatment modality and any need for additional behavioral interventions or supervision requirements.

B. Evaluators shall recognize the need for multiple sessions in order to gain the above information when working with juveniles with developmental/intellectual disabilities who have committed a sexual offense.

2.600 Evaluation methodologies must include a combination of clinical procedures, screening level testing, self-report or observational measurements, advanced psychometric measures, specialized testing and measurement.

Due to of the complexity of evaluating juveniles who commit sexual offenses, methodologies should be guided by the following:

A. Use of instruments that have specific relevance to the evaluation of juveniles;

Discussion: Individuals that are charged as a juvenile and fall under the purview of these Standards should have juvenile offense-specific risk assessments, including re-assessments.

B. Use of instruments with demonstrated reliability and validity (when possible) which are supported by research in the mental health and juveniles who commit sexual offenses treatment fields.

2.600 DD/ID

Due to the complex issues of evaluating juveniles with developmental/intellectual disabilities who have committed a sexual offense, methodologies shall be applied individually and their administration shall be guided by the following:

A. When possible, instruments should be used that have relevance and demonstrated reliability and validity which are supported by research in the mental health and sex offender fields as they relate to persons with developmental/intellectual disabilities.

B. 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.

2.700 The evaluator shall obtain the consent of the parent/legal guardian and the informed assent of the juvenile for the evaluation and assessments in accordance with section 19-1-304, C.R.S. The juvenile and parent/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 juvenile and parent/guardian about the nature of the evaluator's relationship with the juvenile and with the court. The evaluator shall respect the juvenile's right to be fully informed about the evaluation procedures. Results of the evaluation may be reviewed with the juvenile and the parent/guardian upon request or as required by regulation.

The mandatory reporting law (section 19-3-304, C.R.S.) requires certain professionals to report suspected or known abuse or neglect to the local department of social services or law enforcement. Evaluators are statutorily mandated reporters.

2.700 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 as may be necessary to enhance understanding.

Discussion: When the evaluator is working with a juvenile with developmental/intellectual disabilities who has committed a sexual offense and obtaining informed assent, the evaluator (see Section 4.000) related to evaluator qualifications) should be familiar with characteristics of persons with developmental/intellectual disabilities such as cognitive functioning, communication style, mental health issues, vocabulary and language skills, or other significant limitations. If the evaluator feels 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 and the informed assent of the juvenile with developmental/intellectual 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 juvenile with developmental/intellectual disabilities and the legal guardian about the nature of the evaluator's relationship with the juvenile and the court. The evaluator shall respect the juvenile's right to be fully informed about the evaluation procedures. Results of the evaluation may be reviewed with the juvenile and the legal guardian upon request.

The mandatory reporting law (Section 19-3-304 C.R.S.) requires certain professionals to report suspected or known abuse or neglect to the local department of social services or law enforcement. Evaluators are statutorily mandated reporters.

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

2.800 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.

2.900 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.

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*. Evaluators shall include a statement to each completed evaluation as to whether the evaluation is fully compliant with SOMB *Standards* or not.

Sex Offense Specific Evaluation of Juveniles

I. Cognitive Functioning

Evaluation Areas – Required	Possible Evaluation Procedures
▪ Intellectual Functioning Mental retardation, learning disabilities, literacy, adaptive functioning	Cognitive Abilities Scales Clinical Interview Case File/Document Review Collateral Contact/Interview Clinical Mental Status Exam Differential Ability Scales Observational Assessment WISC-III WAIS-III Slosson Intelligence Test – Revised Slosson Full Range Intelligence Test Kaufman Brief Intelligence Test Shipley Institute of Living Scale Universal Nonverbal Intelligence Test Woodcock-Johnson Psychoeducational Battery-Revised Woodcock-Johnson III Woodcock-Munoz Psychoeducational Bateria Bilingual Verbal Abilities Test
▪ Neuropsychological Screening	Clinical Interview Case File/Document Review Collateral Contact/Interview Clinical Mental Status Exam Observational Assessment Neurobehavioral Cognitive Status Examination (Cognistat) Kaufman Short Neuropsychological Assessment Procedure Wisconsin Card Sorting Test Bender Gesalt Visual Motor Test Boston Naming Test Boston Diagnostic Aphasia Exam Neuropsychological Evaluation NEPSY NEUROPSI (Brief Neuropsychological Evaluation in Spanish) Learning Disabilities Diagnostic Inventory
▪ Educational History Memory and learning abilities	Clinical Interview Case File/Document Review Collateral Contact/Interview Clinical Mental Status Exam Observational Assessment History of Academic Achievement and Functioning Test of Memory and Learning Wide Range Assessment of Memory and Learning Wide Range Achievement Test – 3rd Edition Weschler Individual Achievement Test Woodcock Johnson Academic Achievement Woodcock-Munoz Psychoeducational Bateria (Spanish) Weschler Memory Scales for Children Weschler Memory Scales Woodcock Reading Mastery Tests – Revised Strong-Cambell Holland Interest Inventory Self-Directed Search Woodcock-Munoz Academic Achievement Battery (Spanish) Kaufman Functional Academic Skills Test Mini-Battery of Achievement Kaufman Test of Academic Achievement Peabody Individual Achievement Test- Revised IQ Screener (Stanford-Binet)

II. Overall Functioning, Personality, Mental Disorders and Mental Health	
Evaluation Areas – Required	Possible Evaluation Procedures
▪ General/Overall Functioning	Clinical Interview Case File/Document Review Collateral Contact/Interview Clinical Mental Status Exam Observational Assessment
▪ Mental Health Psychopathology, Psychiatric illness ▪ Personality Traits Assets and Strengths ▪ Mental Disorders Co-occurring	Clinical Interview Case File/Document Review Collateral Contact/Interview Clinical Mental Status Exam Observational Assessment (BPRS) Brief Psychiatric Rating Scale (PANSS) Positive and Negative Syndrome Scales MMPI-A MMPI – 2 MACI (Millon Adolescent Clinical Inventory) MAPI (Millon Adolescent PersonalityInventory) MCMI – III Rorschach Inkblot Test Beck Depression Inventory SCAN: A, SCAN:C FRIEF, WCST, Tower of London Reynolds Adolescent Depression Scale, 2nd Ed. Revised Children's Manifest Anxiety Scale, 2nd Ed. Trauma Symptom Checklist for Children (TSCC)
Evaluation Areas – Required	Possible Evaluation Procedures
▪ Social History History of delinquency (known and unknown) History of mental illness/ suicide/ psychiatric involvement (individual and family) Criminal history/ incarceration (individual and family) Social history History of psychiatric diagnosis	Clinical Interview Case File/Document Review Collateral Contact/Interview Clinical Mental Status Exam Observational Assessment Behavior Assessment for Children Child Behavior Checklist (Teacher Report Form, Youth Self-Report) Survey Instrument III Sentence Completion Series BDI-II (Beck Depression Inventory-II)
▪ Developmental History Developmental milestones History of abuse Disruptions in care Placement/transition history History of family structure History of counseling and intervention History of Social Services involvement Drug/Alcohol history Education history	Clinical Interview Case File/Document Review Collateral Contact/Interview Clinical Mental Status Exam Observational Assessment MMPI – A (also in Spanish) MMPI – 2 (also in Spanish) MACI (Millon Adolescent Clinical Inventory) MAPI (Millon Adolescent Personality Inventory) MCMI – III MAYSI Screen (with Spanish translation) CARS (Autism rating scale) Gilliam Autism Rating Scales Sentence Completion Series Thematic Apperception Test SCL-90-R (The Sympton Checklist 90-Revised) Rorschach Inkblot Test Sexual Projective Card Sort Vineland (severity of developmental/adaptive functioning, also in Spanish) Scales of Independent Behavior

III.Developmental Competence

Evaluation Areas – Required	Possible Evaluation Procedures
▪ Daily Living Skills ▪ Socialization ▪ Communication ▪ Motor Skills ▪ Resiliency ▪ Self-Esteem/Self-Concept ▪ Self-Mastery/Self-Competence	Clinical Interview Case File/Document Review Collateral Contact/Interview Individualized Education Program (IEP) Observational Assessment Vineland (adaptive functioning) Scales of Independent Behavior Learning Disabilities Diagnostic Inventory Test of Learning and Memory Vineland Scales of Independent Behavior WISC-IV WAIS–IV BASC-2 Woodcock-Johnson Psycho Educational Battery-Revised Shipley-II

IV. Current Functioning – Individual

Evaluation Areas – Required	Possible Evaluation Procedures
▪ Current Mental Status Stress/coping strategies Engagement of Sexual Deviance (cycle, fantasies) ▪ Current level of denial (offense, risk, history) ▪ Stability in Current Living Situation Academic/vocational stability ▪ Communication/Problem Solving Skills Support group Acting out behaviors ▪ Cognitive Disorders ▪ Diagnostic Impressions	Clinical Interview Case File/Document Review Collateral Contact/Interview Observational Assessment

V. Current Functioning – Family

Evaluation Areas – Required	Possible Evaluation Procedures
▪ Current Family Composition History of divorce/separation Current mental illness ▪ Drug / Alcohol Use ▪ Cultural Issues ▪ Domestic Violence Issues	Family Interview Case File/Document Review Collateral Contact/Interview Family Observation Clinical Assessment of Family Functioning MACI Scale F (Family Discord) Family History Family Genogram Maddock and Larson Incestuous Family Typology Ryan – Family Typology for Sexually Abusive Youth Beaver – Timberlawn Family Evaluation Scale McMaster Family Assessment Device FACES II Family Circumplex Revised Family Environment Scale (RFES) Family Origin Scale (FOS) Fam III, SIPA Relationship Questionnaire

VI. Sexual Evaluation

Evaluation Areas – Required	Possible Evaluation Procedures
▪ Sex History Sexual knowledge (where learned) Sex education history Non-offending sexual history Masturbation (age of onset, frequency, fantasies) Sexual compulsivity/ impulsivity Sexual victimization Range of sexual behaviors Sexual arousal/interest Sexual preference/ orientation Sexual dysfunctions Sexual attitudes/distortions (hyper-masculinity) ▪ Sexually Abusive Behavior Types of sexually abusive behavior the youth has committed Indications of progression over time Level of aggression Frequency of behavior Style and type of victim access Preferred victim type Associated arousal patterns Changes in sexual abuse behaviors or related thinking The youth's intent and motivation The extent of the youth's openness and honesty Internal and external risk factors Victim empathy Victim selection characteristics/typology (diagnosis)	Clinical Interview Case File/Document Review Child Sexual Behavior Inventory Callateral Contact/Interview Clinical Mental Status Exam Observational Assessment SONE Sexual History Behavior Assessment Scales for Children Penile Plethysmograph VRT Assessment Hanson Sexual Attitude Questionnaires Wilson Sex Fantasy Questionnaire Sexual Projective Card Sort Abel & Becker Adolescent Interest Card Sort Sexual History Polygraph: Section 7 PHASE Sexual Attitudes Questionnaire Bumby Cognitive Distortions Scale Streetwise to Sexwise (sexuality education assessment) Adolescent Cognitions Scale Multiphasic Sexual Inventory-II Juvenile (MSI II-J) The Math Tech Sex Test The Adolescent Modus Operandi Questionnaire SO-ISB The Adolescent Sexual Interest Card Sort

VII. Delinquency and Conduct Problems

Evaluation Areas – Required	Possible Evaluation Procedures
▪ Driving ▪ Adjudications ▪ Offenses Non-charged offenses Property offenses	Clinical Interview Case File/Document Review Collateral Contact/Interview Observational Assessment Conners Rating Scales (ADHD) Polygraph Monitoring State-Trait Anger Inventory State-Trait Anxiety Inventory (SASSI-III) Substance Abuse Screening ACTers ADD Rating Scale PCL-SV (Psychopathy Checklist – Screening Version PCL-R (Psychopathy Checklist – Revised) Jesness Inventory Washington State Juvenile Court Risk Assessment/Colorado Juvenile Risk Assessment Instrument Youth Level of Service/Case Management Inventory Child Behavior Checklist

VIII. Assessment of Risk	
Evaluation Areas – Required	Possible Evaluation Procedures
▪ Risk to Self Denial of offense/risk/history ▪ Risk to Others (Violent) Conduct ▪ Criminal Behavior Risk for Sexual Recidivism	Ross & Loss Risk Assessment Interview Protocol For Adolescent Sexual OffendersProtective Factors Scale MMPI-A (scales 4,9) MMPI-2 (scales 4,9) MACI – scales 6a/6b (unruly/forceful) MCMI-III(scales 6a,6b) Violence Risk Assessment Guide/Sex Offender Risk Assessment Guide (normed on adults, some content maybe applicable to juveniles) Sexual Offense Risk Assessment Guide (SORAG) Estimate of Risk of Adolescent Sex Offender Recidivism (ERASOR) Juvenile Sex Offender Assessment Procedure-II (J-SOAP-II) Juvenile Sexual Offense Recidivism Assessment Tool-11 (JSORRAT-II) Multidimensional Inventory of Development, Sex, and Aggression (MIDSA) Multiplex Empirically Guided Inventory of Ecological Aggregates for Assessing Sexually Abusive Adolescents and Children (MEGA) JSO Intake Risk Assessment Juvenile Risk Assessment Tool (J-RAT) Risk Assessment checklist (short and long term risk) Risk Assessment Matrix (RAM) PCL-SV (Psychopathy Checklist – Screening Version more appropriate for juveniles than revised version--normed on adults) PCL-R (Psychopathy Checklist - Revised) Clinical Assessment of Risk for Reoffense (phenomenological factors) Child Sexual Behavior Inventory MACI – scales GG (suicidal ideation) Structured Clinical Assessment of Suicide Risk Suicide Risk Checklist
▪ Native Environment ▪ Current Living Situation ▪ Current Support Group/Resources Friends/associates Extra-curricular activities	Clinical Interview Case File/Document Review Collateral Contact/Interview Observational Assessment Protective Factors Scale CASPARS
▪ Awareness, Internalization of Own Behavior Against Others ▪ Attribution of Responsibility	Victim Impact Statement Collateral information submitted by victim(s) or secondary victim(s) (in some cases)
▪ External Support ▪ Long Range Planning	Review plan submitted by Informed Supervisors and Supervising Officer/Agent
▪ Readiness for Services ▪ Attribution of Responsibility	Clinical Interview Family Interview MSI II-J Ross & Loss Risk Assessment Treatment Progress Inventory for Adolescents Who Sexually Abuse (TPI-ASA)

3.000
STANDARDS OF PRACTICE FOR TREATMENT PROVIDERS
December 2014

3.100 Sex offense specific treatment for juveniles who have committed sexual offenses shall be provided by persons (hereafter referred to as providers or listed providers) meeting qualifications described in Section 4.000 of these Standards.

3.100 DD/ID

Juveniles with developmental/intellectual disabilities who have committed sexual offenses shall receive treatment from an Associate Level and/or Full Operating Level treatment provider and evaluator who demonstrates compliance with and submits an application attesting to having met all requirements identified as Developmental/Intellectual Disability (DD/ID) Standards in this section.

3.120 Providers treating juveniles adjudicated for a sex offense, who are placed on probation, committed to the Department of Human Services, placed on parole, or who are placed in out-of-home placement for a sexual offense, shall provide sex offense specific treatment and care as described in these Standards and Guidelines.

Juveniles who receive deferred adjudications on or after July 1, 2002 for an offense that would constitute a sex offense if committed by an adult or for any offense in which the underlying factual basis involves a sexual offense are subject to these Standards (section 16-11.7-102, C.R.S.).

Discussion: It is also recommended that these Standards and Guidelines be utilized with juveniles and families who are voluntarily seeking intervention regarding sexually abusive behavior. Following a comprehensive evaluation, juveniles who have been adjudicated for non-sexual offenses, placed on diversion or those who are the subject of a dependency and neglect order may be included in the same programs as those developed for juveniles adjudicated for sexual offending behavior.

3.130 The content of sex offense specific treatment shall focus on decreasing deviance and dysfunction and improving overall health with the goal of decreased risk. Treatment planning shall be formulated to set measurable outcomes:

A. Treatment providers shall consider the following treatment content areas for appropriateness based on the individual and ecological needs of the juvenile and discuss them with the MDT, and include applicable content in the treatment plan:

1. Awareness of victim impact, in general for victims of sexual assault and also primarily for the specific victim of the offense(s), without objectification or stereotyping of the victim(s).

2. Recognition of, the past, present, and potential ongoing impact and harm done to any victim(s) of this juvenile.

3. Impact of the juveniles sexual offending behaviors on families, community and self.

4. Restitution/reparation for victims (including victim clarification work) and others impacted by the offense including the community**.**

5. Utilize techniques that assist the juvenile in understanding what the victim's past, present, and ongoing experiences may be from a perspective that is not their own.

6. Ability to define abusive behaviors: abuse of self, others, property, and/or physical, sexual and verbal abuse.

7. Acceptance of responsibility for offending and abusive behaviors.

   Discussion: Acceptance of responsibility for sexual offending and abusive behavior is a critical component of treatment for juveniles who have committed sexual offenses. Treatment providers should strongly consider the information in this discussion point before deciding if a juvenile has successfully completed treatment.

   Sexual offending behavior often includes secrecy, denial, and defensiveness. Juveniles present with different levels of accountability and can fluctuate in their level of accountability and display minimization and blame others, including the victim, for their offending behavior.

   It is important to support victim recovery and community safety by addressing these issues with juveniles. Denial can interfere with treatment engagement and progress, and disengagement from treatment or treatment failure threatens community safety. Denial is typically highly distressing and emotionally damaging to victims.

   The appropriate identification of the victim and the juvenile is a necessary condition for victim recovery. Victim recovery is enhanced when the juvenile is accountable for sexual offending behavior, allowing the victim to focus on how they were victimized.

8. Identification of dynamic patterns of thoughts, feelings and behaviors associated with offending and abusive behaviors.

9. Identification of cognitions supportive of antisocial or violence themed attitudes.

10. The role of sexual interest or arousal in sexual offending or abusive behaviors; definition of non-offensive and non-abusive sexual fantasy; reduction and disruption of deviant sexual thoughts and arousal, when indicated.

    Discussion: Plethysmography is a specialized form of assessment used in treatment with individuals who have committed sexual offenses. Penile plethysmography involves measuring changes in penile circumference and volume in response to sexual or nonsexual stimuli. Plethysmograph testing provides objective information about male sexual arousal and is therefore useful for identifying deviant sexual interests during an evaluation, increasing client disclosure, and measuring changes in sexual arousal patterns over the course of treatment (ATSA, Practice Standards and Guidelines, 2005).

    Visual Reaction Time (i.e., VRT) is a specialized form of assessment used in the treatment of individuals who have committed sexual offenses. VRT is used as a measure of sexual

interest and correlates significantly with self-reported sexual interests and congruent patterns of phallometric responding among non-offending subjects (ATSA, Practice Standards and Guidelines, 2005). Refer to Appendix D for further information related to Plethysmography and VRT.

11. Disinhibiting influences such as stress, substance use, impulsivity, and peer influence.

12. Anger management, conflict resolution, problem solving, stress management, frustration tolerance, delayed gratification, cooperation, negotiation and compromise.

13. Recognition and management of risk factors.

14. Skills for safety planning, risk management, and risk reduction.

15. Identification of physical health and safety needs.

16. Accurate information about healthy sexuality, positive sexual identity, and healthy relationships.

17. Developmental/Intellectual deficits, delays, and skills for successful functioning.

18. Relationship skills such as assessment of personal trustworthiness, basic trust of others, and self-worth.

19. Locus of control, i.e. internal sense of mastery, control, and competency.

20. Family dysfunction and/or deviance including intimacy and boundaries, attachment disorders, role reversals, sibling relationships, criminality, and psychiatric disorders.

21. Recognition of how attitudes of family, peer group, community and culture influence tolerance of offending/abusive behavior.

22. Experiences of victimization, trauma, maltreatment, loss, abandonment, neglect, and exposure to violence in the home or community.

23. Legal parameters and consequences relevant to sexual offending.

24. Diagnostic assessment, stabilization, pharmacological treatments and management of concurrent psychiatric disorders.

B. The treatment plan shall be reviewed at a minimum of every three months and at each transition point. Revisions shall be made as needed.

3.130 DD/ID

A. For juveniles with developmental/intellectual disabilities who have committed sexual offenses, it is imperative to consider the cognitive levels, social capabilities, family involvement and environmental factors in order to provide the most appropriate treatment.

B. Treatment and goals should be written in a way that is simplified, based on the cognitive level. Goals should be reasonable and clear. Objectives should be based on the juvenile's cognitive level, learning style and needs and may not include all of the above objectives. Progress towards these objectives can be measured by the MDT.

3.140 Sex offense specific treatment methods and intervention strategies shall be based on the individual treatment plan that has been developed by the multidisciplinary team, in response to the individual evaluation and ongoing assessments. A combination of individual, group and family therapy shall be used unless contraindicated.[11,12,13,14,15]

When the multidisciplinary team determines a specific type of intervention is contraindicated, the issue(s) shall be documented and alternative interventions shall be listed.

If and when the contraindicators change and the intervention is viable, the treatment plan shall be amended accordingly.

Treatment Modalities:

A. Group therapy promotes development of pro-social skills, provides positive peer support and/or is used for group process (Provider: Client ratios shall be no less than 1:8; 2:12).

1. Treatment providers must monitor and control groups to minimize exposure to deviance, deviant peer modeling and to provide for the safety of all group members.

2. Co-therapy is always recommended.[16]

3. Male and female co-therapists are preferred.[17]

Discussion: Juveniles who commit sexual offenses present a complex set of challenges for group facilitators. Not only are the dynamics multifaceted, the safety of group members is

[11] Sirles, E.A., Araji, S.K.,Bosek, R.L.(1997). Redirecting Children's Sexually Abusive and Sexually Aggressive Behaviors: Programs & Practices. *Sexually Aggressive Children,* S.K. Araji (ed). Thousand Oaks: Sage. Pp.161-192.

[12] National Adolescent Perpetrator Network (1993). The Revised Report from the National Task Force on Juvenile Sex Offending. *Juvenile and Family Court Journal. 44(4*),1-120.

[13]Bernet, W., Dulcan, M.K.(1999).Practice Parameters for the Assessment and Treatment of Children and Adolescents who are Sexually Abusive of Others. *Journal of the American Academy of Child and Adolescent Psychiatry, 38(12)*,55S-76S.

[14] Marshall, W.L., & Barbaree, H.E.(1990). Outcome of Comprehensive Cognitive-Behavioral Treatment Programs. In *Handbook of Sexual Assault: Issues, Theories & Treatment of the Offender*, W.L. Marshall, D.R. Laws, H.E. Barbaree (Eds.) New York, New York: Plenum Press, pp 363-385.

[15] Miner, M.H., & Crimmins, C.L. (1997). Adolescent Sex Offenders -- Issues of Etiology and Risk Factors. *The Sex Offender: New Insights, Treatment Innovations, and Legal Developments Vol II,* B.K. Schwartz & H.R. Cellini (Eds.) Kingston, New jersey: Civic Research Institute.

[16] Marshall, W.L., & Barbaree, H.E. (1990). Outcome of Comprehensive Cognitive-Behavioral Treatment Programs. *Handbook of Sexual Assault: Issues, Theories & Treatment of the Offender*, W.L. Marshall, D.R. Laws, H.E. Barbaree (Eds.) New York, New York: Plenum Press, pp 363-385.

[17] Marshall, W.L., & Barbaree, H.E. (1990). Outcome of Comprehensive Cognitive-Behavioral Treatment Programs. Handbook of Sexual Assault: Issues, Theories & Treatment of the Offender, W.L. Marshall, D.R. Laws, H.E. Barbaree (Eds.) New York, New York: Plenum Press, pp 363-385.

of concern. The intensity of these groups requires a strong team approach; therefore, staff to client ratios may be higher than in other types of groups. It is understood that occasional illness or absence of co-providers may affect ratios.

B. Individual therapy is used to address identified individual treatment needs and/or to support the juvenile in addressing issues in group, family or milieu therapy. For those juveniles who are not appropriate for group therapy, as determined by the treatment provider, in consultation with the Multi-Disciplinary Team (MDT), individual therapy may be utilized to address sex-offense specific treatment goals.

C. Family therapy addresses family systems issues and dynamics. This model shall address, at a minimum, informed supervision, therapeutic care, safety plans, relapse prevention, reunification and aftercare plans (Provider: Client ratios shall be no less than 1:8; 2:12).[18]

D. Multi-family groups provide education, group process and/or support for the parent and/or siblings of the juvenile. Inclusion of the juvenile is optional. The treatment provider monitors and supervises confidentiality (Standard 3.200). Staff to client ratios shall be designed to provide safety for all participants (Provider: Client ratios shall be no less than 1:8; 2:15; 3:16+).

E. Clarification sessions shall occur as prescribed in Section 8.000 of these Standards.

Discussion: Clarification work (i.e., letters, practice sessions with therapist, group work, etc.) should occur in all cases based on the developmental level of the juvenile. Clarification sessions with the victim(s) should only occur at the request of the victim(s).

F. Dyadic therapy.

G. Psycho-education is used for teaching definitions, concepts and skills (Provider: Client ratios shall be no less than 1:12; 2:20).

H. Milieu therapy is used to promote growth, development and relationship skills; to practice pro-social life skills; and to supervise, observe and intervene in the daily functioning of the juvenile. A combination of male and female role models are preferred in staffing milieus.

3.140 DD/ID

Group therapy may not always be available and/or appropriate for juveniles with developmental/intellectual disabilities who have committed sexual offenses. If group therapy is utilized, it is imperative to match the juvenile with other individuals that are similar in cognitive levels. Treatment modalities should be assessed by the MDT:

A. When the multidisciplinary team determines a specific type of intervention is contraindicated, the issue(s) shall be documented and alternative interventions shall be listed.

B. If and when the contraindicators change and the modality is viable, the treatment plan shall be amended accordingly.

[18] Borduin, C.M., Henggeler, S.W., Blaske, D.M., Stein, R.J. (1990). Multisystemic Treatment of Adolescent Sexual Offenders. International Journal of Offender Therapy & Comparative Criminology, 34(2).

C. Due to the intensive needs of juveniles with developmental/intellectual disabilities who have committed sexual offenses, the client ratio should be considered based on the needs of the juvenile and not to exceed 1:6:

1. Treatment providers must monitor and control groups to minimize exposure to deviance, deviant peer modeling and to provide for the safety of all group members.

2. Co-therapy is always recommended.[19]

3. Male and female co-therapists are preferred.[20]

3.141 The primary treatment provider and the multidisciplinary team shall make referrals for individual, family therapy or other adjunct services.

Therapists chosen by the multidisciplinary team to provide individual and/or family therapy are not required to be listed providers with the Sex Offender Management Board. They must have a level of experience and knowledge of juvenile sexual offense dynamics (as determined by the multidisciplinary team) to adequately provide services.

The Board is aware of a variety of factors that may contribute to difficulties for providers and programs to come into compliance with these Standards. It is expected that all individuals and agencies who make referrals and who provide services make a concerted effort to work within these Standards and Guidelines.

When a referring agent or provider has exhausted local options to come into compliance that person or entity shall provide to the Sex Offender Management Board documentation of the juvenile's needs, the circumstances that prevent compliance and the alternative solution.

3.150 Sex offense specific treatment shall be designed to maximize measurable outcomes relevant to the dynamic functioning of the juvenile in the present and future by:

A. Decreasing risk of sexual and non-sexual deviance, dysfunction and offending.

<u>Outcomes</u> relevant to decreased risk include (but are not limited to):

1. Juvenile consistently defines all types of abuse (self, others, property).

2. Juvenile acknowledges risks and uses foresight and safety planning to moderate risk.[21]

[19] Marshall, W.L., & Barbaree, H.E. (1990). Outcome of Comprehensive Cognitive-Behavioral Treatment Programs. *Handbook of Sexual Assault: Issues, Theories & Treatment of the Offender*, W.L. Marshall, D.R. Laws, H.E. Barbaree (Eds.) New York, New York: Plenum Press, pp 363-385.

[20] Marshall, W.L., & Barbaree, H.E. (1990). Outcome of Comprehensive Cognitive-Behavioral Treatment Programs. *Handbook of Sexual Assault: Issues, Theories & Treatment of the Offender,* W.L. Marshall, D.R. Laws, H.E. Barbaree (Eds.) New York, New York: Plenum Press, pp 363-385.

[21] Hanson, K.R., Harris, A. (1998-2001). *Dynamic Predictors of Sexual Recidivism*. Department of the Solicitor General Canada. http://www.sgc.gc.ca/epub/corr/e199801b/e19980lb.htm.

3. Juvenile consistently recognizes and interrupts patterns of thought and/or behavior associated with his/her abusive behavior (dynamic patterns).

4. Juvenile consistently demonstrates emotional recognition, expression and empathic responses to self and others (empathy).

5. Juvenile demonstrates functional coping patterns when stressed.[22]

6. Juvenile accepts responsibility for offending and abusive behavior.

7. Juvenile has demonstrated the ability to manage frustration and unfavorable events, anger management and self-protection skills.

B. Improving overall health, strengths, skills and resources relevant to successful functioning.

<u>Outcomes</u> relevant to increased overall health include (but are not limited to):

1. Juvenile demonstrates pro-social relationship skills and is able to establish closeness, trust and assess trustworthiness of others.

2. Juvenile has improved/positive self-image and is able to be separate, independent and self-advocate.

3. Juvenile is able to resolve conflicts and make decisions; is assertive, tolerant, forgiving, cooperative and is able to negotiate and compromise.

4. Juvenile is able to relax, play and is able to celebrate positive experiences.

5. Juvenile seeks out and maintains pro-social peers.

6. Juvenile has the ability to plan for and participate in structured pro-social activities.

7. Juvenile has identified family and/or community support systems.

8. Juvenile is willing to work to achieve delayed gratification; persists in pursuit of goals; respects authority and limits and supports pro-social attitudes.

9. Juvenile is able to think and communicate effectively; demonstrates rational cognitive processing, adequate verbal skills, and is able to concentrate at a level commensurate with his/her developmental level.

10. Juvenile has an adaptive sense of purpose and future.

3.151 Providers, in conjunction with the multidisciplinary team (MDT), shall develop and update written individualized treatment plans based on the evaluation and ongoing assessment of the juvenile.

[22] Cortoni, F., & Marshall, W.L. (2001). Sex as a Coping Strategy and it's Relationship to Juvenile Sexual History and Intimacy in Sexual Offenders. *Sexual Abuse: A Journal of Research and Treatment, 13(1).*

The individual treatment plan (ITP) serves an important role in the therapy process and shall be updated and amended, as needed, throughout treatment. The ITP serves as a guide for the juvenile to navigate the change process and have a clear understanding of what he/she is expected to complete throughout the course of treatment. The ITP shall be written in a format that allows the juvenile to assess his/her level of progress toward meeting treatment goals throughout therapy.

The ITP shall be written with clearly identified goals (action to be accomplished) and objectives (incremental steps to help the juvenile accomplish the goal). The objectives shall be written based on the juvenile's developmental abilities and shall be set in small increments to help the juvenile gain a sense of success.

The ITP is a tool for the juvenile and shall therefore be written in language the juvenile can understand and shall be modified based on the juvenile's reaching treatment goals or lack thereof.

Treatment plans shall:

A. Protect past and potential victims from unsafe and unwanted contact with the juvenile.

B. Include input from the victim or victim representative to enhance victim impact, victim empathy, and victim clarification goals.

C. Be designed to address strengths, risks, and needs in areas identified by the evaluation (described in section 2.00).

D. Incorporate all identified treatment content areas, as appropriate.

E. Contain clearly stated goals, objectives, and interventions that are individualized and measurable.

F. Utilize strength-based principles to increase protective factors and decrease risk.

G. Address family functioning and enhance the abilities of support systems to respond to the juvenile's needs and concerns.

H. Favor consistency in caregiver relationships.

I. Be reviewed and signed by the juvenile, the provider, the provider's supervisor (when applicable), and the parent or guardian.

J. Be reviewed at a minimum of every three months and at each transition point, and revised as needed.

3.152 Sex offense specific treatment providers shall continue to advocate for treatment until the outcomes in the individual treatment plan have been achieved.

3.160 Sex offense specific treatment providers shall maintain client files in accordance with the professional standards of their individual disciplines and with Colorado state law on health care records.

3.170 Client files shall include, but are not limited to:

A. Evaluations

B. Assessments

C. Presentence investigations

D. Treatment plans

E. Treatment plan reviews

F. Treatment notes

G. Monthly Progress reports

H. Documentation of clarification assignments and progress

I. Critical incidents occurring during treatment

J. Impediments to success and/or lack of resources and systemic response to the issue

K. Discharge summary (upon discharge from treatment)

3.200 Confidentiality

The juvenile who has committed a sexual offense or the person who holds the legal privilege shall sign appropriate releases of information for the exchange and disclosure of information to other members of the multi-disciplinary team (MDT) for the purposes of evaluation, treatment, supervision, and case management. This release of information shall be based on complete informed consent of the parent/legal guardian and voluntary assent of the juvenile. The juvenile and parent/legal guardian shall be fully informed of alternative dispositions that may occur in the absence of consent/assent.

Effective supervision and treatment of juveniles who have sexually offended is dependent upon open communication among the multidisciplinary team members.

3.210 Providers shall notify all clients of the limits of confidentiality imposed by the mandatory reporting law, section 19-3-304, C.R.S.

3.220 Providers shall inform all persons participating in any group that participants shall respect the privacy of other members and shall agree to maintain confidentiality regarding shared information and the identity of those in attendance.

3.300 Treatment Provider--Juvenile Contracts and Advisements

Discussion: The purpose of treatment contracts and advisements is to convey information to the juvenile and the parent/guardian regarding treatment program expectations and policies. Treatment contracts and advisements may also take the form of acknowledgements, agreements, or disclosures. Issues such as the juvenile's developmental stage, level of cognitive functioning

and the purpose of the document should be taken into account. These documents may be useful with juveniles to foster accountability and responsibility.

3.310 Providers shall develop and utilize a written treatment contract/advisement with each juvenile who has committed a sexual offense prior to the commencement of treatment. Treatment contracts and advisements shall address public safety and shall be consistent with the conditions of the supervising agency. The treatment contract/advisement shall define the specific responsibilities and rights of the provider, and shall be signed by the provider, parent/guardian(s) and the juvenile:

A. At a minimum, the treatment contract/advisement shall explain the responsibility of a provider to:

1. Define and provide timely statements of the costs of evaluation, assessment and treatment, including all medical and psychological testing, physiological tests, and consultations for which he/she is responsible.

2. Describe the appropriate releases of information, describe the various parties, including the multidisciplinary team, with whom treatment information will be shared during the course of treatment; and inform the juvenile and parent/guardian that information may be shared with additional parties when appropriate releases of information are signed.

3. Describe the right of the juvenile or the parent/legal guardian(s) to refuse treatment and/or to refuse to sign appropriate releases of information, and describe the risks and the potential outcomes of that decision.

4. Describe the relevant time limits and procedure necessary for the juvenile or the parent/legal guardian(s) to revoke the appropriate release of information.

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

6. Describe the limits of confidentiality imposed on providers by the mandatory reporting law, section 19-3-304, C.R.S.

B. At a minimum, the treatment contract/advisement shall explain the responsibilities of the juvenile and his/her parent/guardian(s) and shall include but is not limited to:

1. Compliance with the limitations and restrictions placed on the behavior of the juvenile as described in the terms and conditions of diversion, probation, parole, Department of Human Services, community corrections or the Department of Corrections, and/or in the agreement between the provider and the juvenile.

2. Compliance with expectations that provide for the protection of past and potential victims from unsafe and unwanted contact with the juvenile.

3. Participation in treatment.

4. Payment for the costs of assessment and treatment of the juvenile and family for which he/she is responsible.

5. Notification of third parties (i.e. employers, partners, etc.) as directed by the multidisciplinary team.

6. Notification of the treatment provider of any relevant changes or events in the life of the juvenile or the juvenile's family/support system.

3.400 Completion or Discharge of Sex Offense Specific Treatment

When a treatment provider is considering making a recommendation to the MDT for completion or discharge from sex offense specific treatment, the following factors shall be considered:

A. The most recent sex offense specific evaluation recommendations

B. The individualized treatment plan and progress on each goal

C. Ongoing risk assessment

D. Collateral information from all sources of information

E. Document all of the above in preparation for a meeting with the MDT

3.410 The treatment provider shall consult with the MDT regarding completion or discharge from treatment. The following options shall be considered:

A. Successful completion of sex offenses specific treatment.

Successful completion of treatment should be understood as the cessation of mandated sex offense specific treatment. It may not be an indication of the end of the juvenile's management needs or the elimination of risk to the community. The multidisciplinary team shall carefully consider victim and community safety before making a determination of completion of treatment. Successful completion of sex offense specific treatment requires the following:

1. Accomplishment of the goals and outcomes identified in the individualized treatment plan.

   Discussion: The individualized treatment plan shall be constructed based upon the juvenile's unique needs, risks, protective factors, and developmental level and ability. Concurrent goals and outcomes should be realistic for a given juvenile (See Standard 3.130DD/ID).

2. Demonstrated application in the juvenile's daily functioning of the principles and tools learned in sex offense specific treatment.

3. Consistent compliance with treatment conditions.

4. Consistent compliance with supervision terms and conditions.

B. Unsuccessful discharge from treatment.

C. Discharge from current level of care to an alternate level with a need for additional sex offense specific treatment.

3.420 For a juvenile who has completed or discharged from treatment, a provider shall submit a written summary including but not limited to the following:

A. Treatment goals and objectives completed by the juvenile.

B. Current level of risk for the juvenile including risk factors and protective factors.

C. A current recommendation regarding whether registration should/should not continue based on information available at the date of the report. (This recommendation is to be used for juveniles who at some point may petition the court to discontinue registration (per section 16-22-113.8, C.R.S.).

D. Assess the viability of support and resources in the juvenile's environment.

E. Develop aftercare plan recommendations if applicable**.**

4.000
QUALIFICATIONS OF TREATMENT PROVIDERS, EVALUATORS, AND POLYGRAPH EXAMINERS WORKING WITH JUVENILES WHO HAVE COMMITTED SEXUAL OFFENSES *Revised September 2016*

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 juveniles who have committed sexual offenses 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: Juvenile 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 juveniles who have committed sexual offenses.

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 registered with the Department of Regulatory Agencies as an unlicensed psychotherapist, 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*;

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 juveniles with developmental/intellectual disabilities who have committed sexual offenses 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:

a. 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.
b. 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.
c. 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 Associate Level (First Application): 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:
   a. Name
   b. Treatment agency
   c. Address
   d. Phone number
   e. Email address
   f. 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 judgement (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: Juvenile -- Associate Level (Initial 3 years): An Associate Level Treatment Provider may treat juveniles who have committed sexual offenses 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 listed with the Department of Regulatory Agencies as an unlicensed psychotherapist, 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 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.

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*. 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*;

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

4.210 Continued Placement of <u>Associate Level Juvenile 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 juveniles who have committed sexual offenses;

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 completed 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.

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*. 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*;

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

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:
   a. Name
   b. Treatment agency
   c. Address
   d. Phone number
   e. Email address
   f. 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 judgement (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: Juvenile - Full Operating Level: 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 juveniles who have committed sexual offenses 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, 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;

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 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.

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

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

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 juveniles with developmental/intellectual disabilities who have committed sexual offenses 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 Juvenile 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 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 provider shall demonstrate continued competency related to juveniles who have committed sexual offenses 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 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 juveniles who have committed sexual offenses;

   If the applicant is reapplying to be a provider for adults and juveniles, training must reflect both populations. Please reference the list of specialized training categories.

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*. 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*;

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

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:

a. Name
b. Treatment agency
c. Address
d. Phone number
e. Email address
f. 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 judgement (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: Juvenile 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 juveniles who have committed sexual offenses.

A. The applicant shall be listed as an Associate Level or Full Operating Level Treatment Provider for juveniles who have committed sexual offenses;

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*;

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

G. DD/ID

Associate Level treatment evaluators who want to provide evaluation services to juveniles with developmental/intellectual disabilities who have committed sexual offenses 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:
   a. 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.
   b. 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.
   c. 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:
   a. Name
   b. Treatment agency
   c. Address
   d. Phone number
   e. Email address
   f. 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 judgement (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 juveniles who have committed sexual offenses 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 juveniles who have committed sexual offenses;

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 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 reference the list of specialized training categories.

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*. The references shall relate to the work the applicant is currently providing

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

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 juveniles with developmental/intellectual disabilities who have committed sexual offenses 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 Juvenile 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 juveniles who have committed sexual offenses;

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 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 reference the list of specialized training categories.

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*. 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*;

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

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 juveniles with developmental/intellectual disabilities who have committed sexual offenses 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:
   a. Name
   b. Treatment agency
   c. Address
   d. Phone number
   e. Email address
   f. 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 judgement (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: Juvenile Full Operating Level: 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 juveniles who have committed sexual offenses 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 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 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 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.

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*. The references shall relate to the work the applicant is currently providing.);

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

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 juveniles with developmental/intellectual disabilities who have committed sexual offenses 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 Juvenile 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 juveniles who have committed sexual offenses 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 Juvenile Treatment Provider and Evaluator.

<u>Or</u>

The evaluator may discontinue their listing as a Full Operating Level Juvenile 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 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 juveniles who have committed sexual offenses.

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.

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*. 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*;

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

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:
   a. Name
   b. Treatment agency
   c. Address
   d. Phone number
   e. Email address
   f. 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 judgement (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, 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:
    a. How the applicant has stayed current on the literature/research in the field (e.g. attend conferences, trainings, journals, books, etc.)
    b. Research that can be cited to support the applicant's philosophy/framework.
    c. How evolving research/literature has changed the applicants practice.
    d. 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* 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* 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* 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;

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 adult sex offenders may apply to be listed as an Associate Level Treatment Provider, Evaluator, and/or Polygraph Examiner for juveniles who have committed sexual offenses.

The Full Operating or Associate Level Treatment Provider, Evaluator, and/or Polygraph Examiner for adult sex offenders 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 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).

4.840 Original Waiver Clause: The original Juvenile *Standards* allowed the SOMB to grant, for a period of one (1) year following the effective date of publication, a waiver of the underlying credential of licensure or academic degree above a baccalaureate to individuals who could document extensive experience in providing services to juveniles who have committed sexual offenses. The waiver process was not intended to be available at any time after one (1) year past the effective date of publication of the Juvenile *Standards*. There is currently no provision for the granting of this waiver.

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 juveniles who commit sexual offenses. 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:

   a. Preparation for a polygraph examination

   b. Review/live observation of an examination

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

   d. 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* as well as all other requirements outlined in the SOMB Administrative Policies

4.910 Required notifications to SOMB: Providers listed under section 4.800 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:

a. Name
b. Agency
c. Address
d. Phone number
e. Email address
f. Supervisor

B. Notify the SOMB in writing within 10 days of any arrest, conviction, nolo contender plea, or deferred judgement (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*. 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 applicant shall complete a minimum of fifty (50), with twenty-five (25) juvenile polygraph tests while operating under the Intent to Apply status.

B. 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;

C. 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;

D. 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*. These references shall include, but not be limited to other members of the community supervision team;

E. 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;

F. 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;

G. The applicant shall demonstrate compliance with the *Standards*;

H. 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 juveniles who commit sexual offenses. 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

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 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 juveniles who have committed sexual offenses. 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 juveniles who have committed sexual offenses (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;

B. 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*. These references shall include, but not be limited to other members of the community supervision team;

C. 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;

D. 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;

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

F. The examiner shall demonstrate compliance with the *Standards*;

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

H. DD/ID

Individuals wanting to provide polygraph services to juveniles with developmental/intellectual disabilities who have committed sexual offenses 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) exams, with twenty-five (25) juvenile post-conviction sex offender polygraph tests on juveniles who have committed sexual offenses,

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 4.900 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:
   a. Name
   b. Agency
   c. Address
   d. Phone number
   e. Email address
   f. Supervisor

B. Notify the SOMB in writing within 10 days of any arrest, conviction, nolo contender plea, or deferred judgement (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 - Full Operating Level: 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 juveniles who have committed sexual offenses, an examiner must meet **all** 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;

B. The examiner shall have conducted at least two hundred (200), with twenty-five (25) juvenile post-conviction sex offender polygraph tests on juveniles who have committed sexual offenses within five (5) years of application.

   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, 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 juveniles who have committed sexual offenses. 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 juveniles 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*. 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*;

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:

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 juveniles who have committed sexual offenses. 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 juveniles who have committed sexual offenses (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;

A. 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;

B. 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*. These references shall include, but not be limited to other members of the community supervision team;

C. 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;

D. 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;

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

F. The examiner shall demonstrate compliance with the *Standards*;

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

H. **DD/ID**
Individuals wanting to provide polygraph services to juveniles with developmental/intellectual disabilities who have committed sexual offenses 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 juveniles with developmental/intellectual disabilities who have committed sexual offenses;

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* 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* 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* 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;

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:
   a. Name
   b. Agency
   c. Address
   d. Phone number

e. Email address
f. Supervisor

B. Notify the SOMB in writing within 10 days of any arrest, conviction, nolo contender plea, or deferred judgement (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	▪ 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	▪ 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	▪ 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	▪ 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:
techniques o Safety and containment planning ▪ Sex offender risk assessment ▪ Parental Risk Assessment ▪ Crossover ▪ Objective measures including: o Polygraph o Plethysmograph o VRT ▪ Psychological testing ▪ Special sex offender populations including: o Sadists o Psychopaths o Developmentally/ Intellectually disabled o Compulsives o Juveniles o Females ▪ Family clarification/ visitation/reunification ▪ Pharmacotherapy with sex offenders ▪ Impact of sex offenses ▪ Assessing treatment progress ▪ Supervision techniques with sex offenders	supervision	diagnosis ▪ Investigations ▪ Addictions and substance abuse ▪ Domestic Violence ▪ Knowledge of criminal justice and/or district court systems, legal parameters and the 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	▪ Healthy sexuality and sex education ▪ Multicultural sensitivity ▪ Developmental stages ▪ Understanding transference and counter-transference ▪ Family dynamics and dysfunction ▪ 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	

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:
▪ 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			offend	

5.000
ESTABLISHMENT OF A MULTIDISCIPLINARY TEAM FOR THE MANAGEMENT AND SUPERVISION OF JUVENILES WHO HAVE COMMITTED SEXUAL OFFENSES

December 2014

5.100 After an adjudication or a deferred adjudication has been entered, and a referral to probation, parole, or out-of-home placement has been made, a multidisciplinary team (MDT), consisting of those individuals identified in Section 5.110, shall be convened as soon as possible to manage the juvenile during the term of supervision.[23,24,25,26] The members of the MDT may change as the treatment and supervision plan evolves. Each member is responsible for making sure the MDT is formed, convened, and communicating on a regular basis.

Discussion: It is also recommended that these Standards and Guidelines be utilized with juveniles and families who are seeking intervention regarding sexually abusive behavior that has been disclosed through self-report or evaluation. Following a comprehensive evaluation that confirms sexually offending/abusive behavior, juveniles who may have been adjudicated for non-sexual offenses, placed on diversion, given a deferred adjudication or whose charges include a factual underlying basis of a sexual nature, or those who are the subject of a dependency and neglect order may be included in the same programs as those developed for juveniles adjudicated for sexual offending behavior. Such juveniles must acknowledge their history of sexually abusive/offending behavior, be held accountable for participation in treatment, and they must be supervised by parents, caregivers, and other natural support systems in a manner congruent with these Standards and Guidelines.

DD/ID Discussion: *Treatment for these "non-adjudicated" juveniles is often challenging. Typically, therapy for juveniles who have committed sexual offenses is cognitive-based; this can present challenges to both the juvenile and therapists as they struggle to understand various aspects of their treatment. Also, non-adjudicated juveniles do not have a probation officer supervising their treatment. This presents challenges to caseworkers determining when a juvenile is finished with their offense-specific therapy, as well as consequences when a juvenile sexually acts out while in the care of Human Services.*

MDT Functions The purpose of the MDT is to manage and supervise the juvenile through shared information. The individualized evaluation, presentence investigation, information from all caregivers, victim input and ongoing assessments provide the basis for team decisions related to risk assessment,

[23] Association for the Treatment of Sexual Abusers (2012). *Adolescents Who Have Engaged in Sexually Abusive Behavior: Effective Policies and Practices*. Beaverton, OR: Association for the Treatment of Sexual Abusers.

[24] The National Task Force on Juvenile Sexual offending (1993) as cited in Hunter, J.A., & Figueredo, A.J. (1999). Factors Associated with Treatment compliance in a Population of Juvenile Sexual offenders. *Sexual Abuse: A Journal of Research and Treatment,* 11(1).

[25] Hunter, J.A., Gilbertson, S., Vedros, D., & Morton, M. (2004). Strengthening community-based programming for juvenile sexual offenders: Key concepts and paradigm shifts. *Child Maltreatment.* 9(2). 177-189.

[26] McGrath, R.J., Cumming, 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).

treatment and behavioral monitoring. Decision making related to the juvenile and their family should occur as a team and should include assessment/reassessment of risk and need of each individual juvenile based on empirically supported data and instruments, developmental/intellectual needs and least restrictive level of supervision and containment available to meet the needs of the juvenile while still keeping victim needs and community safety as the number one priority. No sole decisions related to the above items should occur without consulting with members of the MDT. Collaboration amongst the MDT should be paramount and should occur from the onset of the case. MDTs shall ensure that all decisions related to the juvenile are consistent with existing Court orders[27,28,29,30]

Discussion: Community safety, risk and the overall health of a juvenile are not mutually exclusive. If optimal resources are unavailable, evaluators and providers shall recommend realistic alternatives and document the original or preferred recommendation and the barriers to implementation.

5.110 Each MDT is formed around a particular juvenile and membership may change over time based upon who is currently involved with the juvenile. The MDT may include any individual necessary to ensure the best approach to managing and treating the juvenile. The team may also include extended family members, other clinical professionals, law enforcement, church leaders, peers, victim advocates, victims, coaches, employers and other individuals as deemed appropriate.

Each MDT shall at a minimum consist of:

A. The supervising officer, if assigned (Probation Officer, etc.)

B. The treatment provider

C. The polygraph examiner (when applicable)

D. Department of Human Services (DHS) caseworker, if assigned

E. The Division of Youth Corrections (when applicable)

F. Victim representative

G. Therapeutic care provider (when applicable)

H. Parents, caregivers and other natural support systems

I. Schools/school districts

[27] Hunter, J.A., Gilbertson, S., Vedros, D., & Morton, M. (2004). Strengthening community-based programming for juvenile sexual offenders: Key concepts and paradigm shifts. *Child Maltreatment,* 9(2), 177-189.

[28] Blank, M. et al. (1992). *Collaboration: What Makes it Work? A Review of Research Literature on Factors Influencing Successful Collaboration*. Minnesota: Amherst, H. Wilder Foundation.

[29] Gavazzi, S.M., Yarcheck, C.M., Rhine, E.E., & Partridge, C.R. (2003). Building Bridges Between the Parole Officer and the Families of Serious Juvenile Offenders: A Preliminary Report on a Family-Based Parole Program. *International Journal of Offender Therapy and Comparative Criminology*. 47(3), 291-308.

[30] Longo, R. E. and Prescott, D. (2006). *Current Perspectives: Working With Sexually Aggressive Youth and Youth With Sexual Behavior Problems*. MA: NEARI Press.

J. Court appointed legal representatives (GAL, CASA volunteer)

K. Juvenile

Discussion: It is important to note that although the juvenile who has committed the sexual offense is considered part of the MDT, there are no prescribed responsibilities listed in these Standards. The responsibilities of the juvenile will be considered by the MDT and will be individualized based on treatment and treatment progress.

It is also important to note that although not each MDT member may be present at each MDT meeting/staffing, it is still a crucial part of the process to maintain communication amongst all MDT members on a regular basis. If victim representation is not an ongoing part of the MDT, it is crucial to seek consultation, and victim input on a regular basis as well as provide appropriate victim notification. It is also important to note that membership on the MDT is fluid and will change as the juvenile progresses through treatment.[31,32,33,34,35,36]

The MDT members perform separate and distinct functions relative to their respective role. Maintaining the integrity of the team and the specified relationship with the juvenile are crucial to the success of the team.

In smaller communities professionals may work for two agencies. In these cases their primary role must be identified. The professional may act as a secondary or co-facilitator after primary role clarification is made.

5.110 DD/ID

In addition to the supervising officer from probation, caseworker from DHS, the treatment provider, and the polygraph examiner, any of the following team members, when involved and appropriate, shall be added to the MDT supervising juveniles who commit sexual offenses with developmental/intellectual disabilities:

A. Community Centered Board case manager

B. Residential providers

C. Supported living coordinator

D. Day Program provider

E. Vocational or Educational provider

[31] Center for Sex Offender Management (CSOM). (2000). *The Collaborative Approach to Sex Offender Management*. October 2000.

[32] CSOM. (2000*). Engaging Advocates and Other Victim Service Providers in the Community Management of Sex Offenders*. March 2000.

[33] CSOM. (2000). *Public Opinion and the Criminal Justice System: Building Support for Sex Offender Management Programs.* April 2000.

[34] CSOM. (1999*). Understanding Juvenile Sexual Offending Behavior: Emerging Research, Treatment Approaches and Management Practice.* December 1999.

[35] Wiig, J.K. and Tuell, J.A, (2004). *Guidebook for Juvenile Justice and Child Welfare System Coordination and Integration*. VA: CWLA Press.

[36] Wiig, J.K., Spatz-Widom, C., and Tuell, J.A. (2004). *Understanding Child Maltreatment and Juvenile Delinquency: From Research to Effective Program, Practice, and Systemic Solutions*. VA: CWLA Press.

F. Guardians

G. Authorized representatives

H. Other applicable providers

5.120 The MDT shall facilitate team decision making regarding: team membership, the structure of team meetings (conference call, in-person, etc), the frequency of team meetings (quarterly at a minimum), and the content and goals of the meetings.

Discussion: In the best interest of the juvenile and family, monthly meetings are encouraged regardless of the level of supervision or containment.

5.121 Case files shall be maintained in accordance with the policies of each agency involved including all decisions made as it relates to the juvenile's supervision and treatment needs.

5.130 The MDT shall demonstrate the following operational norms:

A. An ongoing, open flow of information among the members of the team, as appropriate.

B. Team members fulfill their assigned responsibilities in the management of the juvenile.

Discussion: When members of the MDT wish to attend group or other treatment sessions it must be for specifically stated purposes relative to the treatment of the juvenile. Treatment providers should prepare juveniles and their parents/caregivers in advance for attendance of the MDT member. It is understood that treatment providers may set reasonable limits on the number and timing of visits to minimize any disruption of the treatment process.

C. Team members are committed to the team approach and settle among themselves conflicts and differences of opinion that might make them less effective in presenting a unified response.

D. Team members shall seek assistance through supervision with conflicts or alignment issues that occur.

E. Because these Standards apply to adjudicated juveniles, those with a deferred adjudication, or *those whose charges include a factual underlying basis of a sexual nature* the final authority regarding community safety and supervision rests with the supervising officer or DHS caseworker (in the absence of a supervising officer). The supervising officer has final authority in all decisions regarding conditions set by the court or parole board and regarding court orders in the delinquency action. Placement recommendations are to be made by the MDT; however community placements are the responsibility of the DHS and are generally decided by the court. In order to protect victims, community safety and/or the juvenile, critical situations may arise that require a MDT member to make an independent decision. Independent decisions should be the exception rather than the rule. These decisions must be reviewed as soon as possible with the MDT.

F. Team members shall share behavioral observations relevant to the juvenile's current functioning and information regarding cooperation/compliance with the conditions of community supervision and safety plans.

G. Referrals of juveniles to whom these Standards apply for evaluation, assessment, and treatment shall be made only to those providers listed with the Sex Offender Management Board (Section 16-11.7-106, C.R.S). If optimal resources are unavailable refer to section 5.100.

Discussion: The MDT is encouraged to work diligently together before seeking action from the court/parole board. The MDT should be mindful of the level of decision-making that would require court or parole board intervention and seek remedy only after inner-team solutions have been deemed unattainable by the team members. The court or parole board has the ultimate decision-making responsibility.

In the event of a court review or parole board hearing, MDT members should provide reports to the court/parole board as a team with dissenting opinion in the absence of team consensus. Copies of such reports should be forwarded to the pertinent MDT members.

5.140 The responsibilities of the MDT include:

A. Protect the victim and community.

B. Shall ensure that the juvenile and the parent/guardian have signed a waiver of confidentiality to obtain all relevant information required for the evaluation, assessment, treatment and management of the juvenile. The waiver/release must authorize the release of information to and from the mandatory members of the MDT. Such information shall include, but is not limited to:

1. Treatment plans and progress/discharge reports from previous treatment programs and providers.

2. Medical, psychiatric and psychological reports.

3. School records.

4. Presentence investigation report(s).

5. Child abuse investigation report(s).

Relevant information may also be received from and released to professionals working with the victim(s) of the juvenile's offense(s). The privacy associated with victims' records must be respected. Such information may be needed by the team to make decisions about contact, clarification and/or reunification. Information can also be used to correct empathy deficits and to resolve discrepancies in differing accounts of the offense and/or relationship. Team members should exercise good professional judgment in determining what information to share with and about both the victim and the juvenile.

Discussion: The juvenile and parent/guardian must be given the opportunity to give full, informed consent/assent for such waivers/releases, with the advice of legal counsel when requested, and be informed of alternative dispositions that may occur if they are unwilling to sign such waivers/releases. In the absence of voluntary signatures, the release of records must be ordered by the court as a condition of the juvenile being allowed to remain on community supervision.

C. Shall require written safety plans as a precondition for decisions regarding activities. In addition, the MDT shall require written school supervision plans as a precondition for decisions regarding school participation not covered by the treatment plan.

D. Shall require disclosure to certain third parties regarding the nature and extent of the juvenile's sexual offending and/or abusive behavior. The MDT shall specify the extent of information to be disclosed, and should keep in mind applicable mandatory reporting and confidentiality laws.

   Without jeopardizing victim or community safety, decisions made by the MDT should favor the juvenile's involvement in normalizing activities, exposure to positive peer and adult role models, and be supportive of continuity in health, social and familial relationships.

E. Shall discuss and approve changes in treatment providers and/or placements.

F. Shall discuss any plans for contact between the juvenile and the victim and potential victim(s). No contact between the juvenile and the victim shall be allowed unless approved by the MDT or Court order. Please refer to Section 8.000 for further information related to victims.

G. Juveniles who have committed sexual offenses should not be placed in, or allowed to have positions of authority over, or responsibility for other children. Supervision shall always include restrictions that preclude babysitting or other positions of authority with younger children. These restrictions are rarely modified and should be modified only after extensive review by the MDT and approval by the court (if court approval is required).

H. Shall make decisions regarding approval of informed supervisors for a juvenile's contact with children, if such contact is allowed.

I. Shall assess the juvenile's ongoing level of risk to ensure containment and make recommendations for corrective or legal actions that are developmentally appropriate.

J. Shall make recommendations regarding a juvenile's level of community access with specific focus on schools, extra-curricular activities, recreation activities (including organized sports), employment or volunteer work, and access to children, siblings or potential victims.

K. Shall share case information with collateral parties as needed.

L. Shall advocate for developmentally appropriate evaluations, assessments, treatment and interventions.

M. Shall exercise good professional judgment in determining what victim information should be shared within the MDT and with the juvenile, prioritizing victim safety (e.g. victim location).

N. It is recommended that MDT members, as a best practice, receive initial and annual training related to juveniles who have committed sexual offenses. It is also desirable for MDT member supervisors to complete similar training. These trainings may not be appropriate for

non-professional members of the MDT. Such training includes, but is not limited to, the following:

1. Prevalence of sexual assault
2. Risk and re-offense
3. Offender characteristics
4. Differences and similarities between adults and juveniles who commit sexual offenses.
5. Evaluation/assessment of juveniles
6. Current research
7. Informed Supervision: Community management, containment.
8. Interviewing skills
9. Victim issues
10. Sex offense specific treatment
11. Qualifications and expectations of evaluators and treatment providers
12. Relapse prevention
13. Objective measurement tools
14. Determining progress/outcome planning
15. Denial
16. Special needs populations
17. Cultural, ethnic and gender awareness
18. Family dynamics and interventions
19. Developmental theory
20. Trauma Theory: Secondary and vicarious trauma
21. Impact: Professionals' experience of secondary trauma
22. Role of the MDT

Discussion: It is considered best practice for professional MDT members to have training specific to juveniles who have committed sexual offenses before being a member of a team. Training of professional MDT members provides an enhanced skill set to adequately manage the risk posed by the juvenile and helps promote community and victim safety.

5.140 DD/ID

Responsibilities of additional team members for juveniles with Developmental/Intellectual Disabilities who have committed sexual offenses:

A. Team members shall have specialized training, or be provided education or knowledge regarding sexual offending behavior, the management and supervision of juveniles who have committed sexual offenses and the impact of sex offenses on victims;

B. Team members shall be familiar with the conditions of supervision and the treatment contract;

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

D. Team members shall limit the juvenile's contact with victims and potential victims. Residential, supported living, day, vocational, and educational providers of services to other clients with developmental/intellectual disabilities shall recognize the risk to their clients and shall limit the juvenile's access to possible victims in their programs. Clients who are non-verbal or lower functioning are at particularly high risk because of their inability to effectively set limits or report inappropriate behavior or sexual assaults.

5.200 Responsibilities of the Supervising Probation Department

The primary responsibility of the supervising probation officer is to ensure the juvenile is in compliance with the conditions of community supervision. In addition to the responsibilities of the supervising officer as outlined in this section, in the case of probation officers, the duties of the supervising officer are defined by statute, Chief Justice Directives, Probation Standards, and local departmental policies (C.R.S 16-11-209).

Discussion: While all members of the MDT share the responsibility of ensuring the MDT is formed, convened and has on-going communication, officers of the court need to be aware of their statutory mandates and liability if the team is not convened.

Confirmation by the supervising officer that the juvenile is receiving required supervision, treatment, evaluation, assessment and support from the MDT and parents/caregivers is paramount for victim and community safety. If the juvenile is not receiving the required services, the supervising officer shall make a referral for the required service.

The responsibilities of the supervising probation officer include:

5.201 Shall refer all juveniles to whom these Standards apply for evaluation, assessment and treatment only to providers listed with the Sex Offender Management Board (Section 16-11.7-106, C.R.S.). If optimal resources are not available refer to Section 5.100.

5.201 DD/ID

Individuals providing treatment to juveniles with developmental/intellectual disabilities who have committed sexual offenses must be listed as a Developmentally/Intellectually Disabled (DD/ID) provider.

5.202 Shall notify juveniles who have committed sexual offenses and their parent/caregiver that they must register with local law enforcement in accordance with Section 18-3-412.5, C.R.S. The supervising probation officer shall verify that registration has taken place with the local law enforcement agency, and if registration has not occurred, the supervising probation officer shall follow-up with law enforcement.

5.203 Parental responsibility terms and conditions shall be presented to the parent(s) or guardian and the expectations, including but not limited to, participation in treatment and informed supervision shall be explained by the supervising probation officer.

5.204 Shall explain to juveniles who have committed a sexual offense and are transferred to Colorado through the Interstate Compact Agreement that they must agree to comply with the additional conditions of supervision, per the supervising agency.

5.205 Shall require written safety plans in conjunction with the MDT as a precondition for decisions regarding activities. The supervising probation officer shall use the treatment and safety plan, and school supervision plan to measure and assess safety and compliance.

5.206 Shall refer the juvenile to the Duty to Warn protocol in regards to disclosure. This disclosure includes conditions of community supervision as part of the safety plan when the third party may be a potential victim, or the MDT deems it necessary for community safety.

5.207 Shall ensure supervision levels and behavioral monitoring that meet risk level and the individual needs of the juvenile.

5.208 Shall provide a copy of the juvenile's terms and conditions of supervision to other members of the MDT.

5.209 Shall develop the supervision plan on the basis of the individualized evaluation, ongoing assessments, and reports of current behavioral observations by the MDT.

5.210 Shall confer with the MDT (if still convened) prior to requesting early termination of supervision. Early termination may be possible in rare cases, but only after successful completion of treatment and fulfillment of court requirements.

5.211 The supervising probation officer should not allow a juvenile who has been unsuccessfully discharged from a treatment program to enter another program unless the MDT has modified the treatment plan to meet the needs of the victim, community and juvenile. Documentation shall address: the reasons and underlying issues for unsuccessful discharge, and the rationale for a revised plan. A notation shall be entered describing whether or not the level of care is the same, or more or less intensive, than the previous program. The treatment plan must follow the juvenile from one placement and program to another. A juvenile's termination from treatment should not be based solely on the family's unwillingness to support the goals of treatment.

Discussion: The purpose of this Standard is to discourage movement among treatment providers by juveniles and their families as a way of avoiding the requirements of treatment.

5.212 Shall seek a means of continued court ordered supervision, i.e. extension or revocation and re-granting of probation/supervision for a juvenile who has been otherwise compliant but has not achieved his/her treatment goals by an approaching supervision expiration date.

Discussion: There are times when family dynamics play a role in the juvenile's failure to attain treatment goals. Supervising probation officers should be cognizant of family dynamics and should not impose punitive consequences on the juvenile when the juvenile is progressing, but family members are refusing to participate in or are sabotaging the juvenile's treatment. Alternative to support the juvenile's adherence to supervision and management requirements should be sought by the MDT including possible return to court to address the respondent's compliance.

5.213 Should complete initial and ongoing training as required by the Guidelines for the Probation Officers Supervising Juveniles who Have Committed Sexual Offenses.

5.300 Responsibilities of Treatment Providers

5.310 The treatment provider is a required member of the MDT. The provider shall establish a cooperative professional relationship with members of the MDT. **The responsibilities of the treatment provider include:**

A. Shall conduct treatment in compliance with these Standards.

A. **DD/ID**
Associate Level and Full Operating Level treatment providers who want to provide treatment services to juveniles with developmental/intellectual disabilities who have committed sexual offenses shall demonstrate compliance with these *Standards* and submit an application attesting to having met all requirements identified as Developmental/Intellectual Disability (DD/ID) Standards.

B. Shall immediately report to the MDT all violations of the provider/client contract, including those related to specific conditions of probation, parole, community corrections, or out-of-home placement.

C. Shall recommend to the MDT any change in frequency or duration of contacts or any alteration in treatment modality that constitutes a change in a juvenile's treatment plan. Any permanent reduction in duration or frequency of contacts or permanent alteration in treatment modality shall be determined on an individual case basis by the provider and in consultation with the MDT.

Discussion: The treatment provider is the member of the MDT with expertise in the area of treatment planning and is ethically responsible for making treatment recommendations. The MDT should rely on this expertise in making decisions regarding the treatment and management of the juvenile.

D. On a monthly basis, the provider shall submit to the MDT written progress reports documenting at a minimum a juvenile's attendance, participation in treatment, changes in risk factors, changes in the treatment plan, and treatment progress.

E. Upon completion of treatment, the provider shall submit a written discharge summary to the supervising officer, client managers/parole officers, caseworkers, and other MDT members.

F. If a revocation of probation or parole is filed by the supervising officer or client manager/parole officer, particularly when it is related to unsuccessful discharge from treatment, the provider shall furnish written information regarding the juvenile's treatment

progress. The information shall include: changes in the treatment plan, dates of attendance, treatment activities, the juvenile's relative progress and compliance in treatment, and any other material relevant to the court or parole board at hearing. The treatment provider shall be willing to testify if requested.

G. Shall advocate for the parents to support and address the needs, safety, physical, emotional well-being of the victim child and the juvenile as they hold the juvenile accountable when the parents of the juvenile are also the parents of the victims. This parental involvement and family support is critical for the healing of the victim.

H. Shall seek and consider victim input and impact when available. Sources of this information may include, but are not limited to, the actual victim if an adult, the parent or guardian of a child victim, the victim's therapist or a victim representative.

Discussion: Early in the juvenile's treatment, the provider should plan for ongoing victim input and determine if the victim wants to be involved. Involving the victim during the course of treatment can create better outcomes for the victim, juvenile and family. If the victim chooses not to be involved, the provider should utilize a victim representative to provide a victim perspective as defined in Section 5.700.

5.400 Responsibilities of the Polygraph Examiner

5.410 The polygraph examiner is a required member of the MDT when polygraph testing is utilized. The polygraph examiner may be used as a consultant when the MDT is exploring polygraph testing as an intervention.

5.420 The responsibilities of the polygraph examiner include: shall provide information to the team regarding the juvenile's level of risk upon completion of the polygraph. Attendance at MDT meetings shall be on an as-needed basis. At the discretion of the MDT, the polygraph examiner may be required to attend only those meetings preceding and/or following a juvenile's polygraph examination.

5.430 Shall report significant risk behavior or re-offense information to the MDT within 48 hours of receipt of this information.

5.440 Shall provide written reports within two (2) weeks from the testing date to the MDT.

Discussion: Polygraph testing is utilized as a tool in treatment and the results are considered raw data. Parent/guardians should receive the results only in a therapeutic setting.

5.450 No juvenile shall be referred for polygraph examination without the full, informed consent of the MDT in consultation with the polygraph examiner. The reasons for exception shall be documented in the juvenile's file. If the exception(s) change, documentation is required regarding referral for or continued deferment from polygraph examination.

5.460 Shall obtain informed consent of the parent/legal guardian and the informed assent of the juvenile (Section 7.130).

5.470 The polygraph examiner must have training as specified in Section 4.0.

5.500 Responsibilities of the Department of Human Services

5.510 In cases when the Department of Human Services is involved, and in accordance with Volume 7[37] of the Colorado Department of Human Services Rules and Regulations, the responsibilities of the human services caseworker include**:**

A. Assessment of the home situation to determine victim safety and the juvenile's risk level. A written plan to address safety, supervision, and support should be developed and implemented with the family. Informed Supervision must be in place.

B. Establishment of a MDT if one is not in place and work cooperatively with the team regarding treatment decisions.

Discussion: The best interests of the victim are paramount when considering out-of-home placement. Consideration should always be to maintain the victim in the home if it is safe for the victim, and to remove the juvenile who committed the sexual offense if there are safety concerns.

C. Assessment of treatment and service needs. If placement is indicated the juvenile should be placed in care where the providers are or can be trained in the special needs of juveniles who commit sexual offenses and the providers are willing to comply with the Standards under Section 5.700.

Discussion: Thoughtful consideration of long-term placement may be part of the process and will involve much more coordination than is possible in emergency situations. In emergency situations the safety of potential victims in any placement must be considered.

D. On a monthly basis the caseworker should monitor treatment, safety, support, and supervision plans.

E. Should make recommendations to the court about the treatment plan to maintain consistency between any parallel dependency and neglect, and delinquency court proceedings.

F. Should include the sex-offense specific treatment needs in the DHS service plans.

G. Training for DHS staff includes, but is not limited to, a minimum of 40 hours of training per worker per year of child welfare training as outlined in Volume 7.[38] It is recommended that sex offense specific training be part of the required 40 hours for caseworkers who work with juveniles who have committed sexual offenses.

5.600 Responsibilities of the Division of Youth Corrections

5.610 The Division of Youth Corrections (DYC) shall comply with Section 2.000 of these Standards and Section 19-2-922, C.R.S. Juveniles who have been committed to DYC due to committing a sexual offense shall undergo a sex offense specific evaluation at the designated assessment center.

[37] Code of Colorado Regulations. July 1, 2007. 12 CCR 2509-1 Rule Manual Volume 7 General information and Policies. Retrieved from: http://www.sos.state.co.us/CCR/SearchRuleDisplay.do?getEntireRule=yes&pageNumber=1&totalNumberOfResults=28&keyword=volume 7&type=keywordSearch&contentId=1035366

[38] Code of Colorado Regulations. July 1, 2007. 12 CCR 2509-1 Rule Manual Volume 7 General information and Policies. Retrieved from: http://www.sos.state.co.us/CCR/SearchRuleDisplay.do?getEntireRule=yes&pageNumber=1&totalNumberOfResults=28&keyword=volume 7&type=keywordSearch&contentId=1035366

If the juvenile has had a previous sex offense specific evaluation, that evaluation shall be reviewed and updated during the assessment process.

Treatment providers within DYC and programs or facilities contracting with DYC to provide sex offense specific treatment shall comply with these Standards as described in Section 3.000. Providers must meet the qualifications described in Section 4.000 of these Standards.

The responsibilities of the DYC case manager/parole officer/treatment provider include:

5.620 Shall utilize the MDT as outlined in Sections 4.000 and 5.000 of these Standards. Client managers/parole officers shall comply with the intent of these Standards and the Guidelines in Section 19-2-1003, C.R.S.

5.630 Shall assess the juvenile's risk level and develop a written plan to address safety, supervision, and support. Informed supervision must be in place.

5.640 All juveniles who are committed to DYC due to a sexual offense and who are not on parole status, shall be approved by the appropriate Community Review Board (Section 19-2-210, C.R.S), or equivalent, prior to community placement. The MDT, as outlined in Section 5.0, shall make recommendations for placement in accordance with Section 19-2-403, C.R.S.

5.650 Committed juveniles shall be referred to the Juvenile Parole Board (Section 19-2-1002, C.R.S.) when recommended by the MDT, as outlined by Section 5.0 or when the juvenile has completed his/her commitment and is eligible for mandatory parole. When appropriate the MDT shall recommend to suspend, modify or revoke the juvenile's parole. The juvenile's client manager/parole officer shall comply with these Standards and Sections 19-2-1003 and 19-2-209, C.R.S.

5.660 When it is recommended by the MDT that a juvenile who has been committed to DYC for a sexual offense be considered for continued placement after commitment with the Department of Human Services, the client manager/parole officer shall contact the appropriate county department of social/human services (Section 19-2-921, C.R.S) and arrange a staffing with all interested parties.

5.670 A discharge summary shall be completed on all juveniles who have been committed to DYC for a sexual offense who will be released directly to the community without a period of community placement or parole. The summary shall provide the juvenile's institutional adjustment, modus operandi and risk of re-offending. The discharge summary and Notice to Register as a Sexual Offender (Section 18-3-412.5, C.R.S) shall be forwarded to appropriate law enforcement units.

5.680 Should complete initial and ongoing training as required by DYC.

5.700 Responsibilities of the Victim Representative

As a member of the MDT, a 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 MDT has many benefits, including improving supervision of the juvenile, increasing offender accountability, building empathy for the victim, decreasing offender secrecy, preventing an unbalanced alignment with the juvenile, and ensuring a safer community. The exchange of information between the victim or victim representative and MDT is crucial for the rehabilitation of the juvenile and is often beneficial for the healing of the victim.

The victim may choose not to provide or receive information. In that circumstance, or if a victim does not exist on the case (e.g., an internet case), the victim representative will contribute general input regarding the perspective of victims to the MDT. Bringing the victim perspective is important in protecting potential victims and the community.

Upon convening, the MDT 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 the document titled "Resources for Victim Representation"). Due to the importance of victim contribution to the MDT for the reason stated above, reasonable attempts should be made to contact the victim and provide the victim with accurate information regarding juvenile treatment and management. The MDT shall orient the victim representative on the function of the team and their role as a member.

The responsibilities of the victim representative include:

A. Assure that the MDT is emphasizing victim safety, both physically and psychologically, throughout the supervision and management of the juvenile.

B. Should share information received from the victim and concerns of the victim to the MDT when available. Such information could include safety concerns, grooming behaviors, specifics of the offense, and offending behaviors.

C. Should convey information to the victim from the MDT such as, but not limited to, terms and conditions of probation, general treatment contract, treatment and supervision timelines, juvenile placement, juvenile progress in treatment, victim clarification and family reunification planning, and any other pertinent information as determined by the MDT.

   Discussion: Team members should determine what information to share, both with the victim and the MDT, based on what is in the best interest clinically for the victim and the juvenile. Victim and community safety is paramount when determining what information will be shared and victim confidentiality should be respected. The MDT should ensure that proper releases are in place (Guidelines on confidentiality are outlined in Section 3.200 of these standards). This discussion point applies to Section 5.7 B and C.

D. Should provide input on how MDT decisions may affect victims, secondary victims or potential victims.

E. Should assist the MDT in ensuring that victim needs and perspectives are considered and responded to by the MDT to the best of their ability.

F. May provide support, referrals, and resource information to the victim.

G. Should participate in MDT meetings.

H. Should contribute to the treatment content by providing the following types of information to the treatment team:

   1. Awareness of victim impact.

   2. Recognition of harm done to the victim(s).

3. Impact of sexual offending on victim(s), families, community and self.

4. Restitution/reparation to victims (including victim clarification) and others impacted by the offense including the community.

I. May submit questions from the victim to the MDT for review and share the responses to these questions with the victim if appropriate. The representative can also explain to the victim why certain types of information may not be shared.

J. May function as a liaison between and/or resource for the victim(s), victim therapist, and MDT as needed and 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.

K. If appropriate to the case, the representative should assist with planning for victim clarification sessions or family reunification.

L. May assist with issues related to newly identified victims.

5.800 Responsibilities of the Therapeutic Care Provider

5.810 Therapeutic care providers are line staff, counselors, foster parents, group home or CPA parents, TRCCF, PRTF, DYC, SRTF, day treatment and home-based service providers. Different levels of care have been identified which are primarily dependent upon the residential status of the juvenile and the role of the care providers involved.

5.820 Therapeutic care providers provide corrective care and guidance to assist the juvenile in addressing special needs or developmental/intellectual deficits that impede successful functioning. Therapeutic care providers are responsible for implementing interventions to address treatment goals. Standards for therapeutic care providers apply to care in both in-, and out-of-home living settings.

Therapeutic care providers are responsible for providing informed supervision. In addition to the responsibilities described in 5.140, therapeutic care providers shall:

A. Not allow contact with the victim(s) unless and until approved by the MDT.

B. Monitor contact between the juvenile, victim(s), siblings and other potential victims when approved by the MDT.

C. Provide for the physical and psychological safety in the living environment and community for the juvenile.

D. Participate in safety planning.

E. Be involved in case management decisions when appropriate.

F. Support MDT decisions, and implement specific goals identified in the treatment plan.

G. Be educated on sexual offense dynamics and provide relevant information about the juvenile to the MDT.

H. Respond to changes in risk factors and report observations to the MDT.

I. Implement behavior management techniques and provide consequences and interventions to address negative choices.

J. Provide learning opportunities to interrupt behaviors that include, but are not limited to, elements of the sexual offense.

K. Provide opportunities for the juvenile to interact with positive male and female, adult and peer role models.

L. Provide services that promote positive relaxation, recreation and play.

M. Make arrangements for, ensure transportation to and monitor attendance at all of the juvenile's appointments, where appropriate.

N. Share information about special needs, patterns, successful behavior management strategies and information with the MDT, and be involved in case management decisions when appropriate.

5.830 Shall implement a continuum of care that includes intervention, nurturing, supervision and monitoring which supports the MDT's goals and direction.

5.900 Responsibilities of the Parents, Caregivers, and Other Natural Support Systems

Natural support systems may include parents, caregivers, kin, psychological family members, etc.

Parents, caregivers, and other natural support systems for the family and juvenile play an integral role in planning for the treatment, supervision, and success of the juvenile. There individuals have significant information regarding the juvenile and their involvement is key to the success of the juvenile. Their involvement is required in treatment per these Standards in Section 3.140.[39]

The responsibilities of the parent, caregiver, and other natural support system include:

A. Should provide the necessary information regarding the juvenile's history, environment and continued care to adequately plan for the treatment and well-being of the juvenile, including family values and cultural norms and/or traditions.

B. Should partner with the MDT to identify the supports, strengths, and resources, treatment, and case plans that should minimize the juvenile's risk to community safety and ensure victim safety, and maximize overall health of the juvenile.

C. Should be trained in and provide informed supervision.

[39] Gavazzi, S.M., Yarcheck, C.M., Rhine, E.E., & Partridge, C.R. (2003). Building Bridges Between the Parole Officer and the Families of Serious Juvenile Offenders: A Preliminary Report on a Family-Based Parole Program. *International Journal of Offender Therapy and Comparative Criminology.* 47(3), 291-308.

D. Should partner with the MDT to develop and implement safety plans which protects the victim or potential victims, the community, and the juvenile.

E. Should provide input into applicable decisions of the MDT, and proactively support MDT decisions regarding the juvenile's treatment, and victim and community safety.

Discussion: Every effort will be made to make decisions based on a team consensus model, with an understanding that in some circumstances Colorado law, statutory mandates, or agency policy will determine decision outcomes. These decisions are not intended to exclude any members of the MDT and in such circumstances members of the MDT will be informed of the decision(s). It is expected that whenever possible all members of the MDT will have input into how these decisions are implemented.

F. Parents, caregivers, and other natural support systems, when also the parent, caregiver, or natural support system of the victim, are expected to support and prioritize the safety, and physical and emotional well-being, and needs of the victim, and understand and demonstrate the importance of their role in the recovery of the victim.

Discussion: Parents, caregivers, and other natural support systems are expected to provide for the best interests of the juvenile by supporting MDT decision-making, and participating in informed supervision. Parents, caregivers, and other natural support systems who do not meet these expectations may have their participation in the MDT and decision-making limited. If this occurs, it is expected that professional MDT members will work with the parents, caregiver, and other natural support system to help them meet these Standards.

5.910 Responsibilities of Schools/School Districts

The responsibilities of the school representative on the MDT include:

A. Communicating with the MDT regarding the juvenile's school attendance, grades, activities, compliance with supervision conditions and any concerns about observed high-risk behaviors.

B. Assisting in the development of the school supervision plan to include activity specific safety plans when applicable.

Discussion: It is extremely important for juveniles who have committed a sexual offense to engage in normalizing activities within the school when it is deemed safe for the individual to do so. Research[40,41] *indicates that providing normalizing experiences to these juveniles will help increase protective factors and lead to a much more beneficial experience. When appropriate, the school representative will assist in the school supervision plan to ensure that all safety factors are taken into account.*

C. Providing informed supervision and support to the juvenile while in school.

[40] Letourneau, E.; Chapman, J.E., and Schoenwald, S.K. (2008). Treatment Outcome and Criminal Offending in Youth With Sexual Behavior Problems. *Child Maltreatment* 13(2). 133-144.

[41] Seabloom. W. et al. (2003). A 14-to 24- Year Longitudinal Study of a Comprehensive Sexual Health Model Treatment Program for Adolescent Sex Offenders: Predictors of Successful Completion and Subsequent Criminal Recidivism. *Journal of Offender Therapy and Comparative Criminology*. 47(4) 468-481.

D. Developing a supervision safety plan considering the needs of the victim(s) (if in the same school) and potential victims.

E. Attending MDT meeting as requested.

F. Participating in the development of transition plans for juveniles who are transitioning between different levels of care and/or different school settings.

Discussion: The Department of Education, in collaboration with the Sex Offender Management Board, published a Reference Guide for School Personnel Concerning Juveniles Who Have Committed Sexually Abusive and Offending Behavior. School personnel are encouraged to become familiar with this document and the information contained within. This document can be found at: http://dcj.state.co.us/odvsom/sex_offender/index.html

G. Confidentiality of the juvenile

Information is to be provided on a "need to know" basis (Classroom teacher, school administrator, mental health professional, security, transportation, etc.).

Discussion: When working with school administration, suggested language would be "this student needs a high level of supervision at all times" and that "any concerning behavior should be immediately reported to a school administrator." The rationale for providing minimal details is that ANY school staff member who witnesses concerning behavior (regardless of the nature of adjudication) should be appropriately reporting it to the site administrator who should be informed/aware of the nature of the student's offense by participation in the MDT.

H. Confidentiality and safety of the victim and victim's family

The schools/school district are responsible for the confidentiality and safety of the victim(s):

1. The school should determine if victim or family members of the victim are in the same school as the juvenile, while keeping the victim's name and information confidential.

2. If the juvenile is in the same school as the victim(s), the first and "primary" option is transferring the juvenile to another school.

3. If it is not possible to transfer the juvenile, the second option is to adjust the juvenile's schedule to have no contact with the victim(s) for both school and extracurricular activities. The victim's schedule should not be disrupted. School supervision and safety plans should be put in place for the juvenile by the school with the priority of the physical and emotional safety of the victim(s) as the priority.

   Discussion: Victims often suffer additional harm and victimization in the school setting through harassment, pressure and ostracizing by other students, as well as contact by/exposure to the juvenile.

4. Enforcement of safety for the victim(s) should be a priority for the MDT. It is not the obligation of the victim or victim's parents to advocate for their own safety. The MDT should utilize victim representation in school safety planning.

5.920 Responsibilities of Court Appointed Legal Representatives/Guardian ad Litem (GAL)

Discussion: The Office of the Child's Representative provides oversight of all attorneys who represent a child's best interest including a guardian ad litem representing a juvenile who has committed a sex offense in either a delinquency or dependency and neglect matter. Currently, most courts terminate the appointment of a GAL once sentence is imposed. The Office of the Child's Representative supports these Standards requiring an attorney to continue representation in the post sentencing phases. The involvement of the guardian ad litem on the MDT is critically important in proper meeting the needs of the juvenile and the community.

5.921 Best practice duties and responsibilities of the guardian ad litem representing either the juvenile who has committed a sexual offense or an underage victim shall include.

A. When a guardian ad litem is regularly representing children in cases involving juveniles who have committed sexual offenses the attorney should have specific training in the areas of evaluation, intervention, treatment and child development.

B. The Office of the Child's Representative should assist the guardian ad litem in receiving juvenile sex offense specific training by either coordinating with the other agencies and creating access to this specific area of training or by incorporating this education into their own training curriculum. The Office of Child's Representative shall offer child development training to anyone serving as a guardian ad litem.

C. In cases where the guardian ad litem is involved, the GAL should be included as part of the MDT and attend all the team meeting. The guardian ad litem should advocate for elements of the treatment plan that are in accordance with these *Standards* when it is in the best interest of his or her child/client.

D. The guardian ad litem should consult with the MDT prior to taking a position and making recommendations in any legal action regarding contact or visitation with the victim(s) or potential victims(s). The MDT and guardian ad litem must always keep in mind that after receiving information from the team, the guardian ad litem is ethically obligated as required by the Colorado rules of Professional conduct to zealously represent his or her client and make a recommendation that serves his or her client's best interest.

E. When sex offense specific treatment is in the best interest of the client, the guardian ad litem should zealously advocate for timely evaluations and treatment which should commence as soon as possible after initiation of the court process.

F. Will not participate in or initiate any visitation/contact between the victim(s) and the juvenile who has committed the sexual offense unless and until approval by the MDT.

G. Should receive training outlined in Section 5.140.

Discussion: Guardians ad litem who wish to take their clients on passes should receive Informed Supervision training to include, but not limited to, types of abusive behaviors, dynamic patterns associated with abusive behaviors and the designation and implementation of safety plans.

5.922 Court Appointed Special Advocate (CASA)

Best practice responsibilities of the Court Appointed Special Advocate (CASA) Volunteer assigned to either the juvenile who has committed a sexual offense or an underage victim shall include:

A. Shall complete training specific to that of Informed supervision.

B. If the CASA volunteer is assigned to the juvenile who committed a sexual offense, the CASA volunteer must participate as a member of the MDT as requested by the team.

C. Should communicate to the court elements of the treatment plan that are congruent with the *Standards*.

D. Must consult with the MDT prior to making any recommendations regarding visitation/contact between the juvenile and the victim(s).

E. Will not participate or initiate any visitation/contact between the victim(s) and the juvenile who has committed a sexual offense unless and until approved by the MDT.

6.000
ADDITIONAL CONDITIONS OF COMMUNITY SUPERVISION

December 2014

The additional conditions for community supervision referenced in Appendix J are based on those created by the Division of Probation Services. Some terms and conditions have been enhanced for clarity and include the Board's philosophy on restricted contact.

6.000 Probation, parole, supervising officers/agents and DHS caseworkers should use the terms and conditions for the supervision of juveniles who have committed sexual offenses.

The juvenile shall be supervised by the probation department (or other supervising agency) for a period of time to be determined by the court and shall comply with the general terms and conditions of supervision and the additional terms and conditions referenced in Appendix J.

7.000
POLYGRAPH EXAMINATION OF JUVENILES WHO HAVE COMMITTED SEXUAL OFFENSES

Revised September 2016

Polygraph testing involves a structured interview during which approved examiners record several of a juvenile's physiological processes. Following this interview, examiners review the charted record and form opinions about whether the juvenile showed significant, inconclusive, or non-significant reactions when answering each of the relevant questions.

Polygraph testing is one of many decision-support tools and can be a useful tool, where suitable and appropriate, to assist with treatment and supervision. Members of the MDT should consider all clinical and supervisory information as well as information from the polygraph exam, when utilized, when making decisions. The use of polygraph testing can be helpful for juveniles to promote honesty and accountability while helping the juvenile progress past any barriers of denial. When used as a tool the polygraph can be helpful in corroborating the juvenile's progress in treatment and supervision compliance. The results of the polygraph can be useful in assessing improvement relevant to successful functioning as well as for decision making related to increases in involvement in pro-social activities.

The MDT should consider all information from the polygraph exam, including disclosures of information and test results, when making any decisions related to the juvenile's progress in treatment, activities in the community, and contact with potentially vulnerable persons. Information and results obtained from polygraph exams should not be used in isolation when making treatment or supervision decisions.

7.100 Suitability Criteria/Exclusionary Factors for Polygraph Testing:

A. The multidisciplinary team shall review the following suitability criteria and refer for polygraph examination* those juveniles who meet these criteria:

*If the juvenile refuses to answer sexual offense history questions, including sexual offense history polygraph questions, then the provider shall meet with the supervising officer to identify and implement alternative methods of assessing and managing risk and needs. The provider shall not unsuccessfully discharge the juvenile from treatment for solely refusing to answer sexual offense history questions, including sexual offense history polygraph questions.

1. Chronological age of 14 or older and a minimum functional age-equivalency of 12 years. Standardized psychometric testing shall be employed when there is doubt about a juvenile's level of functioning.

   Discussion: Twelve (12) and thirteen (13) year olds may be referred for polygraph examination when the multidisciplinary team determines that the information and results would be clinically useful. There must be a determination of a minimum functional age-equivalency of 12 years, and the juvenile must meet other criteria for suitability for polygraph testing as defined in this Section.

2. Capacity for abstract thinking

3. Capacity for insight

4. Capacity to understand right from wrong

5. Ability to tell truth from lies

6. Ability to anticipate rewards and consequences for behavior

7. Consistent orientation to date, time, place

8. Adequate intellectual/adaptive and executive functioning

9. Does not meet exclusionary factors

B. The multidisciplinary team shall review the following exclusionary factors and not refer juveniles for polygraph testing when any of the exclusionary factors are present:

1. Diagnosis of psychotic condition per the current version of the DSM

2. Lack of contact with reality

3. DSM severity specifier of "severe" for any diagnosis

4. DSM Current – Global Assessment of Functioning score indicative of serious or profound functional difficulties

5. Presence of acute pain or illness

6. Presence of acute distress

7. Recent medication changes that negatively impact functioning

8. Mean Age Equivalency (MAE) or Standard Age Score (SAS) is below 12 years (per standardized psychometric testing)

9. Clear indicators exist that results would be invalid

7.110 When the MDT has determined suitability and a juvenile is referred for a polygraph examination the final determination of suitability shall be made by the polygraph examiner. Examiners shall not conduct polygraph examinations with juveniles when clear indicators exist that results would be invalid.

7.120 Appropriateness Criteria

There may be some cases in which a juvenile meets the suitability criteria but due to other factors in the juvenile's life, he/she may not be appropriate for polygraph testing. It is important for the MDT to review each case, after suitability criteria have been assessed, to determine if the juvenile is appropriate for testing. The following considerations should be reviewed by the MDT:

A. General psychological stability of the juvenile.

B. Past trauma/victimization or potential for re-traumatization of the youth during the examination.

C. Ability to recall past life events with chronicity, order and accuracy.

D. Ability to express understanding of the areas of focus.

E. Past finding of appropriateness. A determination at one point in time that a juvenile is or is not appropriate for testing is not sole grounds for determining that the juvenile is or is not appropriate for testing at a future point in time.

F. Any other factors that may be known to the MDT.

7.121 The MDT must reach consensus when determining that a juvenile who is suitable for testing should not be tested. If the MDT makes such a determination based on appropriateness criteria, the reason for this determination should be documented in formal treatment and supervision reports:

*For juveniles who refuse to answer sexual offense history questions, including sexual offense history polygraph questions, providers shall refer to *Standard 7.100*.

A. For juveniles not found to be suitable and/or appropriate for initial or subsequent polygraph testing, the MDT shall identify specific ways in which the purpose of the polygraph will be addressed in a different manner. For example, the juvenile may still be asked to complete a sex history disclosure packet and review it with the MDT.

B. Other forms of monitoring accountability may include, but are not limited to; collateral contacts, home visits, work site visits, school visits, restrictions and increased supervision and treatment requirements.

7.130 The MDT shall identify question areas for a juvenile's exam prior to the scheduling the exam. This information along with the Sexual History Disclosure Packet shall be referred to the polygraph examiner so that the examiner can formulate suitable questions for the exam based on input from the MDT.

7.140 If the polygraph examiner concurs that the juvenile is suitable and appropriate for polygraph testing, the MDT shall inform the juvenile and parent/legal guardian of the decision and explain the potential consequences of compliance or non-compliance with the procedure, including legal consequences. The juvenile should then be scheduled for testing.

7.150 Polygraph Testing of Juveniles:

A. If the juvenile cannot provide Informed Assent, the examination should not continue.

B. Before commencing a polygraph examination with any juvenile, the polygraph examiner shall document that each juvenile, at each examination, has been provided a thorough explanation of the polygraph examination process and the potential relevance of the procedure to the juvenile's treatment and/or supervision. Review and documentation of informed assent will include information regarding the juvenile's right to terminate the examination at any time and to speak with his/her parent/legal guardian, attorney or supervising officer if desired.

C. As per standardized polygraph examination procedure, polygraph examiners shall be required to explain during the pre-test interview the polygraph instrumentation including causes of psychophysiological responses recorded during testing.

D. **Authorization and release:**
The examiner shall obtain the informed consent of the parent/legal guardian and the voluntary assent of the juvenile in writing or on the audio/video recording, to a standard waiver/release statement. The language of the statement shall minimally include the juvenile's voluntary assent to take the test, that all information and results will be released to professional members of the multidisciplinary 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.

Discussion: Polygraph examiners are not mandatory child abuse reporters by statute; this includes polygraph examiners with clinical training. All members of the multidisciplinary team who are mandatory child abuse reporters are responsible for assuring the timely and accurate reporting of child abuse to the appropriate authorities.

7.160 The multidisciplinary team shall determine and document on an on-going basis in case files the rationale for and type of polygraph testing used, frequency of testing and the use of the results in treatment, behavioral monitoring and supervision. Suitability and appropriateness for testing should be reviewed after each exam and prior to scheduling future exams. Having been tested once should not be considered automatic grounds for future testing and consequently, not being found suitable and/or appropriate for testing should not be considered automatic grounds for not being tested in the future.

7.170 Polygraph testing shall be used as an adjunct tool; it does not replace other forms of monitoring. Information and results obtained from polygraph examinations should never be used in isolation when making treatment or supervision decisions.

7.171 Information and results obtained through polygraph examination shall be considered, but shall not become the sole basis for decisions regarding transition, progress, and completion of treatment. Polygraph test findings for juveniles should be reported as "significant reactions" (deception indicated), "no significant reactions" (no deception indicated) or as "inconclusive" (no opinion). Such findings become a focus area for treatment and supervision. The findings of polygraph tests, as well as the juvenile's compliance or refusal to comply with request for polygraph testing, should not be used as the sole source in making treatment and supervision decisions.

Discussion: The MDT shall only report polygraph findings as significant reaction (deception indicated), no significant reaction (no deception indicated) and inconclusive (no opinion).

7.172 The multidisciplinary team shall respond to polygraph testing results in order to maintain the efficacy of the tool for maximum therapeutic benefit. Multidisciplinary team responses shall be in the form of sanctions, additional restrictions, rewards, or follow-up through the treatment and safety plans commensurate with the information obtained in the results.

Prior to a second examination, the MDT shall consider whether any new information has been disclosed that would explain the results of prior exams.

7.180 The following types of polygraph examinations shall be used with juveniles who have committed sexual offenses:

A. **Sexual History polygraph examination***:
The Sex History polygraph focuses on the juvenile's lifetime history of sexual behavior, including identification of victims and victim selection behaviors, numbers of sexual partners, and deviant or compulsive sexual behaviors:

1. When employed, the sexual history polygraph examination should be initiated in the early stages of treatment to allow for sufficient preparation and follow-up on the information and results.

2. The multidisciplinary team shall assure that juveniles referred for sexual history polygraph examination possess sufficient understanding of laws and definitions regarding abusive and/or illegal sexual behavior.

3. Information and results received from the exam are used to adjust existing treatment and supervision plans and provide information on past history to be addressed in treatment and supervision.

4. Information and results from the exam can be helpful in corroborating information gathered during treatment through the sex history disclosure packet as well as providing a more accurate assessment of static risk.

*For juveniles who refuse to answer sexual offense history questions, including sexual offense history polygraph questions, providers shall refer to *Standard 7.100*.

B. **Maintenance/monitoring polygraph examination**:
Maintenance or Monitoring polygraphs are used at intervals to assess the juveniles behaviors while in treatment and under supervision.

Maintenance polygraphs assess the juvenile's compliance with laws while Monitoring polygraphs assess the juvenile's on-going behaviors:

1. When indicated in accordance with suitability and appropriateness criteria, the multidisciplinary team shall consider maintenance/monitoring polygraph examination as needed, prior to transition to a less restrictive placement setting in the community, or prior to transition from one supervision level to another.

   Alternatively, the multidisciplinary team shall determine whether the juvenile may benefit more from participation in maintenance/monitoring polygraph examination 2-4 months following transition to a less restrictive setting, or may impose requirements for periodic maintenance polygraph examinations.

2. Test questions shall focus on issues that are clinically relevant to the assessment of safety and/or risk, compliance with the conditions of treatment and supervision and progress in treatment.

3. Results and information from the exam provide information related to current behaviors and dynamic risk to be addressed in treatment and supervision and can corroborate information gathered in each of these areas.

4. The use of these polygraphs can be a helpful tool to proactively help juveniles prevent future sexual offending behavior and to gauge readiness for change in supervision levels or assess behaviors at the current level of supervision.

5. Incremental testing of juveniles can help provide time to address results and information gathered from the test prior to any changes in treatment or supervision levels.

C. **Specific Issue or Index Offense polygraph examination:**
The Specific issue or index offense polygraphs are used regarding a specific behavior, allegation or event. The Specific issue polygraph can be used regarding any specific event, allegation or behavior identified throughout the course of treatment and supervision while the index offense polygraph is related to details of the offense of adjudication.

The Specific Issue polygraph can be useful in helping the juvenile address details of a specific event or progress past barriers of denial.

The Index Offense polygraph can be useful in helping juveniles address details of the index offense as well as preparing for clarification and addressing any discrepancies between the juvenile and victim statements.

1. The multidisciplinary team shall, at its discretion, refer juveniles determined to be suitable for polygraph examination according to criteria defined in Section 7.100 for specific issue polygraph examination.

2. Specific issue polygraph examination shall be employed under the following conditions:

    a. Substantial denial of offense

    b. Significant discrepancy between the account of the juvenile who committed a sexual offense and the victims description of the offense

    c. To explore specific allegations or concerns

    d. Prior to victim clarification, if any of the above conditions are present

7.200 Polygraph examiners shall be listed with the Sex Offender Management Board. Polygraph examiners shall adhere to the following standards of practice when testing juveniles who have committed sexual offenses:

A. Polygraph examiners shall use a system consisting of five or more channel polygraph computerized or polygraph instrument capable of simultaneously recording the individual's respiratory patterns, cardiovascular functions, electro-dermal response, metered chart/test time and additional component sensors to monitor test behavior.

B. Polygraph examiners shall employ a standardized comparison question technique that is generally accepted within the polygraph examination profession, in addition to a peak of tension and/or sensitivity/calibration test when appropriate.

C. Before proceeding to the in-test phase of an examination, the examiner shall review and explain all test questions and terms to the juvenile. The examiner shall not proceed until he/she is satisfied with the juvenile's response to each issue of concern:

1. Question construction shall be:

    a. Simple, direct and easily understood by the examinee;

    b. Behaviorally descriptive of the juvenile's involvement in an issue of concern (questions about knowledge, truthfulness, or another person's behavior are considered less desirable);

    c. Time limited (date of incident or time-frame);

    d. Absent of assumptions about guilt or deception;

    e. Free of legal terms and jargon;

    f. Avoid the use of mental state or motivational terminology.

D. Each examination shall be scheduled for a minimum of 90 minutes in length.

E. Polygraph examiners shall record each examination in its entirety. While audio and video recording is preferable, audio recording alone will suffice when video recording is not practical.

F. Polygraph examiners shall submit a written report within two (2) weeks of the examination that will be factual and descriptive of the information and results of each examination. Written reports are intended for treatment and supervision purposes only, and shall be submitted to the supervising officer/agent, caseworker and treatment provider. Each report shall include information regarding:

1. The date of examination

2. Beginning and ending times of examination

3. Name of person requesting examination

4. Name of examinee

5. Birth date of examinee

6. Type of court supervision

7. Reason for examination

8. Date of last clinical polygraph examination (if known)

9. Examination questions and answers

10. Any additional information deemed pertinent by the examiner

11. Reasons for inability to complete the examination

12. Post-test phases of the examination

13. Test results

G. Polygraph examiners shall score the examination data in accordance with physiological criterion that are generally accepted within the science of polygraphy as correlated with deception. In addition, a computerized scoring algorithm may be used; however the examiner must render the final decision with consideration for all the data obtained during the examination.

H. Polygraph examiners shall employ quality control processes as recommended by the American Polygraph Association and generally accepted practice within the polygraph profession.

8.000
VICTIMS AND POTENTIAL VICTIMS: CLARIFICATION, CONTACT AND REUNIFICATION

December 2014

8.100 Victim Clarification[42]

The victim clarification process is designed to primarily benefit the victim. Through this process the juvenile who has committed a sexual offense accepts responsibility for the abusive behavior and clarifies that the victim has no responsibility for the juvenile's behavior; which aids in helping the victim reduce self-blame and assign responsibility to the juvenile. The specific questions posed to the juvenile or topics to be addressed must be clearly defined and the goals and purpose of such communication must be clear to all involved. Issues 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 juvenile's ability to accurately self-disclose about the offending behavior. This process requires collaboration with a victim representative as defined in section 5.700. Following clarification written work, the clarification process may then progress to verbal contact prior to or in lieu of face-to-face contact. Victim participation is never required and clarification sessions should only occur based on the direction of the victim(s), not the family or juvenile. Clarification is always victim centered and based on victim need.[43]

Discussion: Whenever a victim has been in therapy, the victim's therapist is the preferred victim representative and should be consulted regarding the clarification process.

Secondary victims and significant persons in the victim's life are impacted by sexual offenses. Clarification with others (i.e. victim's parents, juvenile's parents, siblings, neighbors, fellow students) who have been impacted by the offense may be warranted in some cases.

Though always victim centered, clarification may provide benefits to both the victim and the juvenile who has committed a sexual offense.

8.110 Victim clarification procedures[44]

It is recommended that prior to a provider beginning clarification procedures they should receive training specific to the topic:

A. **Clarification work**

Clarification work is a multi-step process that should occur whether or not the process progresses to clarification sessions:

[42] Lipovsky, J.A., Swenson, C.C., Ralson, M.E. (1998). The Abuse Clarification Process in the Treatment of Intrafamiliar Child Abuse. Child Abuse and Neglect. Vol.22(7), 729-741.

[43] Digiorgio-Miller, J. (2002). A Comprehensive Approach to Family Reunification Following Incest in an Era of Legislatively Mandated Community Notification. Journal of Offender Rehabilitation. Vol. 35(2), 83-91.

[44] DeMaio, C.M., Davis, J.L., and Smith, D.W. (2006). The Use of Clarification Sessions in the Treatment of Incest Victims and Their Families: An Exploratory Study. Sexual Abuse: A Journal of Research and Treatment. Vol. 18(1)

1. Discussion between the therapist and the juvenile regarding the juvenile's sexually abusive behaviors.

2. Discussion with the juvenile about the clarification process and the importance of the process being victim centered.

3. Any significant difference between the juvenile's statements, the victim's statements and corroborating information about the offense/abuse has been resolved to the satisfaction of the multidisciplinary team. The juvenile is able to acknowledge the victim's statements without minimizing, blaming or justifying.

4. The juvenile will write clarification letters to each victim:

    a. If a victim representative (the victim therapist involved in the case is the preferred representative) working with the victim is known, the SOMB approved provider shall contact such person to determine if the victim wants to receive a clarification letter. If the victim does not want to receive a clarification letter the juvenile is still expected to complete steps c through f.

    b. If a victim representative working with the victim is not known, a member of the MDT shall reach out to the victim to explain the clarification process and determine if the victim wants to receive a clarification letter.

    c. Letters should be written in a manner assuming the victim will receive the letters, regardless of whether or not the letters will actually be sent.

    d. All letters should be reviewed by a victim representative or someone outside of the MDT that is familiar with clarification expectations in order to provide an outside viewpoint of the letters.

    e. Letters should be revised based on input from reviewers.

    f. Letters should be written in the juvenile's words and in a manner in which the victim can understand. It is imperative that letters are written based on the individual needs of the victim(s).

5. The juvenile 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 juvenile's offending behavior.

6. The juvenile 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.

7. Any sexual impulses are at a manageable level and the juvenile can utilize cognitive and behavioral interventions to interrupt deviant fantasies as determined by continued assessment.

8. The juvenile evidences decreased risk by demonstrating changes listed in Section 3.150.

B. **Clarification Sessions:**

The clarification process may progress to clarification sessions when approved by the multidisciplinary team in consultation with the victim's representative (the victim therapist involved in the case is the preferred representative) using the following criteria (Refer to Appendix K, "Guidance Regarding Victims/Family Member Readiness for Contact, Clarification, or Reunification" for further details):

1. The victim(s) requests clarification and the victim's representative concurs that the victim(s) would benefit from clarification.

2. Parents/guardians of the victim(s) (if a minor) and the juvenile offender are informed of and give approval for the clarification process.

3. A specific issue polygraph examination shall be employed prior to clarification sessions under the following conditions:

    a. Substantial denial of offense, or

    b. Significant discrepancy between the account of the juvenile who committed a sexual offense and the victims description of the offense, or

    c. To explore specific allegations or concerns that would effect the clarification process

4. Information gained from as a result of a specific issue polygraph is critical to an effective victim clarification process. The multidisciplinary team shall incorporate the testing results into their decision making regarding victim clarification.

5. The juvenile is able to demonstrate the ability to manage abusive or deviant sexual interest/arousal specific to the victim.

6. Clarification sessions will be victim centered and occur at a location or via a medium chosen or acceptable to the victim. MDT's may consider alternate forms of technology such as, video conferencing, on-line video communication, live or pre-recorded video presentations, etc.

8.200 Contact

Contact includes verbal or non-verbal communication which may be indirect or direct, between a juvenile and victim(s). Contact is first initiated through the clarification process. Following commencement of the clarification process and upon agreement of the multidisciplinary team, contact may progress to supervised contact with an informed supervisor outside of a therapeutic setting. It is generally preferred that clarification take place prior to contact. In some rare cases supervised contact may occur prior to formalized clarification sessions if such contact is requested by the victim(s) and approved by the MDT.

8.210 The multidisciplinary team shall:

A. Collaborate with the victim's representative (the victim therapist involved in the case is the preferred representative); in making decisions regarding communication, visits and reunification in accordance with court directives.

B. Support the victim's wishes regarding contact with the juvenile to the extent that it is consistent with the victim's safety and well-being.

Discussion: A common dynamic in families that may occur is direct or indirect influence or pressure on the victim to have contact with the juvenile who has committed a sexual offense. A third party professional assessment regarding victim needs may be warranted prior to contact with the juvenile.

C. Arrange contact in a manner that places victim safety first. When assessing safety, psychological and physical well-being shall be considered. In addition, the following criteria must be met before contact can be initiated and approved by the multidisciplinary team:

1. An informed supervisor has been approved by the multidisciplinary team. If the supervisor is not known to the victim, then the victim's representative must be present in the case of a child. This adult must meet the requirements of an informed supervisor as outlined in Section 9.000 of these Standards.

2. The juvenile is willing to plan for contact, to develop and utilize a safety plan for all contact and to accept and cooperate with supervision.

3. The juvenile is willing to accept limits on contact by family members and the victim, puts the victim's needs first and respects the victim's boundaries and need for privacy.

4. The juvenile is willing to cooperate with family or third party disclosure related to risk as directed by the multidisciplinary team.

D. If contact is approved, the multidisciplinary team shall closely supervise and monitor the process including:

1. The safety plan must have a mechanism in place to inform the multidisciplinary team and specifically the supervising officer/agent of concerns or rule violations during contact.

2. Victim's and potential victim's emotional and physical safety shall be assessed on a continuing basis and contact shall be terminated immediately if any aspect of safety is jeopardized.

8.300 Family Reunification[4546]

8.310 The multidisciplinary team shall make recommendations regarding reunification based on an on-going assessment of victim safety and needs. Family reunification shall never take precedence over the safety of any victim and it is important to be aware that in some cases reunification may not be appropriate. If reunification is indicated, after careful consideration of all the potential risks, the multidisciplinary team shall closely monitor the process. Even when indicated, family reunification can be a long-term process that involves risk and must be approached with great deliberation.

[45] Welfare, A. (2008). How Qualitative Research Can Inform Clinical Interventions in Families Recovering From Sibling Sexual Abuse. Australian and New Zealand Journal of Family Therapy. Vol. 29(3), 139-147.

[46] Harper, B.M. "Moving Families to Future Health: Reunification Experiences After Sibling Incest" (2012). *Doctorate in Social Work Dissertation.* Paper 26.

Discussion: Agencies or providers who fail to consider the recommendations of the multidisciplinary team are at increased risk of liability if the safety of any victim or potential victim is jeopardized by a reunification effort.

8.320 Reunification should only be considered when clarification has been accomplished. In rare cases reunification may occur prior to a clarification session if the clarification work outlined in section 8.110 A 1-8 has been completed to the satisfaction of the MDT and the needs and safety of the victim have been ensured and:

A. The multidisciplinary team has determined that the juvenile has made significant progress toward goals and outcomes as outlined in Section 3.130.

B. The multidisciplinary team has determined the victim has the abilities to set age appropriate boundaries and limits, and ask for help.

C. The multidisciplinary team has determined the parents/guardians have demonstrated the ability to provide informed supervision (Section 9.000) and demonstrate evidence of:

1. The ability to initiate consistent communication with the victim regarding the victim's safety.

2. The family believes the abuse occurred, has received support and education, and accepts that potential exists for future abuse or offending.

3. The family has established a relapse prevention plan that extends into aftercare and includes evidence of a comprehensive understanding of the offending behavior(s) and implementation of safety plans.

8.330 The multidisciplinary team shall continue to monitor family reunification and recommend services according to the treatment plan. Family reunification does not indicate completion of treatment. Reunification may illuminate further or previously unaddressed treatment issues that may require amendments to the treatment plan.

9.000
INFORMED SUPERVISION PROTOCOL

Revised August 2015

Informed supervisors of juveniles who have committed sexual offenses shall be identified by the MDT at the onset of involvement with any agency that is required to comply with these Standards. If the juvenile is involved with pre-trial services and no MDT has been formed, it is considered best practice for a juvenile who has committed a sexual offense to have informed supervision. Decisions related to informed supervision should be made by the pre-trial officer, in consultation with other involved professionals, to the best of their ability.

ALL JUVENILES WHO HAVE COMMITTED SEXUAL OFFENSES SHALL HAVE INFORMED SUPERVISION.

Informed supervision is the individualized, on-going daily supervision of a juvenile by a qualifying adult with specialized training and a demonstrated ability to apply knowledge from the training to promote victim, community, and juvenile safety by intervening with the juvenile to manage risk factors[47]. The MDT shall make the decision regarding the level of supervision which may include complete visual and auditory supervision of the juvenile at all times. Informed supervisors may include adult parent or caregiver parents (if not directly involved in the treatment process), advocates, mentors, kin, spiritual leaders, teachers, work managers, coaches and other natural supports as identified by MDT[48].

Discussion Point: The procedure for qualifying an adult as an Informed Supervisor is a multi-step process that is determined and approved by the MDT. The process may include specialized training classes, family therapy sessions with an approved treatment provider, and/or other modalities determined by the MDT[49]. In some cases attendance at a specialized training class in and of itself may not be sufficient for qualifying someone as an Informed Supervisor. In all cases the MDT must make the final determination regarding someone's qualifications as an Informed Supervisor.

9.100 Qualifications of an Informed Supervisor:

A. An adult not currently under the jurisdiction of any court or criminal justice agency for a matter that the MDT determines could impact his/her capacity to safely serve as an Informed Supervisor or Therapeutic Care Provider;

[47] Finkelhor, D., Ormrod, R., & Chaffin, M. (2009). Juveniles Who Commit Sex Offenses Against Minors. Washington, DC: U.S. Department of Justice, Office of Justice Programs, Office of Juvenile Justice and Delinquency Prevention; Prisco, R. (2015). Parental Involvement in Juvenile Sex Offender Treatment: Requiring a Role as Informed Supervisor. *Family Court Review, 53*(3), 487–503; Ryan, E. (2015). Juvenile Sex Offenders. *Child Adolescent Psychiatry Clinical North America 25*(1), 81–97.

[48] Schladale, J. (2006). Family matters: The importance of engaging families in treatment with youth who have caused sexual harm. In R. Longo & D. Prescott (Eds.), Current perspective: Working with sexually aggressive youth and youth with sexual behavior problems (pp. 493–514). Holyoke, MA: NEARI Press; Yoder, J., Hansen, J., Lobanov-Rostovsky C., and Ruch D. (2015). The Impact of Family Service Involvement on Treatment Completion and General Recidivism Among Male Youthful Sexual Offenders. *Journal of Offender Rehabilitation 54*(4), 256-277; Zankman, S., & Bonomo J. (2004). Working with Parents to Reduce Juvenile Sex Offender Recidivism. *Journal of Child Sexual Abuse, 13*(3-4), 139-156.

[49] Keane, M., Guest, A., Padbury, J. (2013). A Balancing Act: A Family Perspective to Sibling Sexual Abuse. *Child Abuse Review 22*, 246–254; Thomas, J. (2010). Family therapy: A critical component in treatment of sexually abusive youth. In G. Ryan, T. Leversee, & S. Lane (Eds.), Juvenile sexual offending: Causes, consequences and correction (3rd ed., pp. 357–379). New Jersey: John Wiley & Sons; Thornton, J., Stevens, G., Grant, J., Indermaur, D., Chamarette, C., Halse, A. (2008). Intrafamilial adolescent sex offenders: Family functioning and treatment. *Journal of Family Studies 14*(2-3), 362-374; Yoder J., and Ruch D. (2015). A qualitative investigation of treatment components for families of youth who have sexually offended. *Journal of Sexual Aggression*,

B. If ever accused or convicted of unlawful sexual behavior, child abuse, neglect or domestic violence, he/she presents information requested by the MDT so that the MDT may assess current impact on his/her capacity to serve as an Informed Supervisor[50].

C. Complete Informed Supervision training and implement as recommended by the MDT. Training should include, but is not limited to:

1. History of the SOMB
2. Why Informed Supervision is important
3. Victim Confidentiality
4. Sexual Offending Behaviors
5. Seriousness of juvenile sexual offending
6. Current laws that are relevant to juvenile sexual offending
7. Dynamic patterns associated with abusive behavior
8. Community Supervision and Treatment
9. Safety Plans
10. High Risk Patterns
11. What is an MDT and the Importance of it

Discussion Point: Trainers of Informed Supervision may be from a variety of disciplines including, but not limited to; child welfare, DYC, or SOMB listed treatment providers. The curriculum used is not determined or regulated by the SOMB. It is recommended that individuals providing Informed Supervision training receive training in the relevant topics and stay up to date with changes in the field. Trainers of Informed Supervision should understand and convey the message that being qualified as an Informed Supervisor involves specialized training as well as the ability to demonstrate the application of knowledge gained from specialized training, and in all cases the MDT must make the final determination regarding someone's qualifications as an Informed Supervisor.

D. Have to be identified and approved by the MDT.

9.200 Responsibilities of the Informed Supervisor

A. Respect victim's confidentiality[51].

[50] Prisco, R. (2015). Parental Involvement in Juvenile Sex Offender Treatment: Requiring a Role as Informed Supervisor. *Family Court Review, 53*(3), 487–503; Zankman, S., & Bonomo J. (2004). Working with Parents to Reduce Juvenile Sex Offender Recidivism. *Journal of Child Sexual Abuse, 13*(3-4), 139-156.

B. Is aware of the juvenile's history of sexual offending behaviors as it pertains to their involvement.

C. Does not allow contact with the victim (s) unless and until approved by the MDT[52].

D. Directly observes and monitors approved contact between the juvenile, victim(s), siblings and other potential victims as defined by the MDT[53].

E. Does not deny or minimize the juvenile's responsibility for, or seriousness of sexual offending. Is aware of the current laws relevant to juvenile sexual offending behavior. Can define all types of abusive behaviors and can recognize abusive behaviors in daily functioning[54].

F. Is aware of dynamic patterns of thoughts, feelings and behaviors associated with offending and abusive behaviors and is able to recognize such patterns in daily functioning[55].

G. Understands the conditions of community supervision and treatment.

H. Can design, implement and monitor safety plans for daily activities[56].

I. Is able to hold the juvenile accountable for his/her behavior[57].

J. Has the skill to intervene in and interrupt high risk patterns[58].

K. Communicates with the MDT regarding observations of the juvenile's daily functioning.

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[51] Keane, M., Guest, A., Padbury, J. (2013). A Balancing Act: A Family Perspective to Sibling Sexual Abuse. *Child Abuse Review 22*, 246–254; Lonsway, K., and Archambault, J. (2013). Effective Victim Advocacy in the Criminal Justice System: A Training Course for Victim Advocates. *End Violence Against Women International*, project funded by #2004-WT-AX-K066, #2008-TA-AX-K040 and Grant #97-WE-VX-K004.

[52] Finkelhor, D., Ormrod, R.K., Turner, H.A. (2007). Re-victimization patterns in a national longitudinal sample of children and youth. *Child Abuse and Neglect. 31*(5), 479-502.

[53] Prisco, R. (2015). Parental Involvement in Juvenile Sex Offender Treatment: Requiring a Role as Informed Supervisor. *Family Court Review, 53*(3), 487–503.

[54] Reicher B. (2013). Denying Denial in Children with Sexual Behavior Problems. *Journal of Child Sexual Abuse, 22*(1), 32-51; Worley, K., Church, J., & Clemmons, J. (2011). Parents of adolescents who have committed sexual offenses: Characteristics, challenges, and interventions. *Clinical Child Psychology and Psychiatry, 17*(3), 433-448; Zankman, S., & Bonomo J. (2004). Working with Parents to Reduce Juvenile Sex Offender Recidivism. *Journal of Child Sexual Abuse, 13*(3-4), 139-156.

[55] Driemeyer, W., Yoon, D., & Briken, P. (2011). Sexuality, antisocial behavior, aggressiveness, and victimization in juvenile sexual offenders: A literature review. *Sexual Offender Treatment, 6*, 1-10; Kimonis, E., Fanniff, A., Borum, R. and Elliott, K. (2011). Clinician's Perceptions of Indicators of Amenability to Sex Offender-Specific Treatment in Juveniles. *Sexual Abuse: A Journal of Research and Treatment, 23*(2), 193-211; Miner, M., & Munns, R. (2005). Isolation and Normlessness - Attitudinal Comparisons of Adolescent Sex Offenders, Juvenile Offenders, and Nondelinquents. *International Journal of Offender Therapy and Comparative Criminology, 49*(5), 491-504.

[56] Ohio Family Violence Prevention Center (2010). Excellence in Advocacy: A Victim-Centered Approach, Ohio Office of Criminal Justice Services, 2008-WF-AX-0021.

[57] Englebrecht et al. (2008). "It's not my fault": Acceptance of responsibility as a component of engagement in juvenile residential treatment. *Children and Youth Services Review, 30*(4), 466-484; Hunter Jr., J.A., & Figueredo, A. J. (1999). Factors associated with treatment compliance in a population of juvenile sexual offenders. *Sexual Abuse: A Journal of Research and Treatment, 11*(1), 49-67; McGrath, R., Cumming, G., Burchard, B., Zeoli, S., & Ellerby, L. (2010) Current Practices and Emerging Trends in Sexual Abuser Management: The Safer Society 2009 North American Survey. *Brandon, Vermont: Safer Society Press*.

[58] Carpentier, J., & Proulx, J. (2011). Correlates of Recidivism Among Adolescents Who Have Sexually Offended. *Sexual Abuse: A Journal of Research and Treatment, 23*(4), 434-455; Finkelhor, D., Ormrod, R., & Chaffin, M. (2009). Juveniles Who Commit Sex Offenses Against Minors. Washington, DC: U.S. Department of Justice, Office of Justice Programs, Office of Juvenile Justice and Delinquency Prevention; McCann, K., & Lussier, P. (2008). Antisociality, Sexual Deviance, and Sexual Reoffending in Juvenile Sex Offenders. A Meta-Analytic Investigation. *Youth Violence and Juvenile Justice, 6*(4), 363–85; Worling, J. R., & Långström, N. (2006). Risk of Sexual Recidivism in Adolescents Who Offend Sexually: Correlates and Assessment. In H. E. Barbaree & W. L. Marshall (Eds.),The Juvenile Sex Offender (2nd ed.) (pp. 219-247). New York: Guilford Press.

L. Follows supervision requirements as outlined by the MDT which may include complete visual and auditory supervision of the juvenile at all times.

M. Acknowledges a willingness and ability to comply with standards 9.200 A-L and agrees to communicate any changes of their willingness or ability to the MDT.

Discussion: Informed supervision is an ongoing process and will change as the dynamic needs of the juvenile change. The MDT and the informed supervisor will need to work closely and cooperatively to respond to these needs[59]. MDTs will need to address problems that surface in regards to informed supervisors such as;

- *Learning curves*
- *Training or retraining requirements*
- *Family Dynamics[60]*
- *Significant Life events*
- *Substance use/abuse*
- *Non-compliance with responsibilities*

Responses must be documented in the case file and reflected in treatment and safety plans per these Standards. Informed supervisors are defined as primary care providers, parents (if not directly involved in the treatment process), advocates, mentors, kin, spiritual leaders, teachers, work managers, coaches, and others as identified by the MDT. It is the responsibility of the MDT to educate, inform and evaluate potential informed supervisors regarding their role to sexual offense issues.

[59] Prisco, R. (2015). Parental Involvement in Juvenile Sex Offender Treatment: Requiring a Role as Informed Supervisor. *Family Court Review, 53*(3), 487–503; Yoder & Ruch (2015). Youth who have sexually offended: Using strengths and Rapport to Engage Families in Treatment, *Journal of Child and Family Studies, 24*(9), 2521-2531; Worley, K., Church, J., & Clemmons, J. (2011). Parents of adolescents who have committed sexual offenses: Characteristics, challenges, and interventions. *Clinical Child Psychology and Psychiatry, 17*(3), 433-448; Zankman, S., & Bonomo J. (2004). Working with Parents to Reduce Juvenile Sex Offender Recidivism. Journal of Child Sexual Abuse, 13(3-4), 139-156.

[60] Duane, D., Carr, A., Cherry, J., McGrath, K., & O'Shea, D. (2004). Chapter 9. Supporting parents of adolescent perpetrators of CSA. In A. Carr & G. O'Reilly (Eds.), Clinical Psychology in Ireland Volume 5: Empirical Studies of Child Sexual Abuse (pp. 213-234). Wales: Edwin Mellen Press; Baker, A. J. L., Tabacoff, R. Tornusciolo, G., & Eisenstadt, M. (2003). Family secrecy: A comparative study of juvenile sex offenders and youth with conduct disorders. *Family Process, 42*(1), 105–116.

10.000
VICTIM IMPACT AND A VICTIM CENTERED APPROACH
September 2016

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 evaluation, assessment, treatment and supervision of juveniles who have committed sexual offenses. In order to accomplish the mission of effective supervision of juveniles who have committed sexual offenses 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.[61] 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.[62]

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:

[61] 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.

[62] 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.

- fear
- anxiety
- hypervigilance
- self-blame
- guilt
- shame
- depression
- anger
- irritability
- avoidance
- intrusive thoughts
- flashbacks
- nightmares and sleeping problems
- panic attacks
- Post-Traumatic Stress Disorder
- dissociative disorders
- physiological effects, such as headaches / chronic pain
- memory impairment
- 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
- 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.

10.000 The Multi-Disciplinary 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 juvenile, 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.

10.010 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 Reference Guide for School Personnel.

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 8.000)

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

11.000
CONTINUITY OF CARE AND INFORMATION SHARING
September 2016

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.

11.000 Continuity of Care

11.010 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.

11.020 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.

11.030 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 X for an example.

Discussion point: 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.

11.040 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 "X."

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 5.7 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 point: 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.

11.100 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 Point: 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 "X."

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 Point: 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 X for a sample matrix for recommendations.

11.200 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 "X" 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 appendix X

b. A court filing document for submitting information regarding participation in treatment for adults can be found in Appendix "X."

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
    5. For juveniles: A current recommendation regarding whether registration should/should not continue based on information available at the date of the report.

Appendix A
INFORMED SUPERVISION AGREEMENT *December 2014*

Juvenile: _____

Respondent: _____

Relationship of Respondent: _____

Identified Informed Supervisor:_____

Relationship of Informed Supervisor to Juvenile:_____

The Informed Supervision Protocol requirements for the FIRST 24 HOURS of placement have been met through the identification of:

1) The nature and extent (as is possible) of the alleged or known sexual offending behavior of the juvenile
Notes:_____
_____
_____
_____

2) Immediate risk factors
Notes:_____
_____
_____
_____

3) If being supervised through the juvenile justice system, a review of the terms and conditions of supervision, prior to the juvenile residing with the informed supervisor
Notes:_____
_____
_____
_____

4) Acknowledgement of the requirement to develop the Caregiver--Juvenile Supervision Plan within the next 5 days
Notes:_____
_____
_____
_____
_____.

Informed Supervisor Date Supervising Officer/DHS caseworker Date

Appointment date to develop the initial Caregiver--Juvenile Supervision Plan _____
(See Next Page)

The Informed Supervision Protocol requirements for the FIRST 5 DAYS of placement have been met through the initial development of the Caregiver--Juvenile Supervision Plan. The plan as outlined in Appendix A1 is attached:

Notes: _____

Informed Supervisor	**Date**	**Supervising Officer**	**Date**
(Please Circle One)		**(Please Circle One)**	
Therapeutic Care Provider		**DHS caseworker**	

Appendix A1
INFORMED SUPERVISION
INITIAL CAREGIVER - JUVENILE SUPERVISION PLAN
December 2014

All juveniles who commit sexual offenses shall be provided informed supervision by the primary caregiver (parent/guardian or other caregiver) in any placement.

The supervising officer/agent or DHS caseworker shall review the Informed Supervision Protocol (Section 9.000) and follow the conditions of informed supervision.

Immediately upon receipt of a juvenile who has committed a sexual offense into the juvenile justice or DHS system, the supervising officer/agent shall complete the Informed Supervision Agreement (Appendix A).

The Informed Supervision Agreement (Appendix A) is to be placed in the juvenile's complete case record. This informed supervision agreement is meant to be used at intake and is the minimum foundation of the expected level of informed supervision.

INITIAL CAREGIVER—JUVENILE SUPERVISION PLAN

The required elements of informed supervision are outlined in Section 9.000 of these Standards. The following eight (8) items constitute the basis for the initial Caregiver--Juvenile Supervision Plan.

1. The parent/guardian or caregiver is responsible for supervision of the juvenile 24 hours per day, 7 days per week, including sleeping hours. The parent/guardian or caregiver must be aware of the juvenile's whereabouts and activities at all times including common daily activities such as: collecting mail; placing the trash out; bathing or presence in another room. Informed supervision must be provided while riding in vehicles.
2. The parent/guardian or caregiver must be responsible for line-of-sight supervision of the juvenile whenever the juvenile is around children or potential victims.
3. The parent/guardian or caregiver must make arrangements for another informed supervisor to be present when the parent/guardian or caregiver is not available.
4. The parent/guardian or caregiver must make arrangements for informed supervision when the juvenile is in the community, in school or involved in activities where exposure to other children may occur.
5. The parent/guardian or caregiver must inform the school counselor, social worker or school liaison of the juvenile's potential risk and develop a safety plan with the school.
6. The parent/guardian or caregiver must make arrangements for and participate in sex offense specific evaluations, assessments and treatment with the juvenile.
7. The parent/guardian or caregiver must be involved with the multidisciplinary team to ensure safety and to enhance treatment progress.
8. The parent/guardian or caregiver must recognize the potential risk posed by a juvenile who has committed a sexual offense. The parent/guardian or caregiver must make necessary adjustments to ensure maximum safety and supervision. The parent/guardian or caregiver may need to install motion detectors, cameras, alarms, or other security devices.

(OVER)

The supervising officer/agent and/or DHS caseworker must document their action(s) in the following areas:

1. Review Informed Supervision Protocol with the informed supervisor, parent/guardian or caregiver and the juvenile who has committed a sexual offense.
2. Upon initial placement, including emergency or respite care, the DHS caseworker must assess the residence for environmental considerations and safeguards including sleeping arrangements or play areas.
3. Set an appointment to complete informed supervision requirements within the required time frames.
4. Set regular appointments between named parties including time and place.

Appendix B
THERAPEUTIC CARE PROTOCOL *December 2014*

Therapeutic care providers shall provide all aspects of informed supervision and shall comply with Standard 3.160. A therapeutic care provider shall be aware of and be able to implement the conditions of the Informed Supervision Protocol (Section 9.000) and shall be a signatory on the initial Caregiver--Juvenile Supervision Plan (Appendix A1).

When a caregiver is identified as a therapeutic care provider by the multidisciplinary team, the supervising officer/agent or the DHS caseworker shall review Section 5.800 with the therapeutic care provider within the first 5 days of placement.

An initial therapeutic care plan shall be developed conjointly between the therapeutic care provider and the multidisciplinary team.

All signature forms of Informed Supervision (Section 9.000 and Appendix A) apply to therapeutic care and shall be completed within the prescribed timelines.

Appendix C
POLYGRAPH EXAMINATION *December 2014*

Excerpted and adapted from the Ethical Standards and Principles for the Management of Sexual Abusers (1997), and Practice Standards and Guidelines (2001), the Association for the Treatment of Sexual Abusers.

The polygraph's utility is in its ability to elicit information not available through traditional interviewing techniques. When utilizing polygraph examinations with sexual abusers, therapists should work in conjunction with polygraph examiners in developing protocols for pre-examination interviewing, question formulation, reporting and use of results. Specific decisions relative to instrumentation, interpretation of data and question formulation should be made by trained polygraph examiners.

A. Types of Polygraph Examinations

1. Sexual History Examination
   The sexual history examination is a thorough examination of the juvenile's sexual history. When employed, the sexual history polygraph examination should be initiated within 3-9 months following the onset of treatment to allow for sufficient preparation and follow-up on the information and results.

   Due to the diverse response from various jurisdictions of the criminal justice system, clinicians should be aware of the general implications and local judicial policies regarding newly reported crimes and self-incrimination when requiring clients to undergo sexual history polygraph examinations.

2. Specific Issue Examination
   The specific issue examination is an examination regarding a specific behavior, allegation or event. This examination is generally implemented at the onset of or during the treatment process.

3. Maintenance/Monitoring Examination
   The maintenance examination is a periodic examination of a juvenile's compliance with treatment and/or probation/parole restrictions. This examination serves to identify and deter high risk behaviors. Monitoring or maintenance polygraph examinations are usually implemented every four to six months, but can be done more frequently on those juveniles who present as high risk.

   The examinations further assist the service providers in tailoring more effective intervention strategies.

B. Polygraph Examination Recording Guidelines

All polygraph examinations will be appropriately recorded for diagnostic and documentation purposes.

Recording channels/components required for polygraph examinations have been outlined by the American Polygraph Association which requires that:

1. Respiration patterns made by pneumograph component(s)--at least one respiration component will record the thoracic (upper chest) respiration and/or abdominal (lower stomach) respiration pattern.

2. One of the chart tracings will record the Skin Conductance Response (SCR) also commonly referred to as Galvanic Skin Response (GSR), which reflects relative changes in the conductivity/resistance of very small amounts of current by the epidermal tissue.

3. A cardiograph tracing will be utilized to record changes in the pulse rate, pulse amplitude, and changes in the relative blood pressure.

4. To effectively evaluate the polygraph tracings collected during any polygraph examination it is necessary to obtain easily readable trace recordings. Tracings that are either too large or too small or that have extraneous responses to outside stimuli are difficult to evaluate.

5. Chart tracings consistently less than one-half inch in amplitude in the pneumograph and/or cardiograph tracings, without sufficient documented explanation of physiological cause, may be considered insufficient for analysis purposes.

C. Polygraph Instrument Calibration

Standardized Chart Markings recognized and used within the polygraph profession will be employed to annotate all calibration and examination charts.

Each polygraph instrument will be calibrated on a regular basis to ensure the instrument is functioning properly. The examiner shall maintain true and accurate records of such calibration. The records of these calibrations should be maintained by the examiner for three years.

If the instrument remains stationary, all analog polygraph instruments will be calibrated at least once each week.

If the instrument was moved subsequent to its last calibration procedure, each analog instrument will be calibrated prior to being used.

Digital polygraph instruments will be calibrated according to factory specifications and the manufacturer' s recommendations.

D. Recommended Frequency of Polygraph Examinations

The following guidelines for polygraph examination frequency are recommended to maximize validity and reliability of examination rules:

To safeguard against the possibility of client habituation and familiarization between the examiner and the subject, it is recommended that the polygraph examiner not conduct more than three separate examinations per year on the same client.

A re-examination to resolve a previously failed examination, or where no clear opinion was formed as to the subject 's truthfulness, would not be considered a separate examination.

In order to allow sufficient time for the pre-test, in-test and post-test phases of the examination, most tests will require at least 90 minutes. In many cases, it should be anticipated that the examination session will take longer to complete.

E. Polygraph Testing Techniques and Procedures

Polygraph examination techniques will be limited to those techniques that are recognized by the industry as standardized and validated examination procedures.

To be an approved examination format, the examination procedure must include appropriately designed relevant questions, appropriately designed control questions for diagnostic purposes, and appropriately designed irrelevant questions as applicable to that defined and standardized procedure.

A standardized examination technique or procedure is defined as:

1) A technique or procedure which has achieved a published, scientific database sufficient to support and demonstrate validity and reliability from the application and use of that specific polygraph technique.

2) A technique or procedure that is evaluated according to the published methods for that specific procedure and provides for numerical scoring and quantification of the chart data.

3) A technique or procedure that has not been modified without the support of published validity and reliability studies for that particular modification.

4) A technique or procedure that has been taught as part of the formal course work at a basic polygraph school accredited by the American Polygraph Association.

Recommended procedures include:

1) Standardized and published Zone Comparison Techniques (ZCT)

2) Standardized and published Control Question Techniques (CQT)

3) Other standardized and published procedures that meet the guidelines and requirements described above.

Utilizing these procedures ensures maximum validity and reliability of diagnostic opinions and ensures that opinions rendered are defensible in court.

F. Stimulation/Acquaintance Test

The Stimulation/Acquaintance Test is used to demonstrate that the psychological set of the client and the client's reaction capabilities are established for diagnostic purposes.

This test is a recognized procedure utilized in conjunction with professional examination formats and may be a part of the polygraph examination.

G. Number of Relevant Questions

All standardized and recognized published examination formats and procedures define the number of relevant questions that may be used. Those applications should not be modified or altered.

No recognized examination procedure allows for more than five relevant questions to be asked during any given examination.

H. Single-Issue and Mixed Issue Examinations

Available scientific research has indicated that mixing issues during an examination can significantly reduce the ability to form valid and reliable opinions.

The importance of psychological set, satiation, adrenaline exhaustion and other principles forming the foundation of the polygraph science must be maintained.

I. Relevant Question Construction

In order to design an effective polygraph examination and to adhere to standardized and recognized procedures, the relevant questions should be constructed with the following considerations:

1) Be as simple, direct and short as possible.

2) Not include legal terminology (i.e., sexual assault, homicide, incest, etc.) as this terminology allows for client rationalization and utilization of other defense mechanisms.

3) Ensure the meaning of each question is clear, not allow for multiple interpretations and not be accusatory in nature.

4) Never presuppose knowledge.

5) Contain reference to only one element of the issue under investigation.

6) Use language easily understood by the client.

7) Be easily answerable yes or no.

8) To avoid the use of any emotionally laden terminology (i.e., rape, molest, murder, etc.)

Appendix C-1
RESPONDING TO POLYGRAPH RESULTS *December 2014*

The purpose of this appendix is to assist multidisciplinary teams in their use of polygraph testing with juveniles who have committed sexual offenses. Though several sections address polygraph use throughout these Standards, questions from the field have arisen regarding practical application and implementation. This appendix is not intended to revise existing Standards, but rather to provide guidance to multidisciplinary teams who evaluate, treat, manage and supervise this population.

Representing a cross-section of mandatory members of any multidisciplinary team (Section 5.110) the Sex Offender Management Board committee developed this appendix soon after the first publication of these Standards. Thoughtful consideration of comments and concerns from a variety of consumers provided the framework for the committee's approach.

The outcome is a best practice-based document that answers frequently asked questions, provides guidance regarding testing preparation, and outlines the process multidisciplinary teams should undergo when making decisions about the use of polygraph testing and the results of examinations.

Preparation for Polygraph Testing

Adequate preparation for polygraph examination has been found to contribute to improvements in the quality and quantity of information obtained from the polygraph, and to the accuracy of polygraph results. Structured preparation guidelines will serve to assure that juveniles are provided necessary guidance in preparing for polygraph examination, variability in preparation procedures will be determined by the multidisciplinary team (MDT). The MDT should provide the youth with guidance and structure sufficient to identify and organize the information pertaining to the polygraph test. All written materials should be provided to the examiner prior to or at the time of the examination.

Following are the three types of polygraph examination as listed in these Standards, and the minimal requirements for preparation by the juvenile:

1. Sexual history polygraph examination

    Minimal preparation requirements by the juvenile:

    - Is able to define types of abusive and unlawful sexual behavior (sibling, family member, lack of consent, lack of equality, some form of coercive pressure)
    - Identification of victims of past abusive sexual behaviors and specific types of unlawful sexual contact are clear
    - Demonstrates an adequate conceptual vocabulary regarding the test issues
    - Written preparation materials completed by the juvenile should be provided to the examiner prior to or at the time of the examination.

    Examination areas may include:

    - Sexual offenses
    - Sexual behavior patterns
    - Consensual sexual contacts
    - Masturbation issues
    - Pornography issues
    - Grooming, silencing, and maintenance behaviors
    - Household boundaries

The MDT should assist the youth in preparing for sexual history polygraph testing by ensuring that the youth can define and identify abusive and/or unlawful sexual behaviors. In addition, the MDT should ensure that the youth possess and demonstrates an adequate conceptual vocabulary regarding the issues under investigation (i.e., pornography, masturbation, sexual contact, force, threats, coercion, relatives, consent, etc.)

Discussion: The MDT and/or polygraph examiner may elect to limit the time of reference of disclosure -- during the preparation, pre-test, and in-test phase of the examination -- to more recent history of sexual offense behaviors (i.e., since age 10, or since a memorable event marker). This may be particularly important for those youths whose early childhood experiences include severe chaos or abuse, or highly sexualized behaviors at young ages.

2. Maintenance/monitoring polygraph examination

    Minimal preparation requirements by the juvenile:

    - Is able to define of abusive and unlawful sexual behavior (sibling, family member, lack of consent, lack of equality, some form of coercive pressure)
    - Demonstrates an adequate conceptual vocabulary regarding the test issues
    - Written preparation materials completed by the juvenile should be provided to the examiner prior to or at the time of the examination.

Examination areas may include:

- Re-offense/lapse/relapse behaviors
- Sexual contacts
- Contacts with minors and/or vulnerable persons
- Masturbation issues
- Pornography issues
- Grooming, silencing, and maintenance behaviors
- Recent criminal behaviors
- Compliance issues
- Household boundaries
- School boundaries

3. Specific issue polygraph examination

Minimal preparation requirements by the juvenile

- Is able to define types of abusive and unlawful sexual behavior (sibling, family member, lack of consent, lack of equality, some form of coercive pressure)
- Demonstrates an adequate conceptual vocabulary regarding the test issues
- Conceptual understanding of the nature and time-frame of the issue, allegation, or inconsistency under investigation
- Written preparation materials completed by the juvenile should be provided to the examiner prior to or at the time of the examination
- Examiner should be provided the police/investigation reports, presentence investigation (PSI), and/or victim's statement prior to the examination date

Examination areas may include:

- Any history of involvement in the issue under investigation (absent of any allegation or reason to suspect involvement)
- Specific issues regarding the allegation and/or discrepancies under investigation
- Determine the presence or absence of other unreported behaviors

The MDT will seek to assist youths in preparation for polygraph testing in a manner that is least likely to induce or increase the youth's sexual arousal to deviant sexual themes and stimuli.

Preparation materials, as recommended in this appendix, should assist the juvenile in identifying all relevant sexual behaviors involving abusive or unlawful conduct toward others in addition to the juvenile's history of involvement in other sexual behaviors indicative of sexual preoccupation, sexual deviancy, and risk for sexual recidivism.

It is not mandatory that all treatment providers utilize the same polygraph preparation materials, and some variability in methods is expected in response to the demands of specific sub-groups within the population of juveniles who have committed sexual offenses. Programs that utilize alternative preparation materials to those recommended in this appendix should ensure that their materials address a similar range of clinical and risk predictive issues, and remain sensitive to juveniles' needs for the development of healthy/normative sexual identities.

Responding to Polygraph Outcomes

Polygraph examinations are administered for the following purposes:

- To gain information relevant to the determination of risk level and/or progress in treatment
- To deter problem behavior and encourage complianace and healthy/safe behavioral adjustment
- To verify an individual's honesty with the members of, and compliance with, the requirements of the multidisciplinary team (MDT).

Three types of polygraph examinations are utilized with juveniles who have sexually offended, and the target issues vary accordingly:

1) the juvenile's history of involvement in sexual offense behaviors and sexual behaviors (sexual history polygraph examination)
2) examination of a juvenile's behavior and/or compliance with rules and condition of supervision during a designated time period under supervision and/or while in treatment (maintenance/monitoring examination)
3) investigation of a single or specific issue of concern (i.e.,drug or alcohol use, the nature and extent of the juvenile's offenses against an individual, etc.)

The MDT is required to consider all sources of information when making decisions regarding a juvenile's progress in treatment, transition to less restricitive levels of care, and sucessful completion of treatment. When a polygraph examination is utilized as a source of information, the MDT should remain aware of the following considerations: 1) the nature and purpose of the polygraph test; 2) the information and results obtained from the polygraph test; and 3) the implications of the test results in the individual's treatment and management plan.

The MDT should formulate its response to the information and results from the polygraph test in a manner that is consistent with the objectives of the examination (i.e., community safety needs, individual treatment needs). The MDT should consider the following in formulating its response:

1. Nature and purpose of the polygraph examination

   - Detection of information relevant to risk assessment and treatment planning
   - Verification of compliance with supervision and/or treatment requirements
   - Deterence of problem behaviors

   Discussion: Polygraph examination outcomes may lead to increased or decreased activity restrictions and/or changes in supervision or treatment requirements.

2. Polygraph outcomes

   - Admissions/disclosures
   - Timeliness of admissions and disclosures (i.e., preparation, pre-test, post-test)
   - Scored test results
   - Juvenile's response to the polygraph process and/or results (including efforts to resolve remaining inconsistencies)

   Discussion: The MDT's response to polygraph examination outcomes may vary according to the timeliness of any admissions or disclosures. Juveniles who make 11th hour admissions prior to or during a polygraph examination may be demonstrating a more reluctant attitude toward the treatment and supervision process compared with those who report behaviors in a more timely manner. However, any effort to disclose behavioral issues and/or resolve inconsistencies may be an indicator of progress.

3. Case management context (to be considered when responding to polygraph examination outcomes)

   - Individual's diagnostic/developmental profile

- Length of court supervision (remaining supervision period)
- Progress in sex offense specific treatment
- History of behavioral compliance
- Quality and level of supervision in the individual's environment
- Involvement in community based activities (family, work, school, recreation)

Discussion: When a youth discloses information that changes his/her assessed risk level -- regardless of the test outcome-- the MDT may elect to intensify treatment and supervision requirements. This information may accelerate or delay plans for transition or access to activities in the community. In the event of inevitable transitions, the MDT may elect to delay maintenance/monitoring examinations to a time following the transition to deter problem behavior and support the youth's behavioral adjustment in the new setting.

Questions and Answers
Regarding Polygraph Testing of Juveniles Who Have Committed Sexual Offenses

1. Who makes the referral for a polygraph examination?

   Standard 7.100 states that the MDT makes the referral for a polygraph examination. Polygraph referrals should not be made by an individual member of the MDT without the involvement of the other members.

2. Is it permissible to inform the juvenile's family and/or attorney of the questions or issues to be addressed during the examination?

   The juvenile's family members and/or attorney may be informed of the general areas of inquiry that will be investigated during the examination. The questions asked will be individualized and language and vocabulary may be infinitely variable. The juvenile should not be informed of the exact questions prior to the examination. Such information may limit the individual's willingness to discuss other important issues that may interfere with the examination and would not contribute to favorable test outcomes. The MDT determines question target areas, and the exact language of the test questions will be developed during the examination.

3. What are the areas of inquiry during a maintenance polygraph examination?

   The pre-test interview is conducted to determine the extent of the individual's reported activities within the areas of concern as determined by the MDT. The pre-test interview is conducted in a manner to build a suitable testing rapport between the juvenile and the examiner, stabilize issues that could interfere with the examination results, and assure the examinee is able to focus on the test issues in a clear and accurate manner. Areas of inquiry may include sexual contacts, sexual behaviors, contact(s) with children or vulnerable persons, masturbation issues, compliance issues and issues related to overall honesty and integrity with significant persons involved in the youth's life.

4. How does the sexual history polygraph contribute to risk assessment?

   Risk assessment assumes both quantitative (i.e., how high is an individual's risk level) and qualitative dimensions (i.e., what are specific risk factors that must be monitored and managed). Polygraph testing can provide additional information to both dimensions of risk assessment.

   However, the polygraph test itself is not a measurement of an individual's risk level. Because the polygraph test contains only a limited number of questions, not all of these issues will be addressed during all polygraph examinations. The members of the MDT will identify the issues most salient to the accurate assessment of each individual referred for sexual history polygraph testing.

5. What are the areas of inquiry during a sexual history polygraph examination?

   Areas of investigation during sexual history polygraphs may include sexual offenses, consensual sexual contacts, sexual victimization issues, sexual deviancy/preoccupation and general questions relevant to an individual's level of honesty and integrity.

6. What are the requirements for a completed or resolved sexual history polygraph?

Sexual history polygraph examinations should include, but may not be limited to, questions about sexual contact without consent (i.e., force, threats, coercion, and manipulation), sexual contact involving younger family members or relatives, and sexual contact with persons four (4) or more years younger than oneself.

Questions may also address sexual behavior patterns and sexual offenses against persons who were asleep or unconscious at the time (i.e., drugs or alcohol), or other vulnerable persons. The MDT or examiner may elect to limit the pre-test or in-test questions to the time period since a certain age (i.e., age 10 or other age) or another memorable event or time marker. In accordance with standardized procedure, polygraph examinations may also include questions relevant to an individual's overall level of honesty and integrity.

7. Is there a required or standardized method of preparation for a polygraph examination?

While some preparation for polygraph examination is important, exact methods of preparation may vary across individuals and treatment groups, and may be population dependent. Not enough is known to dictate the specific methods of preparation that will most likely lead to satisfactory test outcomes across varying populations of youths in treatment. Multidisciplinary team members are encouraged to develop preparation materials relevant to the needs of each individual and treatment program. Materials developed by local treatment providers and polygraph examiners have been found useful with some individuals.

In general, the quality and degree of organization of the information contained within each individual's history is the most important factor concerning preparation for polygraph examination.

Care should be taken to minimize exposure to deviancy when assisting youths preparing for polygraph testing.

8. Should the juvenile include in his/her sexual offense history those persons with whom s/he has had contact, yet the juvenile has not defined as a victim?

It may be useful to discuss issues of uncertainty with the examiner. However, it is generally the responsibility of the treatment provider to assist the youth in learning to define and identify his/ her abusive and/or unlawful sexual behavior toward others. These issues should be resolved in treatment before the polygraph examination, which is then conducted to examine the veracity of the juvenile's reports.

9. What should the MDT do when the youth is unsure about the use of force, or threat of force during an offense?

These questions should be resolved in treatment prior to the polygraph examination. The MDT should consider whether the youth possesses the capacity to clearly recall if s/he had engaged in forceful or threatening behavior and should be prepared to document any mental health or developmental/intellectual issues that preclude this awareness.

10. Under what circumstance might a specific issue polygraph be considered for the first polygraph?

A specific issue polygraph, regarding the referral offense, should be considered for a youth's first polygraph examination in cases in which there is a substantial discrepancy between the victim's and the offender's account of the offense, or when a discrepancy serves as a barrier to effective participation and progress in treatment. Investigation of current community safety concerns should take precedence over polygraph examination of the referral offense or sexual history.

11. How should the MDT respond to repeated unresolved polygraphs?

In the case of repeated unresolved polygraphs, the MDT, including the polygraph examiner, should meet to review the case to determine the extent of information already obtained, identify impeding clinical or historical variables, and formulate a hypothesis about possible reasons for the youth's unresolved polygraph results. The MDT should determine whether further polygraph testing is warranted, and should identify target issues for any future polygraph tests. There may be cases in which continued investigation of sexual history is not useful; however, there may be value of maintenance/monitoring polygraphs in order to identify ongoing risk issues and deter problem behavior.

There may be times when continued testing may not be useful. In general, evaluating and adjusting the focus and breadth of the questions during the examination, and paying careful attention to question formulation may resolve repeated unresolved polygraphs.

12. Does the extent of a juvenile's sexual history affect his/her testability?

An extensive sexual history does not preclude a person from passing a polygraph examination. Generally speaking, the greatest factors affecting an individual's ability to resolve polygraph examination questions are the individual's willingness to accurately and clearly identify and describe his/her history of involvement in the behaviors under investigation. Some youths may have trouble clearly delineating their history of involvement in sexual behavior that began at early ages. The MDT should assist the youth to suitably prepare for the polygraph examination, and may elect to limit the scope of the sexual history polygraph to sexual behavior since age 10 or other memorable time marker after which the youth may be able to recall the extent of his/her involvement in sexual activities.

13. Are there circumstances when we should administer polygraphs prior to sentencing?

Polygraph examinations conducted prior to sentencing may not meet the requirements of these Standards. The MDT may wish to have these examinations reviewed by another qualified examiner before accepting them.

Most polygraph examinations prior to sentencing will be specific issue tests (i.e., regarding the allegation or accusation), or monitoring/maintenance polygraphs regarding an individual's behavior while participating in treatment. Polygraph examinations conducted prior to sentencing will fall under the purview of these Standards only when a youth has been referred to sex offense specific treatment (i.e., by social services, pretrial supervision, diversion programs, etc.) In general, non-adjudicated youths should not be referred for sexual history polygraph testing, unless a protective order has been established to preclude prosecution in response to disclosure.

14. Are there circumstances when the MDT should decide not to refer a juvenile for a polygraph examination?

The MDT should not refer a juvenile for polygraph testing when he or she does not meet the referral criteria defined in these Standards.

15. May the juvenile and family have access to the polygraph examination report and/or recording?

While conducted in support of the treatment process, the polygraph examination is not a psychometric assessment. The polygraph examination is an investigative examination, and polygraph examiners who conduct examinations on juveniles who have committed sexual offenses do so as members of the MDT. Communication of the information and results from the polygraph examination is intended to serve the needs of the professional members of the MDT in assessing an individual's risk level, progress in treatment, and compliance and honesty regarding behavioral expectations. Therefore, information and results from the polygraph examination should be communicated only to the professional members of the MDT as specified on the polygraph authorization and release form.

To preserve the objectivity and integrity of the examiner's role on the MDT, and to prevent the influence of family or third-party influence on the examiner, polygraph examiners should refrain from providing information and results directly to the juvenile and/or family members following the completion of the post-test portion of the examination. Information and results from the polygraph examination should be reviewed with the youth and family in a therapeutic setting with a professional member of the MDT. The examiner should only discuss polygraph information and results with the juvenile and/or family members in the context of MDT functions (i.e., staffing or telephone conference).

When polygraph examinations are incorporated into a youth's treatment file, the youth and family may access those reports under certain conditions. The examiners, and related agency, are the only persons authorized to disseminate the examination report, and then only to individuals and agencies named on the authorization and release form. Professionals in various service delivery systems and organizations may be subject to different regulations regarding the redistribution or re-release of information and reports generated or developed outside their own agency. Members of the MDT should familiarize themselves with the regulations that pertain to their profession, agency and/or organization.

Like the polygraph examination report, all recorded materials pertaining to a polygraph examination are subject to the authorization and release form, and may only be released to the professional members of the MDT. Members of the MDT must become familiar with agency and professional regulations pertaining to the redistribution of such materials. Due to the sensitive nature of the information discussed during polygraph examinations, parents and family members who wish to review an examination recording should do so only in the context of a supportive therapeutic setting.

16. May a youth's family make the referral for a polygraph examination to be conducted independently of the MDT?

Polygraph examinations conducted without the involvement and referral from the MDT may not meet the requirements of these Standards.

17. Should the polygraph report be released to the court as a part of the probation or department of human services progress report?

Materials submitted to the court may become a matter of public record, and polygraph examination reports may contain sensitive information. Supervising officers and caseworkers should not attach a copy of the polygraph results to presentence investigations or other reports to the court. Instead, supervising officers and caseworkers should summarize the information from the polygraph in their reports to the court.

18. Can a question about the extent of sexual abuse against a known victim be asked in the context of a sexual history polygraph regarding unknown victims?

This practice is not recommended. Sexual history polygraph examinations are conducted to determine the range and scope of an individual's sexually abusive behavior for the purpose of identifying victims, risk assessment, and treatment planning. Testing the limits of a juvenile's sexually abusive behavior against a particular victim should be the focus of a specific issue polygraph.

19. What is the best way to use the polygraph to verify the absence of concerns of sexual abuse against other younger siblings or vulnerable individuals?

In the presence of a specific allegation or reason to suspect abuse against a particular individual, a specific issue polygraph regarding the allegation is warranted. In the absence of an allegation or reason to suspect abuse against a single younger sibling or individual, a specific issue examination regarding general types of sexual contact with that individual is recommended. In the absence of allegations or reasons to suspect abuse against multiple younger siblings or vulnerable individuals, the test would be structured as a partial sexual history polygraph regarding younger siblings, family members, or vulnerable individuals. These questions may also be resolved in the context of a sexual history polygraph.

20. Is it acceptable to conduct polygraph examinations on multiple issues?

Questions within the scope of a sex history polygraph may contain multiple related issues (i.e., questions about different types of sexual offense behavior, victim selection behaviors, sexual behavior issues). Similarly, questions within a maintenance polygraph may address multiple issues related to re-offenses, sexual contacts, sexual behavior issues, and rule compliance while in treatment and/or under supervision. Specific issue polygraphs may contain multiple questions regarding the specific allegations under investigation.

To reduce the likelihood of erroneous test results in the event that a youth shows significant responses to any individual question on a mixed issue test, the examiner may not render any opinion regarding the absence of significant responses to other questions. To reduce the likelihood of false negative results, the examiner must report the presence or absence of significant reactions to individual questions and may not render any opinion regarding a youth's responses to individual questions that fail to meet the criterion thresholds.

As with other forms of testing and evaluation, addressing a broader range of questions within a single examination may lead to an increased likelihood of unresolved examination results. The polygraph examiner should consult with the other members of the MDT to determine the type and purpose of the test, and the scope of the test questions.

21. Are polygraph examiners mandatory child abuse reporters? Who is responsible for reporting previously unreported victims?

Polygraph examiners are not mandatory child abuse reporters by statute; this includes polygraph examiners with clinical training. However, polygraph examiners who conduct examinations under these Standards are required to report all pertinent information about sexual offenses, sexual contacts, and risk indicative behaviors to the other members of the MDT. All members of the MDT who are mandatory child abuse reporters are responsible for assuring the timely and accurate reporting of child abuse to the appropriate authorities.

22. How does the MDT decide what type of polygraph examination to administer?

To aid in the development of an accurate sense of empathy for victims, youths who present with significant discrepancies in their reports of the abuse compared to their victim's reports may be asked to undergo a specific issue polygraph examination regarding a particular offense. It is not advisable to defer this work until the end of treatment. Maintenance polygraph testing may be requested any time there are concerns about an individual's recent or current behavior, and should be used as a transition support tool (i.e., to assess behavioral readiness for transition and/or to deter and detect the onset of problem behavior after transition).

Polygraph examination of juveniles who have committed sexual offenses is required for juveniles who meet the testing criteria. It is an adjunct tool for treatment providers, supervision officers, and case workers to support the youths' progress in the treatment, safety in the community, and to access more accurate information regarding an individual's risk level and honesty. There is no requirement that various types of polygraph testing be completed in any particular order. Instead, the MDT should assess the safety, placement stability and progress of each youth and decide which type of polygraph examination best suits the objectives of safety and progress at any given time.

23. Should youths be asked polygraph questions regarding their own victimization?

Except in rare circumstances, an individual's history of victimization should not be subject to polygraph testing. Some youths may report their victimization history when reviewing their offense history. It is acceptable for examiners to inquire about a youth's victimization history during the pre-test interview as such information may assist some youths in fully disclosing their sexual history and may lead to an improved test outcome. Care should be taken to avoid causing unnecessary distress when investigating any individual's history of victimization.

24. Should youths be given sexual history disclosure materials to work on at home or in their rooms?

Youths may become aroused to their own history of sexual offense behaviors and history of involvement in sexual behavior patterns. To minimize the likelihood of reinforcing sexual arousal to deviant themes, disclosure work should be done in the context of individual or group therapy. When youths are requested to complete disclosure work independently, they should be instructed to stop at any point they become sexually aroused, and to report any arousal issues to their treatment provider.

25. How does the MDT determine the target questions for various types of post-conviction (post-adjudication) polygraphs?

While all polygraph examinations may include questions relevant to an individual's overall honesty and integrity, sexual history polygraph examinations will likely focus on the unlawful sexual contact issues of greatest likelihood for each individual.

Questions on maintenance/monitoring polygraphs will generally address issues regarding recidivistic offending behavior patterns, any issues of observed deviancy or concern, and other issues salient to an individual's behavior and honesty in treatment. Specific issue polygraphs will address the specific allegations under investigation, any discrepancies in the offender's and victim's statements, and the extent or frequency of abuse.

26. May questions about intent be included in the scope of a polygraph examination?

Questions about state of mind or body may be most useful when formulated in reference to behaviorally descriptive events or activities.

27. How does the polygraph contribute to recommendations surrounding a juvenile's status on probation or in treatment, transition plan, registration requirements and/or expungement following the completion of treatment and probation?

Polygraph examination results can aid in the formulation of the MDT's recommendations surrounding these decisions, though the results and information from the polygraph should never become the sole basis of such decisions. The MDT must make recommendations and decisions with careful consideration of all information relevant to an individual's risk profile, progress in treatment, and available resources.

The lack of available resources should not dictate a recommendation for services that would be less than adequate. Results and information can contribute to these decisions by providing additional information to the MDT regarding the accuracy and integrity of an individual's engagement in treatment, and compliance with supervision and treatment program rules.

Verification of an individual's honesty and non-involvement in problem behaviors during the entire period of time following adjudication, or other reasonable period of time, would provide the most expedient contribution to these recommendations and decisions.

28. May a youth's therapist, parents, or attorney participate in or observe the polygraph examination?

Except during circumstances in which an individual is unable to communicate effectively without the aid of an interpreter, no one is permitted in the examination room except the juvenile and the examiner. Members of the MDT may observe the examination through a video monitor, or review the recording at a later time. In order to minimize distraction and outside influence, no interaction may occur between the youth and any member of the MDT once the polygraph pre-test interview has begun.

Due to the sensitive nature of the information discussed during the polygraph examination, family members should not be allowed to observe the examination as it occurs. Information from the polygraph examination should be reviewed with family members in a supportive therapeutic setting.

The juvenile's attorney is generally not involved in post-conviction (post-adjudication) polygraph examination and ongoing treatment and management of the juvenile. An attorney may elect to observe an examination that is conducted at the attorney's request; however these examinations may not meet the requirements of these Standards.

Glossary of Terminology

The terminology contained in this appendix applies to polygraph examination and related subject matter. Terms and concepts used and defined in this glossary may not have the same meaning outside of sex offense specific services.

Terms with an asterisk* notation are direct quotes from: Krapohl, D. and Sturm, S., (2002). Terminology Reference for the Science of Psychophysiological Detection of Deception. Polygraph, 2002, 31 (3).

Some of the following terms use language commonly applied to adult testing, i.e. conviction, parole, prison, etc. When these terms are encountered, please consider the language used in juvenile settings such as adjudicated, supervision, DYC/commitment, etc.

The remaining terms have been defined by the Juvenile Standards Polygraph Committee of the Sex Offender Management Board that was comprised of a cross-section of professionals in the field.

Coercion
Exploitation of authority, use of pressure through actions such as bribes, threats, or intimidation to gain cooperation or compliance. Also includes threats of loss of relationship, esteem, or privilege, or threats of punishment inflicted by a parent. While coercion is inclusive of force and threats, it is useful to differentiate physical forms of force, or threat of force/harm from other forms of coercion.

Disclosure examination*
See sexual history examination.

Examination*
The entirety of the PPD process, including pretest, test and posttest elements, from onset to completion.

Note: PPD refers to Psychophysiological Detection of Deception

Frame of reference
Conceptual issue in post-conviction polygraph examination referring to the purpose of the examination, i.e. sexual history, maintenance/monitoring polygraph, or offense specific polygraph. Distinct from other specific issue examinations in which a specific accusation or allegation includes an identified victim, date, time, location, and behavioral description.

Incapacitated
Asleep or unconscious from drugs and/or alcohol, or other medical condition. May include persons who are stuporous or unaware due to general or overall functional impairments.

Instant offense examination*
A form of post-conviction sex offender testing, conducted when a subject is in denial of the offense or of some significant element of the offense for which he or she was convicted, and is often used to break down the denial barrier. This is also an examination that can be given when a new allegation has been made while the subject is on probation or parole. The polygraph is used to determine whether the allegations are true. Also called a specific issue examination. See: Cooley-Towel, Pasini-Hill, & Patrick (2000);Dutton, (2000); English, Pullen, & Jones (1996); Heil, Almeyer, McCullar, & McKee (2000).

Masturbation
Purposeful stimulation of one's own genitals through the use of hands or other objects.

Monitoring examination*
A form of post-conviction sex offender testing (PCSOT) that is requested by a probation or parole officer to ensure compliance with the conditions of the offender's release from prison; i.e., alcohol or drug issues, computer violations contact with children, etc. See: Cooley-Towel, Pasini-Hill, & Patrick (2000); Dutton (2000); English, Pullen, & Jones (1996); Heil, Ahlmeyer, McCullar, & McKee (2000).

Note: This type of examination applies to juveniles and would be used similarly to that described above. For the best guidance see Standard 7.170 (B).

No deception indicated (NDI)
In conventional PDD, NDI signifies that (1) the polygraph test recordings are stable and interpretable, and (2) the evaluation criteria used by the examiner led him/her to conclude that the examinee was not being deceptive regarding answers to the question(s) during the examination. NDI and DI (deception indicated) decision options are generally used in specific issue testing and correspond to NSPR (no significant physiological responses) and NSR (no significant physiological responses/no significant reactions) in post-adjudication polygraph testing of juveniles who have committed sexual offenses.

No opinion*
Alternate form of an inconclusive call, especially in the Federal Government. Sometimes used to denote an incomplete call in other sectors.

No significant physiological responses (NSPR/NSR)
Accepted language in decision options in polygraph examination procedures developed by the Department of Defense, and is equivalent to the NDI (no deception indicated) decision option in general use.

Objectifying behaviors
Looking at others as sexual objects with little or no regard for their personhood, feelings or the offender's impact on them. May also include attempts to look inside people's clothing in an attempt to see their sexual organs.

Discussion (labels vs. description): Attempts to account for the nature and extent of sexual offenses against a victim are inherently limited by language-based definitions of individual words, terms and concepts. Over-reliance on individual words or labels to convey an adequate description of events invites argument and dissention about the exact meaning of individual words or labels. It is preferable to provide event-related information in descriptive detail that does not depend on the connotative, denotative, or stipulated definitions of individual words. Such an approach more adequately conveys the events and their potential impact on the individuals involved.

Physical Force
Grabbing, holding, pulling, tugging, pushing down or restraining a victim. Using one's strength or size to overpower a victim's resistance, attempts to escape or attempts to stop or end an offense. Using any physical object to restrain a victim, block escape, or overcome resistance.

Polygram*
Complete graphical recording of physiological data from a polygraph test, with the required annotations. Usually called a *polygraph chart.*

Polygraph*
By definition, an instrument that simultaneously records two or more channels of data. The term now most commonly signifies the instrument and techniques used in the psychophysiological detection of deception, though polygraphs are also used in research in other sciences. In PDD the polygraph traditionally records physiologic activity with four sensors: blood pressure cuff, electrodermal sensors, and two respiration sensors. Some instruments also record *finger pulse amplitude* using a photoplethysmograph.

Post-conviction sex offender testing (PCSOT)
Specialized application of polygraphy that aids in the management of persons who have been convicted of or adjudicated for sexual offenses, and who have been released into the community, though sometimes employed as part of treatment for persons in secured settings. There are four primary types of post-conviction sex offender testing: referral/instant offense examination, sexual history/disclosure examination, maintenance/monitoring examination, and specific issue examination.

Note: Please see Standard 7.100 for clear guidance on the use of these types of polygraph examinations with juveniles who have committed sexual offenses.

Posttest*
Final portion of a polygraph examination. The posttest could include a debriefing of an examinee who passed the examination, or an interview or interrogation of an examinee who failed the examination. The posttest may or may not be a part of any given polygraph technique, and plays no part in the formulation of the results in any polygraph technique.

Note: Section 7.161 describes the language to use regarding the reporting of results. These Standards are not recommending the use of "passed" or "failed" when reporting examination outcomes.

Pretest interview*
The earliest portion of the PDD examination process during which the examinee and examiner discuss the test, test procedure, examinee's medical history, and the details of the test issues. During the pretest interview, in some techniques, the examiner will make behavioral assessments of the examinee to help determine the PDD outcome. The pretest interview also serves to prepare the examinee for testing. The length of the pretest interview ranges from 30 minutes to 2 hours or longer, depending on the complexity of the case, examiner-examinee interactions, and testing technique. All PDD techniques use pretest interviews.

Psychophysiological detection of deception (PDD)*
Common scientific term to denote the use of the polygraph to diagnose deception.

Relatives/family members
Persons who are related by blood, marriage or adoption, including parents, grandparents, step-siblings, aunts, uncles, cousins, nieces, nephews.

Sexual contact
Rubbing or touching another person's sexual organs (i.e., breasts/chest area, buttocks, vagina, penis) either bare (under clothing) or over clothing if done for the purpose of evoking sexual arousal or sexual gratification of oneself or the other person. Sexual contact may also include causing or allowing another person to touch one's own sexual organs either over or under the clothing, if done for the purpose of sexual arousal or gratification. The term *physical sexual contact* is used interchangeably and may be used to improve some individuals' abilities to provide clear and unequivocal answers to polygraph questions.

Discussion: Behavior is typically not defined by an individual's motive. It is worth noting that there are other motivations, besides sexual arousal, for touching the sexual organs of another person (i.e., anger, aggression, retaliation, changing diapers, bathing).

Sexual history examination*
A form of post conviction sex offender testing (PCSOT) which entails an in-depth look at the entire life cycle of an offender and his or her sexual behaviors up to the date of criminal conviction. Sometimes referred to as a *disclosure examination*. See: Cooley-Towel, Pasini-Hill, & Patrick (2000); Dutton, (2000); English, Pullen, & Jones (1996); Heil, Ahlmeyer, McCullar, & McKee (2000).

Note: Please see Section 7.170 for guidance with juveniles who have committed sexual offenses.

Sexually stimulating materials and/or pornography
These may include:

- Erotica - swimsuit calendars, lingerie or underwear advertisements, non-pornographic magazines
- Pornography - nudity in pornographic magazines, movies or websites
- Sexually aggressive pornography - sexual materials depicting violence or force
- Sexually explicit pornography - material depicting sexual acts

Significant physiological responses (SPR/SR)
Accepted language in decision options in polygraph examination procedures developed by the Department of Defense, and is equivalent to the DI (deception indicated) decision option in general use.

The practice of reporting polygraph examination results as SPR/SR or NSPR/NSR is favored out of consideration of the theoretical, technical, and clinical complexities surrounding the use of polygraphy with juveniles who have committed sexual offenses.

Specific issue polygraph examination*
A single issue PDD examination, almost always administered in conjunction with a criminal investigation, and usually addresses a single issue. Sometimes called a *specific* by PDD practitioners to differentiate from pre-employment or periodic testing.

Threats of harm or force
Threats of any bodily harm or injury. Threats to use a weapon, including displaying or brandishing a weapon, or brandishing one's fists. Displays of anger may constitute a threat against a victim, who may perceive the need to cooperate in order to avoid further harm.

Time of reference
Conceptual issue in post-conviction polygraph examination structure that addresses a specific time period of reference (i.e., prior to the date of conviction or adjudication for sexual history polygraph, and a segment of time following the date of conviction or adjudication for maintenance/monitoring polygraph examinations).

Vulnerable person(s)
Any person who is substantially younger (i.e., 4 or more years younger), mentally or medically impaired, or physically handicapped. May include any person (including an older person) who is unable to defend him/herself or unable to access assistance to prevent assault/abuse.

Appendix D
PLETHYSMOGRAPH EXAMINATION *December 2014*

Excerpted and adapted from the Ethical Standards and Principles for the Management of Sexual Abusers, the Association for the Treatment of Sexual Abusers (1997).

The purpose of the phallometric assessment is to provide objective data regarding sexual arousal. It may also promote self-disclosure and reduce minimization and denial of sexual offenses. Additionally, it can assist in monitoring changes in sexual arousal patterns which have been modified by treatment.

A. USES

Physiological assessment can be used to identify the need to reduce and control deviant sexual arousal.

B. LIMITATIONS

Phallometric assessment data should not be used as a sole measure to predict risk of engaging in deviant sexual behavior.

Failure to develop significant responses to deviant sexual themes cannot be used to demonstrate innocence of a specific allegation of sexually deviant behavior.

Development of significant arousal to deviant themes cannot be used to demonstrate guilt of a specific allegation of sexually deviant behavior.

It is inappropriate to use erection responses to determine or make statements about whether or not someone has engaged in a specific sexual behavior or whether someone fits the "profile of a sexual abuser."

Extreme caution should be used in interpreting erection responses to non-standardized sets of stimuli.

C. JUVENILES

Use of phallometric assessment with pre-pubertal youth is not recommended.

Phallometry should only be used with juveniles younger than 14 years of age when the clinician needs more information than is currently available via other, more traditional sources.

For individuals under the age of 14, or for those who may not have attained the maturational level associated with puberty, clinicians should seek interdisciplinary or institutional review of the physiological procedures.

The relationship between phallometric arousal and clinical characteristics appears weaker in an adolescent population than in an adult population. Caution should be used in interpreting adolescent data in a manner parallel to that of adult data.

Adolescents appear more fluid in their sexual interests and patterns of behavior than adults and may not show as high a degree of correspondence between measured arousal patterns and reported offense histories.

D. DEVELOPMENTALLY/INTELLECTUALLY DELAYED

Although there is an absence of empirically based data, clinical impressions indicate that a higher percentage of developmentally/intellectually delayed clients tend to respond with uniformly high arousal. Therefore, the arousal profile is not necessarily indicative of sexual arousal to the described behavior or a reflection of deviant arousal.

Developmentally/intellectually delayed clients may respond to the sexual words and/or to the tone of voice used rather than the content of the description.

Developmentally/intellectually delayed clients may have more difficulty accurately perceiving visual stimuli.

In spite of these limitations, phallometric assessments can offer valuable information to those service providers working with the developmentally/intellectually delayed population.

E. PRELIMINARY PROCEDURES

The examiner should gather supportive information, such as marital and family history, criminal history, present life situation, legal status, sexual history, mental health contacts, and the reason for referral.

It is the responsibility of the examiner to screen the client for contamination factors, such as drug use, medication, last sexual activity, emotional state, physical impairment, etc.

Prior to the examination, the examiner should take steps to ensure that the examination will not be interrupted.

No client with an active sexually transmittable disease or parasite should be tested. The client should sign a disclaimer of any knowledge of a current sexually transmitted disease.

F. LEGAL CONCERNS/INFORMED CONSENT

Consent forms regarding the penile plethysmograph procedure should be read, signed and dated by the client.

Discussion: The Standards in this document require informed assent.

When plethysmography is used with persons under the age of 15, this procedure should be reviewed by a community or institutional advisory group.

Release forms allowing for both the receipt and dissemination of information should be obtained.

Raw data forms must provide information for retrieval of specific stimulus materials that were used in the assessment.

G. LAB EQUIPMENT

Plethysmograph equipment should provide either continuous chart paper readout or, with computerized equipment, a printed readout of response levels to each stimulus.

Equipment should be used as designed. See users' documents.

An arm chair or lounge chair with cleanable surface must be provided. A reclining lounge chair is preferable.

A disposable cover on the chair seat and on the arms of chair is required for each client.

Mercury-in-rubber, Indium-gallium, or Barlow gauges may be used and each gauge must be tested and calibrated before each use. Documentation of gauge calibrations should be provided.

A calibration device or cone is required in ½ cm increments with a minimal range of 6 cm.

Security devices must ensure client's privacy, but must also include emergency entrance and exit with the safety of the client in mind.

Slide projector for visual material should be capable of projecting images spanning a 35 degree visual angle.

An intercom system should be used to provide communication between client and examiner.

Clinician must have a protocol for fitting gauges, trouble-shooting equipment, breakdowns, and malfunctions.

Plethysmograph equipment should be used as designed, according to the user documents.

The penile plethysmograph should be isolated from AC with a DC converter.

H. LAB SETTING AND CLIENT SPACE REQUIREMENTS

Client space must be separated from the clinician's work area by at least an opaque partition that is a minimum of 7 feet high, to ensure client's privacy. A stationary wall is preferred to maintain maximum privacy.

Client space is recommended to be approximately 7 feet by 8 feet in dimension. The minimal requirement for this space is 4 feet by 6 feet.

An intercom system must be used when the client is in a stationary enclosure.

A constant room temperature must be maintained between 76-80 degrees Fahrenheit.

The client room should have adequate ventilation; adjustable lighting is desirable.

Sound-deadening measures should be used in order to ensure that the client's space is as sound-proof as possible.

Security measures must be provided for the laboratory and stimulus material.

It is recommended that a system be devised for the examiner to be able to determine when and if the client is attending to the stimuli being presented.

The door separating the client room from the examiner’s work area should have an inside lock that the client can control.

I. CALIBRATION PROCESS

The strain gauge must be stretched adequately to obtain continuous variation. The mercury gauge requires 20% (slightly stretched on the cone) of its full scale. The Barlow gauge also requires moderate stretching.

The stretched gauge is then placed on a cone allowing measurement of at least ½ centimeter increments. The gauge is moved down the cylinder until 3 cm of stretch is obtained (6 steps). This should be considered 100%, and sensitivity is then set on the plethysmograph.

The steps are then checked for linearity (each step on the cone equals proportionate steps on the plethysmograph). If a variation of greater than 25% occurs between steps, the process should be repeated. If a 25% or greater variation remains, discard the gauge and repeat the process.

If linearity cannot be obtained with multiple gauges, the plethysmograph is not functioning properly.

If the first or last step of the calibration procedure yields 25% or greater variation, the gauge was not fitted properly to the circumference device, or the gauge is faulty.

After the gauge is fitted to the client and adequate time has elapsed for detumescence, the sensitivity should be set at the "0" point.

At the completion of the assessment process, if the client achieved a full erection, then that level of change becomes 100%.

The penile plethysmograph should be calibrated.

Prior to each assessment, gauges should be calibrated over a minimum of six steps using an accurate calibration device.

Care should be exercised to avoid rolling the gauge while placing on the calibration cone.

J. FITTING THE PENILE TRANSDUCER

Placement of the gauge should be at midshaft of the penis.

Client should place gauge on his own penis.

Examiner should assure that wiring has some slack next to the transducer or clinical error may result. Clothing should not touch penis or transducer.

Recording of full penile tumescence should be obtained whenever possible. The examiner should ensure that sufficient arousal has been recorded to accurately interpret data. When data is to be interpreted as a percentage of full erection, it is important to request the client to achieve full erection.

The client should be instructed to exercise care to avoid rolling the gauge while placing it on his penis.

Proper fit can be determined by:

(1) Setting the plethysmograph at zero before the client places the gauge on his penis.

(2) Ensuring the gauge has stretched at least 20% after being placed on the penis.

(3) Ensuring the gauge has not stretched more than 40%.

If the gauge has stretched more than 40%, the gauge is too small. If the gauge has stretched less than 20%, the gauge is too big.

After proper fit has been determined, the plethysmograph is reset to zero.

K. STIMULUS MATERIAL

The examiner will have available a range of sexual stimulus material depicting various Tanner Stages of development for both males and females, including culturally diverse subject material. Stimulus materials should also be available to differentiate between consenting, coercive, forcible, sadistic and aggressive themes with both adults and children.

Visual Stimuli:
Efforts should be made to use new technology which does not make use of human subjects.

Visual stimuli should be devoid of distracting stimuli.

Multiple stimulus presentations should be used for each Tanner stage.

Both sexes should be represented.

Stimulus duration should be consistent with research that has demonstrated validity.

The examiner should be satisfied detumescence has occurred and at least thirty seconds have elapsed before presenting new stimulus.

Audio Stimuli:
Audio stimuli should be sufficient to clearly differentiate minors from adults.

Stimuli should clearly differentiate consenting, coercive, forcible, sadistic and aggressive sexual themes.

Every effort should be made to use standardized stimuli reflecting the client's deviant sexual behavior.

Multiple stimuli presentations representing various normal and deviant sexual activity should be available.

L. DOCUMENTING ASSESSMENT DATA

Physiological assessments should be interpreted only in conjunction with a comprehensive psychological examination.

Written reports may include:

(1) A description of the method for collecting data.

(2) The range of physiological responses exhibited by client.

(3) Any indication of suppression or falsification.

(4) An indication of the validity of the data and validity controls used.

(5) The types of stimulus materials used.

(6) Summary of highest arousal in each category.

(7) Client emotional state.

(8) Level of client cooperation.

(9) Interpretation of data.

Any confounding physical or emotional inhibitors to sexual arousal.

M. DISINFECTANT PROCEDURES

Gauges will be disinfected prior to use, utilizing an accepted liquid immersion method or other accepted laboratory disinfection procedures.

A disposable covering will be used for protection over the chair seat and arms of the chair.

Client will place gauge in receptacle after use of the gauge and before leaving the testing room. Client will also dispose of protective coverings before leaving testing room.

Clinician should use disposable gloves and anti-bacterial soap after contact with gauges. Any items or articles that have been in contact with the client should also be disinfected.

Appendix E
DENIAL *December 2014*

There has been a limited amount of research conducted on denial specific to juveniles who commit sexual offenses. Although it remains unclear as to whether juvenile denial is associated with sexual recidivism (Weinrott , 1998; Kahn & Chambers, 1991), the research that has been conducted with juveniles who commit sexual offenses and engage in denial conclude that accountability is necessary for a positive treatment outcome (Hunter & Figueredo, 1999; Barbaree & Cortini, 1993) and that the treatment of denial should preclude sex offense specific treatment (Becker & Hunter, 1997; Barbaree & Cortini, 1993).

Barbaree & Cortini (1993) created a typology of denial and minimization that is applicable to both adults and juveniles:

Denial of the facts:

- Denial of any interaction with the victim
- Denial the interaction with the victim was sexual
- Denial the interaction with the victim was offensive

Minimization:

- Of responsibility
  - Victim was to blame
  - External attributions (alcohol, was provoked)
  - Irresponsible internal attributions (past victimization, sex drive)
- Of extent of previous offensive behavior
  - Frequency
  - Number of previous victims
  - Force Used
  - Intrusiveness
- Of harm
  - Victim won't suffer long-term effects
  - No consequences were suffered by the victim
  - Benefits out-weigh the harm done to the victim

Salter (1988) also created a classification system of denial among juvenile offenders:

A. Admission with Justification
B. Denial of Behavior
   1. Physical Denial With or Without Family Denial
   2. Psychological Denial
   3. Minimization of the Extent of the Behavior
C. Denial of the Seriousness of the Behavior and Need for Treatment
D. Denial of Responsibility for Behaviors
E. Full Admission with Responsibility and Guilt

French (1988) outlined common denial strategies among adolescent offenders:

Common Denial Strategies:

A. Adolescent denies having committed the offense and offers alternative stories and explanations as to the circumstances of the offense.

B. Adolescent emphatically denies that he had anything to do with the offense, while offering no alternative explanations as to the origin of the accusations.
C. Adolescent avoids the important facts through excessive elaboration on related but insignificant aspects of the offense.
D. Adolescent takes an offensive stance toward the interviewer by means of verbal attack (accuses the interviewer of lying and attempts to expose weaknesses in the interviewer).
E. Adolescent withdraws from the interview by refusing to discuss anything with the interviewer.
F. Adolescent uses "I don't remember" as his response to confrontation.

Barbaree, H.E. & Cortini, F.A. (1993). Treatment of the juvenile sex offender within the criminal justice and mental health systems. In H.E. Barbaree, W.L. Marshall, & S.M. Hudson (Eds.), The Juvenile Sex Offender (pp. 243-263). New York: Guilford Press.

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French, D. (1988). Distortion and Lying as Defense Processes in the Adolescent Child Molester. Journal of Offender Counseling, Services, & Rehabilitation, Vol. 13(1) 27-37.

Hunter, Jr., J.A., & Figueredo, A.J. (1999) Factors associated with treatment compliance in a population of juvenile sexual offenders. Sexual Abuse: A Journal of Research and Treatment, 11, (1), 49-67.

Kahn, T.J., & Chambers, H.J. (1991). Assessing reoffense risk with juvenile sexual offenders. Child Welfare, 70, 333-345.

Salter, A. (1988). Treating Child Sex Offenders and Victims: A Practical Guide. Beverly Hills: Sage Publications.

Weinrott, M. (1998). Recidivism among juvenile sex offenders: Are favorable outcomes only favorable when therapy matters? Handout from Empirically-based treatment interventions for juvenile sex offenders. Presentation sponsored by the Child Abuse Action Network and the State Forensic Service, Augusta, ME.

Appendix F
SPECIAL POPULATIONS *December 2014*

Excerpted and adapted from the Ethical Standards and Principles for the Management of Sexual Abusers, the Association for the Treatment of Sexual Abusers (1997).

There is a growing awareness of the importance of designing and implementing specific treatment programs sensitive to diverse populations. Many of the evaluation and treatment procedures currently being used have been developed by the majority culture and do not reflect awareness or sensitivity to differences within minority populations. It is incumbent upon the service providers in this field to modify and adapt the generally accepted treatment techniques, standards and principles to those special populations that they serve.

A. Where differences of age, gender, race, ethnicity, national origin, religion, sexual orientation, disability, language or socioeconomic status significantly differ from the service provider's experience and/or orientation, it is imperative that the treatment provider obtain the training and/or supervision necessary to ensure the adequacy of the services provided.

B. If it is not feasible to obtain training and/or supervision to adequately provide services to a special clientele, referral to a service provider who does possess the necessary knowledge and skills is required.

C. Emphasis should be placed on the development of specific programs and treatment plans that address the sexually abusive/offending behavior within the context of the minority group culture.

D. Service providers must acknowledge and educate themselves about their own ethnic, cultural, racial and/or professional biases and assumptions.

E. Special care and attention should be given to the environment in which the juvenile will spend most of his or her time, both during and following treatment intervention.

Appendix G
SEX OFFENDER MANAGEMENT BOARD ADMINISTRATIVE POLICIES *Revised September 2016*

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. Appendix G 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. 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.

3. 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 G.

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 F.

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 G 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 Appendix G may be found on the SOMB website.

Appendix H
DENIAL OF PLACEMENT ON PROVIDER LIST *December 2014*

The Board reserves the right to deny placement on the Provider List to any applicant applying to be listed as a treatment provider, evaluator, or polygraph examiner under these Standards.

Reasons for denial include, but are not limited to:

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

B. The Board determines that the applicant is not in compliance with the standards 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 applicant has been convicted of or received a deferred judgment for any criminal offense

E. The applicant has been found to engage in unethical behavior by any licensing or certifying body or has had a license or certification revoked, canceled, suspended or been placed on probationary status by any professional oversight body

F. The applicant is addicted to or dependent on alcohol or any habit forming drug as defined in section 12-22-102, C.R.S., or is a habitual user of any controlled substance as defined in Section 12-22-303, C.R.S.

G. The applicant has a physical or mental disability which renders the applicant unable to treat clients with reasonable skill and safety or which may endanger the health or safety of persons under the individual's care

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

Appendix I
SYNOPSES OF SUPPORTING RESEARCH *December 2014*

The Colorado Sex Offender Management Board has worked diligently to promote research based Standards and Guidelines. Following is a listing and synopsis of the research or published articles cited as footnotes in these Standards.

The authors' terminology regarding juveniles who commit sexual offenses is used in each synopsis for consistency with the citation.

Introduction

Judith Becker (1998) conducted a thorough review of recent empirical research on the characteristics and treatment of juvenile sex offenders. Her findings revealed a lack of longitudinal data available to support the speculation that if adolescents commit a sexual offense, they will continue offending into adulthood. In addition, she cautions against the notion of juveniles needing monitoring for the rest of their lives if they have committed a sexually inappropriate behavior. Similarly, Becker and Hunter (1997) provided recidivism rates from several studies of juvenile sexual offenders who have received treatment:

> Kahn and Chambers' (1991) 20 month follow-up study on 221 juvenile sex offenders treated in 10 programs had a sexual recidivism rate of 7.5% with an overall recidivism rate of (both sexual and nonsexual) 44.8%.
>
> Schram, Milloy, and Rowe (1991) conducted an extended follow-up study with Kahn and Chambers' sample, of which 197 participated, and found 12.2% having been arrested for a sex offense and a 10% conviction rate.
>
> Bremer (1992) reported recidivism rates of residentially treated juvenile sex offenders with a follow-up period ranging from several months to six years. Eleven percent re-offended sexually, 6% were convicted for nonsexual offenses.
>
> Becker (1990) provided 2-years of follow-up data on 80 juvenile sex offenders who were treated on an outpatient basis and found 8% had sexually re-offended.

Guiding Principles 2,3

In 1998, Kim English concluded a multi-faceted 2-year study (English, Pullen, & Jones, 1996) that involved surveys of probation and parole supervisors; extensive literature review on victim trauma and sex offender treatment; a systemic document review of materials ranging from agency memoranda and protocols to legislation and administrative orders; and field research in the area of community management of sex offenders. The findings suggested a sex offender containment approach that consisted of five components; one of which focused on community safety. Within this component, English concluded, "The effects of sexual assault on victims are often brutal and long-lasting…Psychological recovery from the assault is often prolonged for victims of these types of assaults." For those reasons, the community safety component valued and supported the need for a victim-oriented philosophy (as well as a public safety approach) for the containment and treatment of sex offenders.

Guiding Principle 12

Hagan and Gust-Brey (2000) followed the transition of 50 12-19 year-old perpetrators of sexual assault against children upon their return to the community after successfully completing a sex offender treatment program. The goals of their study were to determine the risk they presented for sexual and other re-offending. Ten years later, 86% of the adolescent perpetrators had been involved in another crime. Only 20% re-offended sexually, while 60% re-offended non-sexually.

Guiding Principle 12, 20

In 1996, M. Weinrott conducted a critical review of studies on juvenile sexual aggression. In his review of recidivism studies, he concluded that most males who sexually abuse younger children do not re-offend sexually (at least during the 5-10 years following apprehension). He also stated that juvenile sex offenders are more likely to come to the attention of police for nonsexual offenses.

Guiding Principle 14

Ageton and her colleagues (as cited in Prentky, et al., 2000) developed a theoretical model for adolescent sexual offenders that included strain measures, bonding to conventional social order, integration into a delinquent peer group, and a variety of variables aimed at sexual assault. Of these variables, four correctly classified 77% of the juveniles that re-offended sexually—involvement with delinquent peers, crimes against persons, attitudes towards rape and sex assault, and family normlessness. Further discriminant analysis revealed that involvement with delinquent peers correctly classified 76% of the cases.

Guiding Principle 14

Bagley and Shewchuk-Dann (1991) (as cited in Righthand and Welch, 2001) conducted a comparison study of juvenile sex offenders and other juvenile offenders in two residential treatment centers. They found sexually assaultive juveniles typically come from families that evidence severe pathology, including child maltreatment, and that the parents had higher levels of marital stress. They also found that the parents of the sexually assaultive group had more mental health problems that required intervention and the fathers had greater rates of alcohol abuse. Miner, Siekert, and Ackland (1997) (as cited in Righthand and Welch, 2001) described the juvenile sex offenders in their sample as, "coming from chaotic family environments. Nearly 60% of the biological fathers had substance abuse histories and 28% had criminal histories. Biological mothers, when compared to fathers, were less likely to have substance abuse histories or criminal histories. The mothers, however, were more likely than the fathers to have a history of psychiatric treatment." Smith and Israel (1987) (as cited in Righthand and Welch, 2001) found that some parents of juveniles who sexually assaulted their siblings "were physically and/or emotionally inaccessible and distant."

Guiding Principle 20

Worling (2000) collected recidivism data from a National Database for 148 adolescent sex offenders (ages 12-19 years) who were assessed at the SAFE-T program. The treatment group was made up of 58 offenders who participated in at least 12 months of specialized treatment (group, family, and individual treatment) and the comparison group consisted of 90 adolescents who received only an assessment, refused treatment, or dropped-out prior to a 12 month period. The follow-up period ranged from 2–10 years. He found the sexual assault recidivism rate for the comparison group (18%) was 72% higher than the recidivism rate for the treatment group (5%). For nonviolent offenses, the comparison group was 59% higher than the treatment group.

Section 1.600

Marshall (1999) reported, "Although formal assessments of the offenders are essential, it is also crucial to have available information from external sources (police reports, victim statements, and possibly court records) so that the interviewer may challenge the offender's report. We have found that offenders typically represent themselves in an exculpatory manner and that many outright deny they ever committed an offense (Marshall, 1994). Without the external information, we would have little basis to challenge the offender's account, and as a consequence, we would come to inaccurate conclusions."

Section 2.100

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."

Section 3.120

Borduin, Henggeler, Blaske, Stein (1990) compared the efficacy of multisystemic therapy (MST) and individual therapy in an outpatient treatment setting for 16 male adolescent sexual offenders. Multisystemic treatment targeted characteristics of the adolescent offender and his family and peer relations that have been linked with sexual offending. Specifically, it looked at cognitive processes, family relations, peer relations, and school performance. Individual therapy provided counseling that focused on personal, family, and academic issues. The MST group had recidivism rates of 12.5% for sexual offenses and 25% for nonsexual offenses. The Individual Therapy group had significantly higher recidivism rates: 75% for sexual offenses and 50% for nonsexual offenses.

Section 3.120

Marshall and Barbaree (1990) looked at outcome evaluations of several cognitive-behavioral programs for the treatment of sexual offenders. These programs are comprehensive in terms of the range of problems addressed in treatment, from social-skills training to reducing deviant interests and increasing appropriate sexual desires. One of the studies reviewed had a comparison group of traditional psychotherapy. This study of incarcerated sex offenders who received a behavioral program was found to be far more effective than a more traditional psychotherapy program in meeting the within-treatment goals (Marshall & Williams, 1975). They went on to say, "The behavioral program achieved its goals in changing various features of these offenders, whereas psychotherapy did not." In addition, Marshall and Barbaree concluded that most cognitive-behavioral programs combine individual therapy components with group therapy components. They presented rationale for group therapies led by co-therapists (both male and female): 1) individual therapy is costly and sometimes inefficient in that what needs to be learned is better presented to groups of patients by more than one therapist, 2) having both a male and female therapist can offer different views on sexual offending, 3) modeling by two therapists of egalitarian male/female relationships can facilitate change in attitude, and 4) other group members can provide insight into fellow offenders' problems on the basis of personal experience, which the therapist does not possess.

Section 3.140

Miner and Crimmins (1997) conducted a study with 78 youths in sex offender treatment programs in Minnesota. Two comparison groups were also used, using data from the third nationwide survey of the longitudinal sample of the NYS (National Youth Surevey). The two comparison groups were comprised of violent youth with no behaviors considered to be a sex offense, and non-delinquent youth. Some of the findings from this study suggested that sex offenders hold negative attitudes toward delinquent behavior, more so than non-delinquent youth, and are "more normless in their beliefs about family interactions than either of the other groups." In addition, sex offenders were more likely to be isolated from peers and families than non-delinquent youth and violent youth. Overall, the study supported a social control theory of sex offending, independent from other forms of juvenile delinquency. The primary difference in this sample was the isolation from both peers and their families for the sex offender group. Because of this finding, Miner and Crimmins concluded that breaking the process of social isolation may have some impact on the development of sexually inappropriate behavior. Using group therapy, social-cognitive intervention strategies, and family interventions would help to achieve these goals.

Section 3.140

Sirles, Araji, and Bosek (1997) conducted an overview of numerous programs and practices used by therapists who are working with sexually abusive children and their families. Although most of the programs reviewed haven't been tested empirically, their overview identified theories used to guide programs as well as goals for intervention. As a result, a list of 10 factors were suggested as an aid in program development and treatment planning:

1. The treatment of preadolescent sexual aggression requires a comprehensive knowledge of biopsychosocial theories of sexuality and aggression to guide in the development of intervention models.
2. A treatment model should incorporate theories of child development, sexual abuse, trauma, reciprocal cycles of abuse, learning, relapse prevention, and systems theories.
3. The treatment should incorporate cognitive and behavioral interventions that place responsibility for behavior with the child and address sexual aggression as a learned behavior that is changeable.
4. Family systems theory and therapy need to be integrated into treatment models to address dysfunctional family dynamics.
5. Group, peer, or pair therapy are useful methods for working with sexually aggressive youth. Children are best managed and treated in developmentally/intellectually divided age groups.
6. Treatment that is individually tailored and offense specific offers the greatest likelihood for success.
7. Treatment goals should target eliminating sexually abusive and aggressive behavior, increasing behavior controls, and developing competencies for coping with precursors to sexual aggression.
8. When appropriate, treatment needs to address the history of sexual abuse of the perpetrator—that is, victimization issues.
9. Parental groups are an effective means for teaching parents the skills necessary to prevent further aggression and abuse by themselves and their children.
10. When needed, referrals should be made to specialized programs, agencies, or therapists to facilitate as comprehensive a treatment approach as local services allow.

Section 3.140

Bernet and Dulcan (1999) also conducted an overview of the currently available psychosocial and biological treatment of children and adolescents who are sexually abusive of others, along with the literature available. Again, most of these treatment types haven't been tested empirically, however, they were able to conclude that, "group therapy with juvenile sex offenders provides a context in which the sexual abuser is unable to easily minimize, deny, or rationalize his or her sexual behaviors. Peer group therapy, as the medium for therapeutic interventions, is used in a number of different ways depending on the setting, group membership, severity of the sexual offenses, group goals and objectives, whether the groups are open or closed, and the length of the group experience." They also found through their research that family therapy may be most useful in cases of incest. Furthermore, "Family therapy facilitates the learning of new ways of communicating and building a support system which will help interrupt the abuse cycle and ultimately be supportive to the offender's capacity for regulating and modulating aggressive sexual behavior." Bernet and Dulcan found that individual therapy is usually used in conjunction with other treatment approaches.

Section 3.151

Hanson and Harris (1998 – 2001) conducted a study of dynamic risk factors that involved retrospective comparisons of 208 sexual offenders who had recidivated while on community supervision and 201 offenders who had not recidivated. The study has several findings, some of which include: the recidivists viewed themselves as little risk for committing new sexual offenses and took few precautions to avoid high risk situations; were more likely to engage in socially deviant sexual activities; showed little remorse or concern for their victims; had a generally chaotic, antisocial lifestyle, resisted personal change, and held strongly antisocial attitudes; had poorer self-management strategies; had poor social support; and had an increase in anger and subjective distress.

Section 3.151

Cortoni & Marshall (2001) studied sexual activity functions as a coping strategy for sexual offenders among 89 incarcerated offenders, 59 of whom were sexual offenders. Sexual offenders reported using sexual activities (both consenting and non-consenting) as a coping strategy for stressful and problematic situations at a higher rate than non-sexual offenders. When compared to non-sex offenders, sex offenders evidenced a sexual preoccupation during adolescence, which was related to the use of sex as a coping strategy.

Section 3.540

Becker and Hunter (1997) discussed the treatment of adolescent sex offenders in their article, "Understanding and Treating Child Adolescent Sexual Offenders." Because of the numerous reasons juveniles may deny their behavior (shame, embarrassment, fear of consequences), they stated the first step in treatment for the juvenile should include having the juvenile accept responsibility for his or her behavior. Educating the juvenile about what treatment can offer, such as learning how to develop and sustain healthy relationships with peers, may help persuade them to discuss problem areas. Also, juveniles placed in group treatment with other juveniles who have accepted responsibility for their behavior gives them both an opportunity to see that they're not alone and allows the "admitters" of the group to relate to the "deniers"—that they were once in that place.

Section 3.540

In Ryan and Lane's book, Juvenile Sexual Offending, Lane writes about juvenile sex offenders in denial. She reported that if a youth is in denial or not taking responsibility for a sexually abusive behavior, he or she will not benefit from offense-specific treatment, nor will he or she be able to manage his or her sexually abusive behavior patterns. Therefore, efforts should be made to first address his or her denial and ascertain what type of treatment setting would be most appropriate.

Section 3.540

Kahn and Chambers (1991) conducted a two-year study of juvenile sexual offenders who received both community and institution based treatment. Recidivism data was collected over a 20-month follow-up period. Of their findings, one of a few variables found to have a significant relationship to sexual re-offending was blaming the victim. Offenders who blamed their victim and used verbal threats had somewhat higher sexual recidivism rates than those who did not. A surprising find was that of the eight adolescents who denied their sexual offenses, none re-offended sexually during the follow-up period. Kahn and Chambers stated that there could be several explanations for that finding, but it is worth further exploration and study.

Section 3.540

In The Juvenile Sex Offender (Barbaree, Marshall, Hudson, 1993), Barbaree and Cortoni address the issue of denial and minimization among juvenile sex offenders. They stated that an offender in denial will not be able to progress in treatment. In addition, denial and minimization need to be reduced in order for the offender to develop victim empathy, which is necessary to work toward change in his or her behavior. Therefore, they suggested addressing denial and victim empathy as a first stage in treatment.

Section 3.610

Langstrom and Grann (2000) analyzed risk factors for 46 young sex offenders from 1988 – 1995. Sixty-five percent of this sample re-offended (20% re-offended sexually). Risk factors they found to be associated with elevated risk of sexual re-offending for this sample include early onset of sexually abusive behavior, male victim choice, more than one victim , and poor social skills.

Introduction, Section 5.100

The Association for the Treatment of Sexual Abusers, an international organization with a membership of over 2000 professionals committed to the prevention of sexual assault through effective management of sex offenders, adopted a position paper on the effective management of juvenile sexual offenders in March of 2000. This paper states that there is little evidence to support the assumption that most juvenile sexual offenders are destined to become adult sexual offenders. The reasoning for this, as stated in the paper, is the significantly lower frequency of more extreme forms of sexual aggression, fantasy, and compulsivity among juveniles than among adults which suggests that many juveniles have sexual behavior problems that may be more amenable to treatment. They go on to say that recent studies suggest that many juveniles who sexually abuse will cease this behavior by the time they reach adulthood, especially if provided with specialized treatment and supervision. Research also states that juvenile offenders may be more responsive to treatment because of their emerging development. In addition, ATSA believes that effective public policy requires the balancing of criminal justice sanctions, to enhance public safety and to punish criminal acts, with providing interventions to juveniles who are amenable to treatment.

Section 5.100

The National Task Force on Juvenile Sexual Offending (1993) as cited in Hunter and Figueredo's (1999) paper on the factors associated with treatment compliance of juvenile sexual offenders states that the interface between mental health and criminal justice systems is necessary for a sound public health policy in regard to juvenile sexual offenders.

Section 5.100

McGrath, Cumming, and Holt (2002) conducted a study with treatment providers, probation officers, and parole officers about their collaboration in the treatment and supervision of sex offenders. One hundred and ninety treatment programs throughout the nation completed a survey questionnaire that asked about program size and approach; age, gender, education, and professional affiliation; type, frequency, and value of different methods of communication their program had with probation officers; and a rating of several scenarios of communication between treatment providers and probation officers commonly used throughout the US. Treatment provider and probation officer communication was shown to be valued, common, and frequent. Over 87% described open communication as essential for effectively managing this population in the community.

Section 5.100

Bischof, Stith, and Whitney (1995) studied the family environments of adolescent sex offenders and other juvenile delinquents. The Family Environment Scale (FES) Form-R was completed by 105 adolescent males in various outpatient and residential programs. Thirty-nine were sex offenders, 25 were violent non-sex offenders, and 41 were non-violent, non-sex offenders. Although a nondelinquent control group was not used in this study, FES has been normed to the general population and those norms were used as comparison scores. No differences were found among the delinquent groups, however, several differences were evidenced among the delinquent groups when compared to the normative scores. The delinquent groups considered their families to be less cohesive, less expressive, and having a lower level of independence when compared with the non-delinquent group scores. These findings suggest that the families of adolescent sexual offenders are similar to those of violent and nonviolent juvenile delinquents in most ways assessed by the FES. Therefore, family interventions which have been demonstrated effective with juvenile delinquents in general are likely to be helpful with juvenile sex offenders as well.

Appendix J
ADDITIONAL CONDITIONS OF SUPERVISION *December 2014*

❑County Court ❑District Court ❑Denver Juvenile Court ❑Combined Court _____ County, Colorado Court Address: People of the State of Colorado, In the interest of Juvenile: and concerning Respondent: ▲	COURT USE ONLY ▲
Attorney or Party Without Attorney (Name and Address): Phone Number: E-mail: FAX Number: Atty. Reg. #:	Case Number: ML Number: SID Number: Division Courtroom

ADDITIONAL CONDITIONS OF PROBATION FOR JUVENILES WHO COMMIT SEXUAL OFFENSES

The Juvenile will be supervised by the probation department for a period of _____ ❑months ❑years and will comply with the following additional conditions:

_____ **1**. Pursuant to Sections 16-22-108, C.R.S., you must register as a sex offender with the local law enforcement agency within 5 business days after being given notice to register. If you move, you must re-register within 5 business days following your move. You must also fill out an address change form with the law enforcement office you last registered. Regardless of whether or not you move, you must register annually on your birth date or per statute.

_____ **2.** Genetic Marker Testing: If you are adjudicated of any Felony, or Misdemeanor offense involving unlawful sexual behavior or if you receive a deferred adjudication for an offense involving unlawful sexual behavior you shall be required to submit to and pay a fee for a test of your biological substance to determine genetic markers (DNA) in accordance with Section 19-2-925.6 C.R.S.

_____ **3**. You shall attend and actively participate in offense-specific evaluation and treatment at a program approved by the probation officer in consultation with the multidisciplinary team. You will abide by the rules of the treatment program and successfully complete the program to the satisfaction of the supervising officer/ agent in consultation with the multidisciplinary team

_____ **4**. You shall submit, at your own expense, to any program of psychological or physiological assessment and monitoring at the direction of the probation officer in consultation with the multidisciplinary team. This includes but is not limited to the

polygraph, plethysmograph and/or visual reaction time measuring instruments to assist in treatment, planning and case monitoring.

_____ **5**. You shall not have contact with children three or more years younger than yourself unless and until approved in advance and in writing by the probation officer in consultation with the multidisciplinary team.

_____ **6**. If you have contact (even incidental/accidental) with other children from whom you are restricted, it is your responsibility to immediately remove yourself from the situation in a safe and responsible manner. You must notify your probation officer and your treatment provider immediately.

_____ **7.** You shall not go to or loiter near parks, playgrounds, recreation centers, swimming pools, or arcades unless a safety plan is approved and in place by the probation officer and in consultation with the multidisciplinary team.

_____ **8.** You shall have no contact with the victim(s), including letters, electronic communication, by telephone or communication through another person except under circumstances approved in advance by the probation officer in consultation with the multidisciplinary team. You shall not enter onto the premises, travel past or loiter near where the victim(s) reside(s) unless authorized in advance by the probation officer in consultation with the multidisciplinary team.

_____ **9.** Before you may return to or attend the same school as the victim(s), victim input must be obtained by the multidisciplinary team describing the victim's perspective on your presence in the school. If you are allowed to enroll in the same school as the victim(s), prior to your return a safety plan must be completed, it must be ready to implement and approved by the multidisciplinary team.

_____ **10**. You shall complete and comply with a school safety plan.

_____ **11**. You may not enter into a position of trust or authority with any child. Any employment, including babysitting, or volunteer work must be approved in advance and a safety plan shall be designed specific to the setting by the probation officer in consultation with the multidisciplinary team.

_____ **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 which show nudity or sexually explicit material.

_____**13.** You and/or your parent/guardian will be financially responsible for all examinations, evaluations and treatment unless other arrangements have been made through your probation officer in consultation with the multidisciplinary team..

_____ **14**. You shall not change treatment programs without prior approval of the probation officer.

_____ **15.** You shall sign releases of information to allow the probation officer to communicate with other professionals involved in your supervision and treatment, and to allow all professionals involved to communicate with each other. This will include a release of information to the therapist of the victim(s).

_____ **16**. You shall not go on overnight visits away from your home without prior approval of your probation officer in consultation with the multidisciplinary team. Overnight visits may be approved only after the development of a safety plan with the appropriate multidisciplinary team members. The safety plan must be approved by your parent/ caregiver and notice made to the parent/ caregiver at the overnight location who must become an informed supervisor.

_____ **17.** You shall not be allowed to subscribe to or use any internet service provider, by modem, LAN, DSL or any other avenue and shall not be allowed to use another person's internet or use the internet through any commercial means unless and until approved by the supervising officer/agent in consultation with the multidisciplinary team. You may not participate in chat rooms. A safety plan with a supervision component must be in place prior to access. This includes but is not limited to satellite dishes, PDAs, electronic games, web televisions, internet appliances and cellular/digital telephones. When access has been approved with permission from the court, you shall agree to sign, and comply with, the conditions of the "Computer Use Agreement." Additionally, you will allow your probation officer, or other person trained to conduct computer searches, including a non-judicial employee, who is hereby permitted to view your probation files to the extent necessary, to conduct computer searches. You may be required to pay for such a search.

_____ **18**. You shall not utilize, by any means, any social networking forums offering an interactive, user-submitted network of friends, personal profiles, blogs, chat rooms or other environment which allows for real-time interaction with others without permission from the probation officer and the multidisciplinary team.

_____ **19.** You shall not use or possess distance vision enhancing or tunnel focusing devices, any cell phone cameras, cameras or video recording devices except under circumstances approved in advance and after the development of a safety plan approved by the probation officer in consultation with the multidisciplinary team.

_____ **20**. When applicable, you understand that your relationships and dating may be completely or partially restricted until the multidisciplinary team determines that you have exhibited the ability to maintain yourself in a consistently safe manner. You understand that you are required to inform, at minimum, the probation officer and treatment provider of your relationships and or dating activities on an ongoing and timely basis.

_____ **21.** You also understand that the multidisciplinary team may require further disclosure to any potential sexual partner of the nature and extent of your sexually offending behavior history prior to any sexual contact occurring.

_____ **22.** You shall allow your probation officer to search your personal residence or vehicle. Your personal property is subject to seizure if it violates any of the terms and conditions of your probation.

_____ **23.** You may be subject to location monitoring using Electronic Home Monitoring (EHM), Global Position Satellite (GPS), or other forms of electronic monitoring at the discretion of your probation officer and it may be at your own expense.

24._____

_____

_____

25. _____

_____

_____

Date: _____ _____

❑Judge ❑Magistrate

I have received an identical copy of the Additional Conditions of Probation and I have read them carefully with full understanding. I understand that if I violate the Additional Conditions of Probation, I will be brought before the Court for revocation of probation and imposition of sentence.

_____ _____

Juvenile Date Probation Officer/Witness

I/We the parent(s) or guardian(s) will cooperate as directed by the Court or probation officer with efforts for rehabilitation of this juvenile.

_____ _____

Parent/Guardian Date Parent/Guardian

Appendix K
GUIDANCE REGARDING VICTIMS/FAMILY MEMBER READINESS FOR CONTACT, CLARIFICATION, OR REUNIFICATION *December 2014*

The following are considerations for Multi-Disciplinary Teams (MDTs) 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 MDT 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.

A. Victim Readiness

- Contact and Clarification:

The person who has been victimized is able, based on their age and developmental level, to:

1. 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).

2. Accurately assess and identify the offender's responsibility for the abuse and aftermath and does not blame self.

3. Place responsibility on the offender and does not minimize or deny responsibility based on fear of repercussions.

4. Avoid perceiving self as destroyer or protector of the family.

5. Demonstrate assertiveness skills and is willing to disclose any further abuse or violations of a safety plan.

6. Demonstrate a reduction of symptoms and is not actively experiencing Post Traumatic Stress Disorder.

7. Express feeling safe, supported, protected and in control, but not controlling.

8. Maintain positive and supportive relationships with those who have demonstrated an ability to support them.

9. 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:

1. Demonstrate awareness of previous grooming tactics of the offender.

2. Recognize ongoing grooming patterns.

3. Exercise assertiveness skills and confront the offender as needed.

4. Identify and seek out external support if needed.

B. Non-Offending Parent or Guardian Readiness

The non-offending parent or guardian:

1. Believes the victim's report of the abuse.

2. Recognizes and understands, without minimizing, the impact of the abuse on the victim.

3. Holds the offender solely responsible for the abuse without blaming the victim in any way.

4. Has received appropriate education regarding their role as a non-offending parent.

5. Demonstrates the ability to be supportive and protective of the victim.

6. Is more concerned with victim impact and recovery than consequences or inconveniences for the offender.

7. Has received appropriate education regarding sexual offender behavior.

8. Has received full disclosure of the extent of the offender's sexual offense(s)/abusive behavior(s).

9. Is aware of the grooming tactics used by the offender for not only the victim, but also other family members.

10. Supports and implements the family safety plan.

11. Demonstrates the ability to recognize and react properly to signs of high risk or offending behavior.

12. Can demonstrate assertiveness skills that would allow him/her to confront the offender and is willing to disclose high risk or offending behavior.

C. Secondary Victim, Sibling or Other Children in the Home Readiness
This individual:

1. Has an understanding of the nature of abuse and the impact on the victim.

2. Does not blame the victim or minimize the abuse.

3. Understands the offender is solely responsible for the abuse.

4. Has received information about offender treatment and high risk and grooming behaviors.

5. Can express the ways the abuse has affected and impacted his/her life.

6. Demonstrates healthy boundaries, including the ability to identify and set limits regarding personal space and privacy.

7. Is aware of the family safety plan.

Appendix L
YOUNG ADULT MODIFICATION PROTOCOL *December 2014*

Young Adult Modification Protocol[63]

The SOMB recognizes that due to responsivity[64] 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.[65,66,67,68,69,70,71,72]

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

[63] 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

[64] 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.

[65] 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.

[66] 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).

[67] Siegel, D.J. (2006). Brain, mind, and behavior. In D. Wedding & M. Stuber (Eds.), *Behavior and Medicine, Fourth Edition*. Cambridge, MA: Hogrefe & Huber.

[68] 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.

[69] 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

[70] Steinberg, L. (2008). A social neuroscience perspective on adolescent risk-taking. *Developmental Review, 28,* 78-106.

[71] 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.

[72] 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.

manages risks. Such assessment should include strengths and protective factors.[73] 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.

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.[74]

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.

[73] 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.

[74] 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.

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
- 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[75] 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 should selectively employ methods that have generally been shown to work. Further,

[75] 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.

participants' response to treatment will be enhanced by effortful attendance to their individual learning style, abilities and culture."[76]

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.

[76] 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 M
SEXUALLY STIMULATING MATERIALS *December 2014*

Applicable Standards from the *Standards and Guidelines for the Assessment, Evaluation, Treatment and Behavioral Monitoring of Adult Sex Offenders (Adult Standards):*

Standard 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.

Standard 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.

A. 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.

B. 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.

C. 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.

D. 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.

E. 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.

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