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
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COLORADO
Division of Criminal Justice
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Introduction

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 (section 16-11.7-103(4)(j)(l), C.R.S.)[1]

In 2000, The Colorado General Assembly amended and passed legislation (section 16-11.7-103(4)(j)(l), C.R.S.)[2] that required the Sex Offender Management Board to develop and prescribe a standardized set of procedures for the evaluation and identification of juveniles who have committed sexual offenses. The legislative mandate to the Board was to develop and implement methods of intervention for juveniles who have committed sexual offenses, 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 adjudicated or receive a deferred adjudication (including those with a deferred adjudication who are placed on Diversion) for a sexual offense, and those whose charges include an underlying factual basis of a sexual offense (section 16-11.7-103(4)(j)(l), C.R.S.)[3]:

- Placed on probation or parole,
- Committed to the State Department of Human Services,
- Placed in the custody of the County Department of Human Services/Social Services,

[1] 16-11.7-103(4)(j)(I) Guidelines and standards for treatment of juvenile offenders. The board shall develop, implement, and revise, as appropriate, guidelines and standards to treat juveniles who have committed sexual offenses, including juveniles with intellectual and developmental disabilities, incorporating in the guidelines and standards the concepts of the risk-need-responsivity or another evidence-based correctional model, which guidelines and standards may be used for juvenile offenders who are placed on probation, committed to the department of human services, placed on parole, or placed in out-of-home placement. Programs implemented pursuant to the guidelines and standards developed pursuant to this subsection (4)(j) must be as flexible as possible so that the programs may be accessed by each juvenile offender to prevent him or her from harming victims and potential victims. Programs must provide a continuing monitoring process and a continuum of treatment options available to a juvenile offender as he or she proceeds through the juvenile justice system. Treatment options may include, but need not be limited to, group counseling, individual counseling, family counseling, outpatient treatment, inpatient treatment, shared living arrangements, and treatment in a therapeutic community. Programs implemented pursuant to the guidelines and standards developed pursuant to this subsection (4)(j) must be, to the extent possible, accessible to all juveniles who have committed sexual offenses and who are in the juvenile justice system, including juveniles with behavioral, mental health, or co-occurring disorders.

[2] Ibid.

[3] Ibid. (1)

- In out-of-home placement for sexual offending or abusive behavior.
- In addition to the above, these standards are required when:
    - the juvenile was less than eighteen years of age at the time of the sex offense, and
    - is subsequently convicted of the sex offense in adult district court pursuant to section C.R.S. 19-2-517 or 19-2-518 prior to or after the age of eighteen, and
    - The juvenile is sentenced prior to attaining the age of twenty-one.

The Board provides the following guidance regarding use of the Standards for juveniles who are not under the Statutory purview of the SOMB. These Standards and Guidelines may be utilized as best practice in the following situations where there are concerns of abusive, harmful, or illegal sexual behavior:

- Juveniles and families who are seeking intervention regarding sexually abusive behavior that has been disclosed through self-report or evaluation.
- Following a comprehensive evaluation which identifies a concern related to sexualized behavior for:
    - Juveniles who have been adjudicated for a non-sexual offense,
    - Juveniles placed on Diversion, without a Deferred Adjudication, or
    - Juveniles who are the subject of a Dependency and Neglect (D&N) order, or
- A juvenile who has committed a sexual offense is either found incompetent to stand trial, or is not charged with an offense but rather the case is opened on a D&N Petition, or
- A juvenile is receiving services for sexualized behavior provided by a County Department of Human Services/Social Services (DHS/DSS) without a legal requirement.

Due to developmental and contextual considerations, the identification of individual differences among juveniles who commit sexual offenses is a valuable method 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 is developed. As a general rule intervention developed for adults should not be applied to juveniles except in rare cases (for example, when developmentally appropriate and research supports their use) (section 16-11.7-104(1), C.R.S.)[4].

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 framework established by the Guiding Principles and the foundation of these Standards. This discretionary influence is vital to properly apply these Standards to the wide range of developmental and case specific considerations.

The term "shall" is used in the standards to establish the general expectation to be followed and to give a baseline of what treatment providers, evaluators, and polygraph examiners are expected to follow. The standards are written for the population as a whole with the understanding there is significant diversity that requires individualized treatment, supervision, and approaches. Information exists within the body of the standards to provide guidance on how to document individualization of

[4] 16-11.7-104(1) On and after January 1, 1994, each convicted adult sex offender and juvenile who has committed a sexual offense who is to be considered for probation shall be required, as a part of the presentence or probation investigation required pursuant to section 16-11-102, to submit to an evaluation for treatment, an evaluation for risk, procedures required for monitoring of behavior to protect victims and potential victims, and an identification developed pursuant to section 16-11.7-103 (4).

the standards and factors to consider that might warrant further individualization than the standards offer as written.

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 regarding the *Standards and Guidelines* 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 and Guidelines* are a dynamic document and the most current version of these *Standards and Guidelines* can be found on the SOMB website.
https://dcj.colorado.gov/dcj-offices/domestic-violence-and-sex-offender-management/somb/somb-standards-bulletins - (section 16-11.7-103(4)(k), C.R.S.)[5]

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 on 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.

[5] 16-11.7-103(4)(k) Evaluation of policies and procedures for juvenile offenders. The board shall research and analyze the effectiveness of the evaluation, identification, and treatment procedures developed pursuant to this article for juveniles who have committed sexual offenses. The board shall revise the guidelines and standards for evaluation, identification, and treatment, as appropriate, based upon the results of the board's research and analysis. The board shall also develop and prescribe a system to implement the guidelines and standards developed pursuant to paragraph (j) of this subsection (4).

Research Citations

The following Juvenile Standards and Guidelines in the Introduction Section have research or statutory support (the Standards are either footnoted or are supported by a review of the literature and the statute): Introduction.

All footnotes and research references in these Standards were evaluated by the staff researcher and presented to the Standards Revisions Committee regarding the revisions being discussed. Not all research considered directly supported the revisions; however, the research was reviewed in its totality to inform the revisions process regardless of whether it supported the standard revision or not. The research in these Standards was evaluated based on the quality of the research design and the quality/strength of their findings as it related to the revisions being discussed.

Should additional research or statutory information become available in the future pertaining to the topic of these Standards it will be evaluated and incorporated, should it be of sound quality.

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Guiding Principles

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

1. **The highest priority of these Standards and Guidelines is to maximize community safety through the effective delivery of quality evaluation, treatment and management of juveniles who commit sexual offenses.**[6]

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.[7] 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.[8] 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.[9]

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.**[10]

   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

[6] Center for Sex Offender Management (2007). Enhancing the Management of Adult and Juvenile Sex Offenders: A Handbook for Policymakers and Practitioners. *Center for Effective Public Policy, U.S. Department of Justice, Office of Justice Programs*, 2005-WP-BX-K179 and 2006-WP-BX-K004.

[7] Mason, F. & Lodrick, Z. (2013). Psychological consequences of sexual assault. *Best Practice & Research Clinical Obstetrics and Gynaecology, 27*(1):27-37; Tjaden, P. & Thoennes, N. (2006). Extent, nature, and consequences of rape victimization: Findings from the National Violence Against Women Survey. *Washington, DC: U.S. Dept. of Justice, Office of Justice Programs, National Institute of Justice*; Walsh et al. (2012). National prevalence of posttraumatic stress disorder among sexually revictimized adolescent, college, and adult household-residing women. *Archives of General Psychiatry, 69*(9):935-942; Wilson, D. (2010). Health Consequences of Childhood Sexual Abuse. *Perspectives in Psychiatric Care. 46*(1): 56-64.

[8] Chen et al. (2010). Sexual abuse and lifetime diagnosis of psychiatric disorders: Systematic review and meta-analysis. *Mayo Clinic Proceedings, 85*(7):618–629.

[9] Feiring, C., & Taska, L. (2005). The Persistence of Shame Following Sexual Abuse: A Longitudinal Look at Risk and Recovery. *Child Maltreatment, 10*(4):337-349; Lodrick, Z. (2010). Victim guilt following experience of sexualized trauma: investigation and interview considerations. *The Investigative Interviewer, 1*:54–57; Patterson, D. (2010). The Linkage Between Secondary Victimization by Law Enforcement and Rape Case Outcomes. *Journal of Interpersonal Violence, 26*(2):328-347; Tamarit, J., Villacampa, C., and Filella, G. (2010). Secondary Victimization and Victim Assistance. *European Journal of Crime, Criminal Law and Criminal Justice, 18*(3):281-298.

[10] Briere & Scott (2006). Principles of trauma therapy: A guide to symptoms, evaluation, and treatment. Thousand Oaks, CA: Sage Publications; Morrison (2007). Caring about sexual assault: the effects of sexual assault on families, and the effects on victim/survivors of family responses to sexual assault. *Family Matters, 76*:55-63; O'Doherty, T., McLaughlin, S., Deirdre O'Leary, D. (2001). Recovery work with child victims of sexual abuse: A framework for intervention. *Child Care in Practice, 7*(1):78-88.

to meet the needs of the juvenile in a manner that does not compromise or negatively impact community safety.

4. **Safety, protection, developmental growth and the psychological wellbeing of victims and potential victims is a priority for the Multidisciplinary Team (MDT).**[11]

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

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.**

6. **Treatment and supervision decisions should be informed by a comprehensive evaluation**[12] **and ongoing assessments.**[13]

   It is important to understand that risk assessment measures have limitations and that findings need to be used appropriately (i.e. within the scope of their empirically established limits). 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.

7. **Risk assessment of juveniles who have committed sexual offenses should be based on an empirically supported protocol.**[14]

   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) of adjudication/deferred judgement.

8. **A multidisciplinary team will be convened, and is responsible for the evaluation, treatment, care and supervision of juveniles who commit sexual offenses.**[15]

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[11] Gootschall et al. (2015). Value, Challenges, and Solutions in Incorporating Victim Impact Awareness in Offender Rehabilitation - The Results of Qualitative Interviews with Stakeholders. *Victims & Offenders: An International Journal of Evidence-based Research, Policy, and Practice, 10*(3):293-317.

[12] Chu, M., & Thomas, S. (2010). Adolescent Sexual Offenders: The Relationship Between Typology and Recidivism. *Sexual Abuse: A Journal of Research and Treatment, 22*(2):218-233; Rich, P. (2009). Juvenile Sexual Offenders: A Comprehensive Guide to Risk Evaluation. John Wiley & Sons; Ryan, G., Leversee, T. F., & Lane, S. (2010). Juvenile sexual offending: Causes, consequences, and correction, (3rd ed.). Wiley; Singh, J. P., Desmarais, S. L., Sellers, B. G., Hylton, T., Tirotti, M., & Van Dorn, R. A. (2014). From risk assessment to risk management: Matching interventions to adolescent offenders' strengths and vulnerabilities. *Children and Youth Services Review, 47* (Part 1), 1-9; Wijk, A. P., Mali, B. R., Bullens, R. A., & Vermeiren, R. R. (2007). Criminal Profiles of Violent Juvenile Sex and Violent Juvenile Non-Sex Offenders: An Explorative Longitudinal Study. *Journal of Interpersonal Violence, 22*(10), 1340-1355.

[13] 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; Fanniff, A., & Becker, J. (2006). Developmental considerations in working with juvenile sexual offenders. In R. E. Longo & D. S. Prescott (Eds.), Current perspectives: Working with sexually aggressive youth and youth with sexual behavior problems (pp. 119-141). Holyoke, MA: NEARI Press; Hempel et al. (2013). Review of Risk Assessment Instruments for Juvenile Sex Offenders What is Next? *International Journal of Offender Therapy and Comparative Criminology, 57*(2):208-228; Oneal, B. J., Burns, L. G., Kahn, T. J., Rich, P., & Worling, J. R. (2008). The Treatment Progress Inventory for Adolescents who Sexually Abuse (TPI-ASA). Sexual Abuse: A Journal of Research and Treatment, 20(2), 161–187.

[14] Rich, P. (2009). Juvenile Sexual Offenders: A Comprehensive Guide to Risk Evaluation. John Wiley & Sons; Ryan, G., Leversee, T. F., & Lane, S. (2010). Juvenile sexual offending: Causes, consequences, and correction, (3rd ed.). Wiley; Singh, J. P., Desmarais, S. L., Sellers, B. G., Hylton, T., Tirotti, M., & Van Dorn, R. A. (2014). From risk assessment to risk management: Matching interventions to adolescent offenders' strengths and vulnerabilities. *Children and Youth Services Review, 47* (Part 1), 1-9.

[15] Center for Sex Offender Management (2007). Enhancing the Management of Adult and Juvenile Sex Offenders: A Handbook for Policymakers and Practitioners. *Center for Effective Public Policy, U.S. Department of Justice, Office of Justice Programs*, 2005-WP-BX-K179 and 2006-WP-BX-K004; Center for Juvenile Justice Reform (2012). Addressing the Needs of Multi-System Youth - Strengthening the Connection between

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

9. **Treatment and supervision decisions should be guided by available research and best practice.**[16]

   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.

10. **Treatment and supervision should be individualized and responsive based on the juvenile's risks and needs.**[17]

    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.

11. **Evaluation, ongoing assessment, treatment and supervision of juveniles who have committed sexual offenses should be non-discriminatory, humane and bound by the professional code of ethics and law.**[18]

    Professionals responsible for the evaluation, assessment, treatment and supervision 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.

12. **Assessment of the degree of progress in treatment is based on the juvenile's application of relevant changes in their daily functioning.**[19]

Child Welfare and Juvenile Justice, Georgetown Public Policy Institute, Washington, D.C.; Lobanov-Rostovsky, C. & Hansen, J. (2013). Evaluation of Policies and Procedures for Juvenile Offenders and Best Practices for the Treatment and Management of Adult Sex Offenders and Juveniles who have Committed Sexual Offenses, Denver, CO: Colorado Department of Public Safety.

[16] Bumby, K. M., & Talbot, T. B. (2007). Treating Juveniles who Commit Sex Offenses: Historical Approaches, Contemporary Practices, and Future Directions. In M. C. (Ed.), Working with Children and Youth who Sexually Abuse: Taking the Field Forward (pp. 245–261). Lyme Regis, UK: Russell House; Mears, D., & Bacon, S. (2009). Improving criminal justice through better decision making: Lessons from the medical system. *Journal of Criminal Justice, 37*(2):142–154.

[17] Brogan, L., Haney-Caron, E., NeMoyer, A. & DeMatteo, D. (2015). Applying the risk-needs-responsivity (RNR) model to juvenile justice. *Criminal Justice Review, 40*(3):277-302; 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; Hempel et al. (2013). Review of Risk Assessment Instruments for Juvenile Sex Offenders: What is Next? *International Journal of Offender Therapy and Comparative Criminology, 57*(2):208-228; Hoge, R. D. (2016). Risk, need, and responsivity in juveniles. In K. Heilbrun (Ed.) APA Handbook of Psychology and Juvenile Justice (pp. 179-196). Washington D.C.: APA; Lipsey, M. W. (2009). The Primary Factors that Characterize Effective Interventions with Juvenile Offenders: A Meta-Analytic Overview. *Victims and Offenders, 4*(2):124-147; Rich, P. (2009). Juvenile Sexual Offenders: A Comprehensive Guide to Risk Evaluation. John Wiley & Sons; Ronis, S. & Borduin, C. (2007). Individual, Family, Peer, and Academic Characteristics of Male Juvenile Sexual Offenders, *Journal of Abnormal Child Psychology, 35*(2):153-163; Worling J. R. (2013). Desistence for adolescents who sexually harm (Unpublished document). Retrieved from http://www.erasor.org/new-protective-factors.html.

[18] Birgden, A. & Cucolo, H. (2011). The Treatment of Sex Offenders Evidence, Ethics, and Human Rights. *Sexual Abuse: A Journal of Research and Treatment, 23*(3):295-313.

[19] Hempel, I., Buck, N., Cima, M., Marle, H. (2013). Review of Risk Assessment Instruments for Juvenile Sex Offenders: What is Next? *International Journal of Offender Therapy and Comparative Criminology, 57*(2):208-228.

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

13. Treatment should be holistic and enhance overall health and protective factors.[20]

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.[21] 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.[22] Treatment plans should also reinforce developmental and environmental assets.

14. Assessment, treatment and supervision should be viewed through an ecological framework of Development.[23]

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.

The individualization of evaluations, assessment, treatment and supervision requires particular attention to social and cultural factors. Recognition of these factors are essential when interacting with clients from different social, cultural, and religious backgrounds. A basic premise is to recognize the client's culture, your own culture, and how both affect the client-provider relationship. This premise extends to all professional members of the MDT and positive support persons and is essential in creating an equitable and inclusive environment regardless of differences in culture or lifestyle.

15. Family members/Primary Caregivers should be considered an integral part of evaluation, assessment, treatment and supervision.[24]

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

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[20] Leversee, T., & Powell, K. (2012). Beyond Risk Management to a More Holistic Model for Treating Sexually Abusive Youth. In B. K. Schwartz, The Sex Offender (Chapter 19). Kingston, NJ: Civic Research Institute.

[21] Caldwell, M. (2010). Study Characteristics and Recidivism Base Rates in Juvenile Sex Offender Recidivism. *International Journal of Offender Therapy and Comparative Criminology, 54*(2):197-209; 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):363–385; Worling, J. R., & Langstrom, 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.

[22] Perry, G., & Ohm, P. (1999). The role healthy sexuality plays in modifying abusive behaviours of adolescent sex offenders: Practical considerations for professionals. *Canadian Journal of Counseling, 32*(2):157-169.

[23] Borduin et al. (2009). A Randomized Clinical Trial of MST with Juvenile Sexual Offenders: Effects on Youth Social Ecology and Criminal Activity, *Journal of Consulting and Clinical Psychology, 77*(1):26-37; Pullman et al. (2014). Examining the developmental trajectories of adolescent sexual offenders, *Child Abuse & Neglect, 38*(7):1249-1258.

[24] Schroeder, R., Osgood, A., Oghia, M. (2010). Family Transitions and Juvenile Delinquency. *Sociological Inquiry, 80*(4):579-604; Spice, A., Viljoen, J., Latzman, N., Scalora, M., and Ullman, D. (2012). Risk and Protective Factors for Recidivism Among Juveniles Who Have Offended Sexually. *Sexual Abuse: A Journal of Research and Treatment, 25*(4):347–369; Thorton et al. (2008). Intrafamilial adolescent sex offenders: Family functioning and treatment, Journal of Family Studies, 14(2-3):362-375; Yoder et al. (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.

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.[25] It is expected that the MDT will work with the family/primary caregiver to help them support the juvenile through cooperative involvement.

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, including both in and out of a school setting. Research indicates that association with delinquent peers, the absence of pro-social adult role models, and the disruption of caregiver relationships increase the risk of delinquent development.[26]

17. **A continuum of care for treatment and supervision options should be available and utilized as needed.**[27]

    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.

18. **For juveniles who have been removed from the home family reunification can only occur after careful consideration of all the potential risks.**[28]

    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

[25] Baker, A., 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.

[26] Burton, D. & Duty, K. & Leibowitz, G. (2011). Differences between sexually victimized and non-sexually victimized male adolescent sexual abusers: Developmental antecedents and behavioral comparisons. *Journal of Child Sexual Abuse, 20*(1):77-93; Miner & Munns (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; Righthand, S. & Welch, C. (2004). Characteristics of youth who sexually offend. *Journal of Child Sexual Abuse, 13*(3-4):15-32.

[27] Hunter, J. A., Gilbertson, S. A., Vedros, D., & Morton, M. (2004). Strengthening community based programming for juvenile sex offenders: Key concepts and paradigm shifts. *Child Maltreatment, 9*(2):177-189; Silovsky, J. F., Swisher, L. M., Widdifield Jr., J., & Burris, L. (2011). Clinical considerations when children have problematic sexual behavior. In P. Goodyear-Brown (Ed.). Handbook of child sexual abuse: Identification, assessment, and treatment. New Jersey: John Wiley & Sons.

[28] Hackett et al. (2014). Family Responses to Young People Who have Sexually Abused: Anger, Ambivalence and Acceptance, Children & Society, 28(2):128–139; Silovsky et al. (2011). Prevention of child maltreatment in high-risk rural families: A randomized clinical trial with child welfare outcomes. Children and Youth Services Review, 33(8):1435–1444; Swisher, L., Silovsky, J., Stuart, R., & Pierce, K. (2008). Children with Sexual Behavior Problems. Juvenile and Family Court Journal, 59(4):49-69; Harper, B. (2012). Moving Families to Future Health: Reunification Experiences After Sibling Incest. Doctorate in Social Work (DSW), Dissertations. Paper 26; Price, D. (2004). Rebuilding Shattered Families: Disclosure, Clarification and Reunification of Sexual Abusers, Victims, and Their Families, Sexual Addiction & Compuisivity, 11(4):187-221.

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.

19. **Juveniles shall not be labeled as if their sexual offending behavior defines them.**[29]

    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.[30] Not all juveniles who have engaged in sexually abusive behavior require extensive or intensive interventions in order to reduce their risk for reoffending 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.

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.**[31]

[29] Miner et al. (2006). Standards of Care for Juvenile Sexual Offenders of the International Association for the Treatment of Sexual Offenders, Sexual Offender Treatment, 1(3); Schultz, C. (2014). The Stigmatization of Individuals Convicted of Sex Offenses: Labeling Theory and The Sex Offense Registry. Themis: Research Journal of Justice Studies and Forensic Science, 2(4):64-81.

[30] 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; Fanniff, A., & Becker, J. (2006). Developmental considerations in working with juvenile sexual offenders. In R. E. Longo & D. S. Prescott (Eds.), Current perspectives: Working with sexually aggressive youth and youth with sexual behavior problems (pp. 119-141). Holyoke, MA: NEARI Press; Hempel et al. (2013). Review of Risk Assessment Instruments for Juvenile Sex Offenders

What is Next? International Journal of Offender Therapy and Comparative Criminology, 57(2):208-228.

[31] Brogan, L., Haney-Caron, E., NeMoyer, A. & DeMatteo, D. (2015). Applying the risk-needs-responsivity (RNR) model to juvenile justice. Criminal Justice Review, 40(3):277-302; 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; Reicher (2013). Denying Denial in Children with Sexual Behavior Problems, Journal of Child Sexual Abuse, 22(1):32–51.

Research Citations

The following Juvenile Standards and Guidelines in the Guiding Principles have research support (the Standards are either footnoted or are supported by a review of the literature): Guiding Principle 1. – 20.

All footnotes and research references in these Standards were evaluated by the staff researcher and presented to the Standards Revisions Committee regarding the revisions being discussed. Not all research considered directly supported the revisions; however, the research was reviewed in its totality to inform the revisions process regardless of whether it supported the standard revision or not. This research was then incorporated into the Standards and presented to the SOMB for ratification by the Board. The research in these Standards was evaluated based on the quality of the research design and the quality/strength of their findings as it related to the revisions being discussed. The research reviewed and utilized in this revision can be found in the SOMB's online repository at: https://dcj.colorado.gov/dcj-offices/domestic-violence-and-sex-offender-management/domestic-violence-and-sex-offender

Should additional research become available in the future pertaining to the topic of these Standards it will be evaluated and incorporated, should it be of sound quality.

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Definitions

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

Adjudication: "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.

Amenability to Treatment: The level of ability and willingness, even if minimal, to participate in treatment to address changes in thoughts, feelings and behaviors.

Assessment: A process and on-going process of evaluation which might include the use of Standardized measurement instruments intended for treatment planning and review purposes.

Clinical Indicators: Clinical indicators can be anything that provides information about a client's overall clinical presentation, which may include but is not limited to interviews, quality of treatment participation, polygraph examination results and disclosures, scores on dynamic risk assessments, psychological evaluation, behavioral observations, and collateral reports.

Coercion: Use of pressure through actions such as bribes, threats or intimidation to gain cooperation or compliance.

Commitment: A legal process by which a juvenile is placed in the custody of the State Department of Human Services, Division of Youth Corrections.

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 for Sexual Activity: Agreement between individuals that includes all of the following: 1) emotional and intellectual equality; 2) honesty; 3) understanding what is proposed, based on functioning and experience; 4) permission to disagree or refuse without penalty or harm; 5) understanding what is going to happen, including potential consequences and alternatives.

Consensus: An opinion or position reached by a group as a whole. A consensus decision does not require an agreed upon position but rather a decision all members of the group can accept and implement.

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 workers advocate for the best interest of abused and neglected children in juvenile courts through the service of specially selected and trained community volunteers from diverse cultural and ethnic backgrounds. CASA volunteers are everyday citizens appointed by judges to be a trained advocate who works directly with all the parties to make sure the best interests of the child are always front-and-center.

Dependency and Neglect Court Case:

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 and result of the transfer of custody from the family to the County Department of Human Services. 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 services that could include placement for juveniles.

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 intellectual disability.

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

AND/OR

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

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

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.

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

Grooming: Subversive actions perpetrated to gain access and trust of the victim and the victim's support system. Manipulating 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): An attorney appointed by the court to look out for the best interests of the child during the course of legal proceedings.

Guideline: Guidelines are recommendations within the standards and 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.).

Individualized Education Plan (IEP): The Individual Education Program Plan (IEP) requires that the student must qualify for special education and is limited to those with special education needs resulting from intellectual and/or emotional disorders/disabilities that result in significant educational delays. The 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.

Informed Assent[32]: 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.

Juvenile Who Has Committed A Sexual Offense: A juvenile who has been adjudicated for one of the following offenses;

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

[32] 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.

23. Public Indecency, If a Second Offense is Committed Within 5 Years of the Previous Offense, or a Third or Subsequent Offense is Committed;
24. Invasion of Privacy for Sexual Gratification;
25. Criminal Attempt, Conspiracy, or Solicitation to commit any of the above offenses.

Parents, Caregivers and Other Natural Support Systems: 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.

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: A database maintained by the Sex Offender Management Board of professionals approved to provide treatment, evaluation, or polygraph services to juveniles who have committed sexual offenses.

Relapse Prevention: An element of treatment designed to address behaviors, thoughts, feelings and fantasies that were present in the juvenile's instant offense, dynamic patterns of abuse and consequently, part of the risk for relapse.

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.

Risk Related Sexual Interest and Behavior Patterns: Any sexual interest or behavior that is empirically linked to risk factors for sexual offending and abusive behavior as well as sexual interest(s) or behavior that impairs the individual's ability to function as a healthy, pro-social member of the community. Such factors include cognitive, emotional, or behavioral sexual patterns determined to be sexually abusive or sexually problematic. This may involve a disregard for negative consequences, the unmanaged need for instant gratification, a lack of impulse control, and/or results in disruption to other aspects of the client's life.

Risk Related sexual interest patterns may include, but are not limited to, the following:

- Sexual interest in prepubescent and pubescent children

- Sexualized violence
- A presentation of multiple/specific paraphilia's

Risk Related sexual behavior patterns may include, but are not limited to, the following:

- Disregard for the negative consequences caused by sexual behaviors and interest
- Sexual preoccupation
- Hypersexuality
- Sexual compulsivity
- Sexual coping

Safety Planning: Purposeful planning of preventive interventions which the juvenile and/or others can use to moderate risk in specific situations.

Sex Offense Specific 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 recommendations. 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.

Sex Offense Specific Treatment and Supervision:

Sex Offense Specific Treatment and Supervision is an individualized approach designed to stop sexual offending, general delinquency, and abusive behavior, while increasing the juvenile's understanding of harm to victims and communities and the ability to function as a healthy, pro-social member of the community. Juveniles who have committed sexual offenses are a diverse group of individuals. Effective interventions are evidence-based, holistic, and individualized according to each youth's risk, needs, developmental level, family support, and protective and responsivity factors. This may include adjunct therapies to address unique needs of individual juveniles. Current studies suggest that cognitive-behavioral, skills-based, and multi-systemic approaches that involve caregivers in treatment have the most research support. Interventions for juveniles who have committed sexual offenses and who have other indicators of risk associated with delinquency should include interventions for general delinquent conduct. Progress in treatment is measured by the achievement of change rather than the passage of time.

Sexual Abuse Cycle: A theoretical model of understanding the sequence of thoughts, feelings, behaviors and events within which decisions regarding sexual offending and abusive behavior occur.

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 or for the purpose of sexual abuse of 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, gratification, or abuse. 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.

Standard: Standards are requirements and 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).

Abbreviations:

1. Child Placement Agency (CPA)
2. Department of Human Services/Social Services (DHS/DSS) – For the purpose of these Standards, DHS/DSS is generally intended as a reference to county departments.
3. Division of Youth Corrections (DYC)
4. Multidisciplinary Team (MDT)
5. Sex Offender Management Board (SOMB), also referred to as "Board"

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1.000 Presentence Investigations of Juveniles Who Have Committed Sexual Offenses

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.[33]

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.[34]

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).[35]

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[33] Colorado Revised Statutes (2021). 16-11.7-104 – Sex offenders – evaluation and identification required - (1) On and after January 1, 1994, each convicted adult sex offender and juvenile who has committed a sexual offense who is to be considered for probation shall be required, as a part of the presentence or probation investigation required pursuant to section 16-11-102, to submit to an evaluation for treatment, an evaluation for risk, procedures required for monitoring of behavior to protect victims and potential victims, and an identification developed pursuant to section 16-11.7-103 (4).

[34] Center for Sex Offender Management (2008). The Comprehensive Approach to Sex Offender Management. Retrieved from: https://cepp.com/wp-content/uploads/2015/12/the-comprehensice-apprach-to-sex-offendermanagement.pdf

35 Center for Sex Offender Management (2008). The Comprehensive Approach to Sex Offender Management. Retrieved from: https://cepp.com/wp-content/uploads/2015/12/the-comprehensice-apprach-to-sex-offendermanagement.pdf

1.400 A presentence investigation (PSI) report shall address all the criteria pursuant to section 19-2-905, C.R.S.[36]

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.[37]

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:

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

[36] Colorado Revised Statutes (2021). 19-2-295 – Presentence investigation. (1) (a) Prior to the sentencing hearing, juvenile probation for the judicial district in which the juvenile is adjudicated shall conduct a presentence investigation unless waived by the court on its own determination or on recommendation of the prosecution or the juvenile. The presentence investigation must take into consideration and build on the intake assessment performed by the screening team. The presentence investigation may address, but is not limited to, the following:

[37] Colorado Revised Statutes (2021). 19-2-295 – Presentence investigation. (1) (a) Prior to the sentencing hearing, juvenile probation for the judicial district in which the juvenile is adjudicated shall conduct a presentence investigation unless waived by the court on its own determination or on recommendation of the prosecution or the juvenile. The presentence investigation must take into consideration and build on the intake assessment performed by the screening team. The presentence investigation may address, but is not limited to, the following: XI) Review of placement and commitment criteria adopted pursuant to section 19-2-212, which shall be the criteria for any sentencing recommendations included in the presentence investigation; (XII) Assessment of the juvenile's needs; and (XIII) Recommendations and a proposed treatment plan for the juvenile.

1.700 Evaluations received by the presentence investigators 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.[38]

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.

[38] Colorado Revised Statutes (2021). Presentence or probation investigation. (b) (I) Each presentence report prepared regarding a sex offender, as defined in section 16-11.7-102 (2), with respect to any offense committed on or after January 1, 1996, shall contain the results of an evaluation and identification conducted pursuant to article 11.7 of this title.

Research Citations

The following Juvenile Standards and Guidelines in Section 1.000 have research or statutory support (the Standards are either footnoted or are supported by a review of the literature and the statute): 1.100, 1.200, 1.300, 1.400, 1.500, and 1.700. All footnotes and research references in these Standards were evaluated by the staff researcher and presented to the Standards Revisions Committee regarding the revisions being discussed. Not all research considered directly supported the revisions; however, the research was reviewed in its totality to inform the revisions process regardless of whether it supported the standard revision or not. The research in these Standards was evaluated based on the quality of the research design and the quality/strength of their findings as it related to the revisions being discussed. The research reviewed and utilized in this revision can be found in the SOMB's online repository at:

https://dcj.colorado.gov/dcj-offices/domestic-violence-and-sex-offender-management/somb/about-the-sex-offender-management

The following Juvenile Standards and Guidelines in Section 1.000 but do not have research or statutory support, and are primarily procedural in nature: 1.100, 1.600, and 1.900. The SOMB staff did a search for research and statutes applicable to the Standards noted above. Research and literature was not found applicable to these Standards, so in absence of research the Standards are based on best practices procedures, professional association guidelines, and the professional expertise of the members of the Board. Should research become available in the future pertaining to the topic of these Standards it will be evaluated and incorporated, should it be of sound quality.

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2.000 Evaluation and Ongoing Assessment of Juveniles Who Have Committed Sexual Offenses

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. A thorough review of relevant prior treatment and supervision information can aid in the planning of treatment needs for the client and ensure continuity of care. To this end, it is imperative that the Evaluator make every reasonable effort to identify and obtain past records to determine what treatment may have been completed, what components of treatment need additional focus, and what components of treatment have not yet been completed. (Refer to Appendix F "Sex Offense-Specific Intake Review for Clients Who Have Been in Prior Treatment" and Appendix E "Sexual Offense History Decision Aid.") 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 with a focus on Risks Needs and Responsivity. The evaluation should thoroughly explain any strengths and limitations to the prediction of sexual recidivism and the instruments used during the evaluation. The evaluation should also explain the overall benefits of the evaluation process and how the information can be used to inform services.

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 disability 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. 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 and requirements:

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. Prior treatment involvement (Refer to Appendix F "Sex Offense- Specific Intake Review for Clients Who Have Been in Prior Treatment" and Appendix E "Sexual Offense History Decision Aid") 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 treatment and supervision of the juvenile; due to the court's ability to waive registration requirements if there is a corresponding recommendation against registration from the evaluator, the evaluation shall include a recommendation regarding whether or not the court should order the juvenile to register as a sex offender. When providing a recommendation for or against registration, the evaluator shall include supporting reasoning and rationale for the recommendation.

   Discussion: For additional information regarding registration recommendations, it is recommended that evaluators review the SOMB White Paper regarding juvenile registration, the ATSA position paper regarding Registration and Community Notification of Children and Adolescents Adjudicated of a Sexual Crime: Recommendations for Evidence-Based Reform (2020), C.R.S. 16-22-103(5), and available research.

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

I. To provide information to youth, families, and/or referral sources regarding the purpose, potential misuses, benefits, and limitations of assessing juveniles and of the specific instruments used during the evaluation.

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

Discussion: Risk assessments are time limited.[39] *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.*

2.110 Timeframes for Evaluations

Evaluations should be completed within 90 days of acceptance of the referral to ensure the timeliness of recommendations. In the event that circumstances prevent the evaluation from being completed within 90 days, the evaluator shall notify the referral source and the client (or their representative) of the delay and the barriers preventing the completion. The evaluator shall update the referral source and client every 30 days until the evaluation is

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

completed and shall document the barriers that prevented timely completion and the attempted solutions within the evaluation.

Discussion: Upon acceptance of a referral, evaluators should make every effort to complete their work in a timely manner. Dates determined by the Court most often drive timeframes. Barriers may arise during evaluations that require additional time by the evaluator such as; the time needed to get collateral information, review extensive documentation, and availability of the client. In rural areas of the state, the availability of the evaluator may also be a factor. It is the responsibility of the evaluator to provide updates to all parties involved and document any barriers and reasons for any delays in the completion of the evaluation.

If the evaluation will not be able to be started at the time of acceptance of the referral, such as in the case of evaluator wait lists, the evaluator shall notify the referral source to determine if an alternate referral will be made. When a referral source has agreed to have a client on the evaluator's waitlist, notification to the client every 30 days is not required until the evaluation has started and has exceeded 90 days.

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.

A. The recommendations shall be based upon a formulation of all pertinent data collected in the evaluation process.

B. Each recommendation shall be clearly supported by information within the body of the evaluation.

C. Recommendations regarding assignment of risk level shall be based on all available information and not on a single assessment instrument.

Discussion: In response to the Family First Prevention Services Act (FFPSA) there may be circumstances in which the recommended level of care or services do not match where the juvenile is currently placed/residing or the services the juvenile is receiving. In these circumstances the evaluator should make note of the recommended level of care/services and explain any known circumstances that prevent the youth from being placed at the recommended level of care or receiving the recommended services, such as but not limited to; not qualifying for a Qualified Residential Treatment Program (QRTP) by a qualified individual.

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

A. Pre-adjudication/Pre-plea: Information and/or assessments compiled before an admission of guilt may be less 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*.[40] Evaluators shall include a statement to each completed evaluation as to whether the evaluation is compliant with SOMB Standards or not. For further guidance, please refer to Section 2.900.

Discussion: When an evaluation is completed pre-adjudication/pre-plea the client may not be under the statutory purview of the SOMB, however, the evaluator is still bound to the above requirement regarding a statement of compliance.

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:

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

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

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

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

5. 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?

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

7. 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

[40] Colorado Revised Statutes (2020) 16-11.7-104 (1) On and after January 1, 1994, each convicted adult sex offender and juveniles who has committed a sexual offense who is to be considered for probation shall be required, as a part of the presentence or probation investigation required pursuant to section 16-11-102, to submit to an evaluation for treatment for risk, procedures required for monitoring of behavior to protect victims and potential victims and an identification developed pursuant to section 16-11.7-103 (4).

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.

B. 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*.

Discussion: For juveniles who completed a pre-plea/pre-sentence evaluation, or for juveniles appealing or denying the offense, the MDT should review the need for a new or updated evaluation following the legal disposition of the case. If the pre-plea/pre-sentence evaluation was completed over six months ago, the MDT should discuss the need for an updated evaluation. Should the Court order a new evaluation be completed, the MDT shall follow the Court's order.

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.

Evaluators shall administer assessment tools (e.g., mental health, substance abuse, etc.) in accordance with the tool's user's manual. When using an assessment tool with any evaluation client, where the tool has not been specifically validated on the client's unique characteristics (for example, gender, race, ethnicity, culture, etc.), the rationale for using the tool shall be included in the evaluation. The evaluator shall specifically note the strengths and limitations of the tools used and any impact this has on the overall evaluation results, based on the unique characteristics of the client being evaluated.

Discussion: Evaluation instruments and processes will be subject to change as more is learned in these areas. For some populations, there may not be a validated risk assessment available, and therefore risk assessment should be based on clinical reasoning and judgment, and other relevant factors. When in doubt, the evaluator should err on the side of protecting community safety in drawing conclusions and making recommendations. Evaluators should follow updates related to improvements made to assessment instruments, as they are periodically modified and improved upon. In addition, new tools may become available and may be utilized, as well. When making recommendations the evaluator should focus on recommendations that support the application of risk, need, and responsivity principles and prioritize victim and community safety.

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

A. Cognitive functioning;

B. Personality, characteristics

C. History of mental health functioning, diagnoses, and diagnostic impressions

D. Developmental competence;

E. Current individual functioning;

F. Current family functioning;

G. Sexual evaluation; including assessment of sexual development and normative behaviors.

H. Delinquency and conduct/behavioral issues;

I. Current mental health functioning, case conceptualization, and/or diagnostic impressions (including underlying diagnostic symptoms in the absence of a formal diagnosis, and/or a formal diagnosis when warranted)

J. Community risks and protective factors;

K. Awareness of victim impact;

L. External relapse prevention systems including informed supervision;

M. Amenability to treatment. (Refer to Appendix E "Sexual Offense History Decision Aid" and Appendix F "Sex Offense Specific Intake Review for clients Who Have Been in Prior Treatment.")

Ongoing assessment throughout treatment and any reassessments should identify changes to the areas outlined above.

Discussion: Evaluators shall administer risk assessment instruments in accordance with the instrument's user's manual. When using an instrument with any evaluation client, where the instrument has not been specifically validated on the client's unique characteristics (for example, gender, race, ethnicity, culture, etc.), the rationale for using the instrument shall be included in the evaluation. The evaluator shall specifically note the strengths and limitations of the instruments used and any impact this has on the overall evaluation results, based on the unique characteristics of the client being evaluated.

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 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.[41] 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.[42]

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.

[41]Colorado Revised Statutes (2020) 19-1-304 (1) (d) Except as otherwise authorized by section 19-1-303, any social and clinical studies, including all formal evaluations of the juvenile completed by a professional, whether or not part of the court file or any other record, are not open to inspection, except to the juvenile named in the record; to the juveniles parent, guardian, legal custodian, or attorney; or by order of the court, upon a finding of legitimate interest in and need to review the social and clinical studies.

[42] Colorado Revised Statutes (2020) 19-3-304 Except as otherwise provided by section 19-3-307, section 25-1-122 (4) (d), C.R.S., and paragraph (b) of this subsection (1), any person specified in subsection (2) of this section who has reasonable cause to know or suspect that a child has been subjected to abuse or neglect or who has observed the child being subjected to circumstances or conditions that would reasonably result in abuse or neglect shall immediately upon receiving such information report or cause a report to be made of such fact to the county department, the local law enforcement agency, or through the child abuse reporting hotline system as set forth in section 26-5-111, C.R.S.

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.

Research Citations

The following Juvenile Standards and Guidelines in Section 2.000 have research support (the Standards are either footnoted or are supported by a review of the literature): 2.000, 2.100, 2.210 (41), 2.300, 2.400, 2.600, 2.700 (41), and all of the Evaluation Areas, which include research-supported instruments except for Current Functioning – Individual. All footnotes and research references in these Standards were evaluated by the staff researcher and presented to the SOMB regarding the revisions being discussed. Not all research considered directly supported the revisions; however, the research was reviewed in its totality to inform the revisions process regardless of whether it supported the standard revision or not. This research was then incorporated into the Standards and presented to the SOMB for ratification by the Board. The research in these Standards was evaluated based on the quality of the research design and the quality/strength of their findings as it related to the revisions being discussed. The research reviewed and utilized in this revision can be found in the SOMB's online repository at:

https://dcj.colorado.gov/dcj-offices/domestic-violence-and-sex-offender-management/somb/about-the-sex-offender-management

The following Juvenile Standards and Guidelines in Section 2.000 were revised but do not have research support given their procedural nature: 2.200, 2.500, 2.800, and 2.900. The SOMB staff did a search for research applicable to the Standards noted above. Research was not found applicable to these Standards, so in absence of research the Standards are based on best practices procedures, professional association guidelines, and the professional expertise of the members of the Board. Should research become available in the future pertaining to the topic of these Standards it will be evaluated and incorporated, should it be of sound quality.
Statutory Citations:

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 Personality Inventory) 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)
▪ 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 Symptom 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 in Risk Related Sexual Interests and Behavior Patterns ▪ 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 (CSBI) Collateral 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 6 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 Sexual Offense History Decision Aid

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 Offenders Protective 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 Re-offense (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) Sexual Offense History Decision Aid

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3.000 Standards of Practice for Treatment Providers

Treatment for juveniles who have committed sexual offenses shall be individualized to address the identified risks and needs of a particular juvenile. When creating the treatment plan and determining which of the content areas identified in section 3.130 A. 1-24 should be addressed, the provider shall be sensitive to, and not discriminate based on, diverse factors including but not limited to cultural identity, language, development, sex (including gender identity, gender expression and sexual orientation), medical, past trauma/victimization, religion, national origin, citizenship, age, veteran status, disability, marital status and/or education/cognitive/adaptive functioning.

Individualized treatment shall follow the fundamentals of Risk, Need, and Responsivity and account for the unique dynamics of each client. While some youth may present with similar histories and require similar treatment, a template universal approach should not be used. This is consistent with the Association for the Treatment of Sexual Abusers (ATSA) Guidelines for Assessment, Treatment, and Intervention with Adolescents.

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.[43]

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.[44]

[43] Colorado Revised Statutes (2020) 16-11.7-103 (4) (i) Standards for identification and evaluation of juvenile offenders. The board shall develop, prescribe, and revise, as appropriate, a standard procedure to evaluate and identify juveniles who have committed sexual offenses, including juveniles with developmental disabilities. The procedure shall provide for an evaluation and identification of the juvenile offender and recommend behavior management, monitoring, treatment, and compliance and shall incorporate the concepts of the risk-need-responsivity or another evidence-based correctional model based upon the knowledge that all unlawful sexual behavior poses a risk to the community and that certain juveniles may have the capacity to change their behavior with appropriate intervention and treatment. The board shall develop and implement methods of intervention for juveniles who have committed sexual offenses, which methods have as a priority the physical and psychological safety of victims and potential victims and that are appropriate to the needs of the particular juvenile offender, so long as there is no reduction in the safety of victims and potential victims.

[44] Colorado Revised Statutes (2020) 16-11.7-103 (4) (j) (I) Guidelines and standards for treatment of juvenile offenders. The board shall develop, implement, and revise, as appropriate, guidelines and standards to treat juveniles who have committed sexual offenses, including juveniles with developmental disabilities, incorporating in the guidelines and standards the concepts of the risk-need-responsivity or another evidence-based correctional model, which guidelines and standards may be used for juvenile offenders who are placed on probation, committed to the department of human services, placed on parole, or placed in out-of-home placement. Programs implemented pursuant to the guidelines and standards developed pursuant to this paragraph (j) shall be as flexible as possible so that the programs may be accessed by each juvenile offender to prevent him or her from harming victims and potential victims. Programs shall provide a continuing monitoring process and a continuum of treatment options available to a juvenile offender as he or she proceeds through the juvenile justice system.

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.).[45]

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 abusive, illegal, or harmful behavior 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.

Treatment options may include, but need not be limited to, group counseling, individual counseling, family counseling, outpatient treatment, inpatient treatment, shared living arrangements, and treatment in a therapeutic community. Programs implemented pursuant to the guidelines and standards developed pursuant to this paragraph (j) shall be, to the extent possible, accessible to all juveniles who have committed sexual offenses and who are in the juvenile justice system, including juveniles with mental illness or co-occurring disorders.

[45] Colorado Revised Statutes (2020) 16-11.7.102 (1.5) "Juvenile who has committed a sexual offense" means a juvenile who has been adjudicated as a juvenile or who receives a deferred adjudication on or after July 1, 2002, for an offense that would constitute a sex offense, as defined in subsection (3) of this section, if committed as an adult, or a juvenile who has committed any offense, the underlying factual basis of which involves a sex offense.

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.

   Discussion: Juveniles have a right against self-incrimination. Juveniles who have filed an appeal should not be treated as though they are in denial. The MDT should discuss what, if any, implications the appeal has on the juvenile's ability to comply with these standards and may modify the standards accordingly. Providers should determine if a protection order, use immunity, or other court order is in place that protects against the use of any of the juvenile's statements to self-incriminate. If in place for the juvenile the standards may be followed as written.

   Juveniles who are appealing the sex crime adjudication can still benefit from participation in sex offense specific treatment, the sexual behavior disclosure process, and discussion of behaviors unrelated to the adjudication. Juvenile's may also be able to participate in the sexual history polygraph process, excluding the crime of adjudication, if determined to be appropriate to do so by the polygraph examiner and the MDT.

   Accountability is a key factor in treatment and it is important to note a client cannot fully progress and successfully complete treatment until the individual and ecological factors identified in their treatment plan have been addressed. It is expected that a juvenile will be able to take accountability and acknowledge their abusive behavior. In the rare event a juvenile is unable to directly verbalize their abusive behavior, however, other clinical indicators demonstrate a level of accountability, the provider shall document the circumstances of the case and the rationale for why the juvenile

should be allowed to progress and/or successfully complete treatment in the absence of a direct verbalization of the abusive behavior. Regardless of the type of discharge, if specific aspects of sex offense specific treatment were not addressed due to a pending appeal that should be noted in the discharge summary.

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 abusive, illegal, and/or harmful 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 abusive, illegal, and/or harmful 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, 2017).

    It should be recognized that to date, no research on plethysmography (PPG) has included non-offending youths, and "norms" have not been established for the use of this measure. Therefore, the use of the PPG with adolescents under the age of 18 is not recommended, except for in rare cases for older adolescents in which case dynamics, assessment of risk and identified risk factors establish a clearly identifiable benefit. If the PPG is used, the treatment provider should document the empirically based rationale and monitor for possible detrimental impact.

    Viewing Time is a specialized form of assessment used in the treatment of individuals who have committed sexual offenses. Viewing Time is used as a measure of sexual interest and correlates significantly with self-reported sexual interests.

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. (Refer to Appendix D, "Guidelines for the Use of Sexually Stimulating Materials" for further details).

Discussion: A goal of treatment is to help juveniles who have committed sexual offenses to gain an increased understanding of healthy, non-abusive sexuality. To achieve this goal, treatment providers and supervising officers must engage the juvenile in non-judgmental discussion of sexual topics and materials. The MDT should support the development of healthy sexual relationships, when appropriate, that involve consent, reciprocity, and mutuality.

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 risk factors, dynamics and patterns including intimacy and boundaries, attachment disorders, role reversals, sibling relationships, criminality, and psychiatric disorders.

21. Recognition of how personal beliefs and cultural identity factors as well as family, peer group, community and cultural factors may influence tolerance of offending/abusive behaviors or protections against future offending/abusive behaviors.

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.

C. When considering the content areas above and reviewing the treatment plan it may be necessary to adjust treatment content or modality based on the unique factors of a particular juvenile. Possible adjustments may include, but are not limited to:

1. Recognizing group therapy is not appropriate for all youth

2. Recognize the need for multi-modal treatment interventions that rely less on language-loaded treatment approaches and incorporate more visual, experiential, and kinesthetic learning on a consistent basis;

3. Breaking down treatment concepts into attainable steps

4. Addressing past trauma/victimization prior to addressing offending behavior

5. Discussing cultural norms that may impact attitudes about gender and sexuality in the context of current law and how differences may impact behavior.

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.[46,47,48,49,50]

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 contra-indicators 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 negative peer modeling and harmful behaviors and to provide for the safety of all group members.

Discussion: If circumstances necessitate facilitating groups with dissimilar levels of risk, the treatment provider shall implement strategies to monitor for potential harm, adverse dynamics, and undue influence on low risk clients.

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[46] 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.

[47] 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.

[48]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.

[49] 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.

[50] 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.

2. Co-therapy is always recommended.

3. Male and female co-therapists are preferred.

   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 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).[51]

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 and clarification work shall occur as prescribed in Section 9.000 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. Two people engaged in a therapeutic setting facilitated by a provider.

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 is preferred in staffing milieus.

I. In-person therapy is the preferred and expected modality in which sex offense specific treatment should occur. In some cases, teletherapy may be an appropriate modality to meet the individual needs of the client. If using teletherapy, providers shall follow the criteria outlined in appendix P.

[51] 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).

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 contra indicators change and the modality is viable, the treatment plan shall be amended accordingly.

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 negative peer modeling and harmful behaviors and to provide for the safety of all group members.

   Discussion: If circumstances necessitate facilitating groups with dissimilar levels of risk, the treatment provider shall implement strategies to monitor for potential harm, adverse dynamics, and undue influence on low risk clients.

2. Co-therapy is always recommended.

3. Male and female co-therapists are preferred.

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.

Discussion: When adjunct services are implemented at the direction of the MDT to meet the individualized needs of the juvenile the MDT should determine the on-going sex offense specific treatment needs. If a juvenile has completed the sex offense specific components of treatment or if the MDT determines adjunct services should take priority an SOMB listed provider is not required to remain involved while adjunct services are in place. The MDT should continually re-assess needs and incorporate an SOMB listed provider as needed.

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 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.[52]
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.[53]
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.

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[52] 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.

[53] 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).*

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.

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 based on initial assessment of individual risks and needs and shall be updated, as needed, through on-going assessment of individual risks and needs as well as the juvenile's response to treatment. (Refer to Appendix E "Sexual Offense History Decision Aid" and Appendix F "Sex Offense- Specific Intake Review for Clients Who Have Been in Prior Treatment.")

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. Support victim impact, victim empathy, and victim clarification goals. (See Section 9.000 for guidance.)

Discussion: Providers should include input from the victim or victim representative when possible.

C. Be designed to address strengths, risks, and needs in areas identified by the evaluation or any assessments completed (Refer to Section 2.000 and Appendix E "Sexual Offense History Decision Aid")

D. Incorporate all identified treatment content areas and outcomes, as appropriate. (Refer to Section 3.130 and Section 3.150)

E. Contain clearly stated goals, objectives, and interventions that are individualized, specific, measurable, achievable, relevant, and time-bound.

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. A copy of the treatment plan shall be offered to the juvenile and provided upon request.

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

K. Be provided to the supervising officer/agency when initially updated, and whenever revised, along with monthly summaries or progress reports as per 5.310(D). The treatment plan may also be released to individuals with a valid release of information.

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.[54] 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.

A. Authorization for the Release of Information (ROI): When a provider needs to share information about a client with an entity not covered by the waiver of confidentiality a signed release of information (ROI) shall be in place.

a. Treatment ROI: This ROI shall explain that written and verbal information will be shared between the treatment provider and the individual or agency named on the ROI. The ROI must include information regarding the time limit of the authorization as well as the procedure to revoke the authorization.

b. Substance Use Disorder Treatment ROI: For clients undergoing substance use disorder treatment co-occurring with sex offender treatment, this ROI shall comply with the provisions of 42 C.F.R. § 2.31.

c. Research ROI: Prior to entering information into the SOMB Data Collection System the provider must have a signed research ROI. The provider shall inform the client that this ROI is voluntary and is solely for communication with the SOMB for the purpose of research

[54] Colorado Revised Statutes (2020) C.R.S. 12-245-220 Disclosure of confidential communications - definitions. (1) A licensee, registrant, or certificate holder shall not disclose, without the consent of the client, any confidential communications made by the client, or advice given to the client, in the course of professional employment. A licensee's, registrant's, or certificate holder's employee or associate, whether clerical or professional, shall not disclose any knowledge of the communications acquired in that capacity. Any person who has participated in any therapy conducted under the supervision of a licensee, registrant, or certificate holder, including group therapy sessions, shall not disclose any knowledge gained during the course of the therapy without the consent of the

person to whom the knowledge relates.

related to the Standards and Guidelines for juveniles who have committed sexual offenses in Colorado, in compliance with 45 CFR § 64.508 and 16-11.7-103(4)

E. Releases of Information are a voluntary aspect of Sex Offense Specific treatment. The ROI is an authorization by the client for the provider to share/receive confidential information from an identified individual or agency for the purposes of providing treatment services.

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.[55] *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.*

3.130 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.

[55] CCR 726-1-16 - RECORDS REQUIRED TO BE KEPT AND RECORD RETENTION (C.R.S. Section's 12-43-203(3), 12-43-222(1)(u)) (a)General. Except as provided in subsection (g) of this Rule, every social worker shall create and shall maintain records on each of her/his social work/psychotherapy clients. Every social worker shall retain a record, as defined in subsection (b) of this Rule, on each social work/psychotherapy client for a period of seven (7) years, commencing on the termination of social work/psychotherapy services or on the date of last contact with the client, whichever is later.

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 (Clinical Indicators) 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.

Discussion: When discharging a client based on maximum benefit gained, the treatment provider should provide an explanation of what areas/goals have been achieved in treatment and what areas/goals are still being addressed but the juvenile has made as much progress as they are capable of making. It should be noted that benefits gained from therapy may increase overtime outside of the context of therapy, especially in juveniles who are continuing to develop and mature. A discharge based on maximum benefit gained does not suggest that a juvenile may not benefit from therapy, including sex offense specific therapy, in the future, that there are no additional treatment needs, or that the juvenile has completed all treatment goals.

A discharge for this reason is an indication that the juvenile has made sufficient progress on treatment goals related to sexually abusive behavior, has addressed their risk of

sexually offending, does not present with an active or acute risk of sexual harm, and is unlikely to make additional progress with continued treatment at this time.

3.420 For a juvenile who has completed or discharged from treatment, a provider shall submit a written summary within 30 days, Discharge summaries shall be provided to all MDT members involved, including the juvenile, at the time it is completed. Regardless of the type of discharge, if specific aspects of sex offense specific treatment were not addressed due to a pending appeal, or any other reason, such information shall be noted in the discharge summary. Information shall include but not be 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. For juveniles required to register as a sex offender, the provider shall provide a current recommendation regarding whether registration should/should not continue based on information available at the date of the report. When providing a recommendation for or against continued registration, the provider shall include supporting reasoning and rationale for the recommendation. (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.). Please refer to Appendix J "Notice of Recommendation Concerning Removal from Sex Offender Registry."

Discussion: For additional information regarding registration recommendations, it is recommended that treatment providers review the SOMB White Paper regarding juvenile registration, the ATSA position paper regarding Registration and Community Notification of Children and Adolescents Adjudicated of a Sexual Crime: Recommendations for Evidence-Based Reform (2020), C.R.S. 16-22-113(1)(e), and available research.

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

E. Develop aftercare plan recommendations if applicable.

Research Citations

The following Juvenile Standards and Guidelines in Section 3.000 have research support (the Standards are either footnoted or are supported by a review of the literature): 3.000, 3.100 (43, 44), 3.100 DD/ID, 3.120 (45), 3.130, 3.140, 3.141, 3.150, 3.151, 3.160, 3.300, and 3.310. All footnotes and research references in these Standards were evaluated by the staff researcher and presented to the SOMB regarding the revisions being discussed. Not all research considered directly supported the revisions; however, the research was reviewed in its totality to inform the revisions process regardless of whether it supported the standard revision or not. This research was then incorporated into the Standards and presented to the SOMB for ratification by the Board. The research in these Standards was evaluated based on the quality of the research design and the quality/strength of their findings as it related to the revisions being discussed. The research reviewed and utilized in this revision can be found in the SOMB's online repository at:

https://dcj.colorado.gov/dcj-offices/domestic-violence-and-sex-offender-management/domestic-violence-and-sex-offender

The following Juvenile Standards and Guidelines in Section 3.000 were revised but do not have research support given their procedural nature: 3.140 DD/ID, 3.152, 3.170, 3.200, 3.210, 3.220, 3.400, 3.410, and 3.420. The SOMB staff did a search for research applicable to the Standards noted above. Research was not found applicable to these Standards, so in absence of research the Standards are based on best practices procedures, professional association guidelines, and the professional expertise of the members of the Board. Should research become available in the future pertaining to the topic of these Standards it will be evaluated and incorporated, should it be of sound quality.

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4.000 Qualifications of Treatment Providers, Evaluators, and Polygraph Examiners Working with Juveniles Who Have Committed Sexual Offenses

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

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

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

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

D. The applicant shall not have any conviction for any municipal ordinance violation, misdemeanor, felony, or court-martial conviction if the municipal ordinance violation, misdemeanor, felony or court-martial conviction is related to the ability of the approved applicant to practice under these Standards as reviewed and determined by the Application Review Committee. The term "conviction," as it is used in Section 4.000 of these Standards & Guidelines, is defined in Appendix A ("Sex Offender Management Board Administrative Policies"). A certified copy of the judgment from a court of competent jurisdiction of such conviction shall be conclusive evidence of such a record;

E. The applicant shall submit to a current administrative background investigation (Section 16-11.7-106 (2)(a)(III), C.R.S.);[56]

F. The applicant shall demonstrate compliance with Section 4 of the *Standards and has attested to the commitment to comply with these Standards and Guidelines ;*

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 who commit sexual offenses with developmental/intellectual disabilities,[57] shall demonstrate compliance with these *Standards* and submit an application demonstrating competency specific to working with this population.

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

1. The SOMB Clinical Supervisor shall review SOMB related work product (such as treatment plans and reports) conducted by the applicant. The SOMB Clinical Supervisor shall review, and co-sign all evaluations conducted by the applicant. The SOMB supervisor is responsible for doing due diligence to monitor and maintain awareness of the SOMB related clinical work performed by the applicant for which the

[56] Colorado Revised Statutes 16-11.7-106(2) **(III)** The board shall require a person who applies for placement, including a person who applies for continued placement, on the list of persons who may provide sex-offender-specific evaluation, treatment, and polygraph services pursuant to this article to submit to a current background investigation that goes beyond the scope of the criminal history record check described in subparagraph (I) of this paragraph (a). In conducting the current background investigation required by this subparagraph (III), the board shall obtain reference and criminal history information and recommendations that may be relevant to the applicant's fitness to provide sex offender-specific evaluation, treatment, and polygraph services pursuant to this article.

[57] Colorado Revised Statutes 16-11.7-103(4)(b)(I) The board shall develop, implement, and revise, as appropriate, guidelines and standards to treat adult sex offenders, including adult sex offenders with intellectual and developmental disabilities, incorporating in the guidelines and standards the concepts of the risk-need-responsivity or another evidence-based correctional model, which guidelines and standards can be used in the treatment of offenders who are placed on probation, incarcerated with the department of corrections, placed on parole, or placed in community corrections. Programs implemented pursuant to the guidelines and standards developed pursuant to this subsection (4)(b) must be as flexible as possible so that the programs may be accessed by each adult sex offender to prevent the offender from harming victims and potential victims. Programs must include a continuing monitoring process and a continuum of treatment options available to an adult sex offender as he or she proceeds through the criminal justice system. Treatment options must be determined by a current risk assessment and evaluation and may include, but need not be limited to, group counseling, individual counseling, family counseling, outpatient treatment, inpatient treatment, shared living arrangements, or treatment in a therapeutic community. Programs implemented pursuant to the guidelines and standards developed pursuant to this subsection (4)(b) must, to the extent possible, be accessible to all adult sex offenders in the criminal justice system, including those offenders with behavioral, mental health, and co-occurring disorders. The procedures for evaluation, identification, treatment, and monitoring developed pursuant to this subsection (4) must be implemented only to the extent that money is available in the sex offender surcharge fund created in section 18-21-103 (3).

supervisor is providing supervision and to ensure this work adheres to the requirements outlined within the *Standards and Guidelines*.

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

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

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

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

4.110 All Applicants Begin at the 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 Associate Level Treatment Providers and Evaluators:

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 SOMB related work product (such as treatment plans and reports) conducted by the applicant. The SOMB Clinical Supervisor shall review, and co-sign all evaluations conducted by Associate Level Treatment Providers and Associate Level Evaluators.

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

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

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

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

C. Notify the SOMB in writing within 10 days upon the issuance of any summons and within 10 days of any arrest. You must also notify the SOMB in writing within 10 days upon sustaining any, conviction, entering a nolo contender plea, or entering into any deferred judgment or deferred prosecution agreement for a municipal ordinance violation, misdemeanor, or felony; however, no such notification needs to be made if the underlying offense (or alleged offense) is for a traffic violation involving 7 points or less. Finally, the SOMB must be notified in writing within 10 days of a provider becoming the restrained party in either a criminal or a civil order of protection. The SOMB will be updated by the Colorado Bureau of Investigation of any of the above, and will consider such information, including proper and timely 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 commit 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 approved by the Department of Regulatory Agencies as an Unlicensed Psychotherapist, Certified Addiction Technician, Certified Addition Specialist, Licensed Addiction Counselor, Licensed and Provisional Marriage and Family Therapist, Licensed Professional Counselor (Provisional or Candidate) Psychologist Candidate, or Clinical Social Worker, and not be under current disciplinary action that the ARC determines would impede the applicants' ability to practice as an SOMB listed provider;

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

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

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

D. Within the past five (5) years, the applicant shall have taken forty (40) hours of training which includes the SOMB Introductory training to the Standards or the SOMB Standards Booster 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 administrative background investigation (Section 16-11.7-106 (2)(a)(III), C.R.S.)[58] 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 any conviction for any municipal ordinance violation, misdemeanor, felony, or court-martial conviction if the municipal ordinance violation, misdemeanor, felony or court-martial conviction is related to the ability of the approved applicant to practice under these Standards as reviewed and determined by the Application Review Committee. The term "conviction," as it is used in Section 4.000 of these Standards & Guidelines, is defined in Appendix A ("Sex Offender Management Board Administrative Policies"). A certified copy of the judgment from a court of competent jurisdiction of such conviction shall be conclusive evidence of such a record;

I. The applicant shall demonstrate compliance with Section 4 of the Standards and has attested to the commitment to comply with these Standards and Guidelines;

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

4.210 Continued Placement of Associate Level Juvenile Treatment Providers 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 sexual offending;

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.

[58] Colorado Revised Statutes 16-11.7-106(2) **(III)** The board shall require a person who applies for placement, including a person who applies for continued placement, on the list of persons who may provide sex-offender-specific evaluation, treatment, and polygraph services pursuant to this article to submit to a current background investigation that goes beyond the scope of the criminal history record check described in subparagraph (I) of this paragraph (a). In conducting the current background investigation required by this subparagraph (III), the board shall obtain reference and criminal history information and recommendations that may be relevant to the applicant's fitness to provide sex offender-specific evaluation, treatment, and polygraph services pursuant to this article.

C. Every three (3) years the provider shall complete forty (40) hours of training which includes the SOMB Introductory training to the Standards or the SOMB Standards Booster training as determined by the SOMB Clinical Supervisor and applicant based upon individualized training needs.

D. These training hours may be utilized to meet the qualifications for both sex offenders and adult treatment providers. The provider shall demonstrate a balanced training history. Please see the list of training categories.

E. The applicant shall not have any conviction for any municipal ordinance violation, misdemeanor, felony, or court-martial conviction if the municipal ordinance violation, misdemeanor, felony or court-martial conviction is related to the ability of the approved applicant to practice under these Standards as reviewed and determined by the Application Review Committee. The term "conviction," as it is used in Section 4.000 of these Standards & Guidelines, is defined in Appendix A ("Sex Offender Management Board Administrative Policies"). A certified copy of the judgment from a court of competent jurisdiction of such conviction shall be conclusive evidence of such a record;

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 provider shall report any practice that is in significant conflict with the Standards;

H. The provider shall demonstrate compliance with Section 4 of the Standards and has attested to the commitment to comply with these Standards and Guidelines;

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

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

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

1. Name

2. Treatment agency

3. Address

4. Phone number

5. Email address

6. Supervisor

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

C. Notify the SOMB in writing within 10 days upon the issuance of any summons and within 10 days of any arrest. You must also notify the SOMB in writing within 10 days upon sustaining any, conviction, entering a nolo contender plea, or entering into any deferred judgment or deferred prosecution agreement for a municipal ordinance violation, misdemeanor, or felony; however, no such notification needs to be made if the underlying offense (or alleged offense) is for a traffic violation involving 7 points or less. Finally, the SOMB must be notified in writing within 10 days of a provider becoming the restrained party in either a criminal or a civil order of protection. The SOMB will be updated by the Colorado Bureau of Investigation of any of the above, and will consider such information, including proper and timely 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 commit 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, Licensed Psychologist, Licensed Clinical Social Worker, Licensed Professional Counselor, Licensed Marriage and Family Therapist, Clinical Psychiatric Nurse Specialist or Licensed Addiction Counselor, and not be under current disciplinary action that the ARC determines would impede the applicants ability to practice as an SOMB listed provider;

OR

The provider shall have maintained SOMB listing, in good standing, as an associate level treatment provider for at least 10 years (initial listing plus three renewal cycles) and be approved with the Department of Regulatory Agencies as a Unlicensed Psychotherapist, Certified Addiction Specialist, Marriage and Family Therapist (Provisional or Candidate),

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

C. The provider shall have demonstrated the required competencies.

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

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

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

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

E. Within the past five (5) years, the applicant shall have taken forty (40) hours of training which includes the SOMB Introductory training to the Standards or the SOMB Standards Booster training (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 any conviction for any municipal ordinance violation, misdemeanor, felony, or court-martial conviction if the municipal ordinance violation, misdemeanor, felony or court-martial conviction is related to the ability of the approved applicant to practice under these Standards as reviewed and determined by the Application Review Committee. The term "conviction," as it is used in Section 4.000 of these Standards & Guidelines, is defined in Appendix A ("Sex Offender Management Board Administrative Policies"). A certified copy of the judgment from a court of competent jurisdiction of such conviction shall be conclusive evidence of such a record;

H. The provider shall submit to a current administrative background investigation (Section 16-11.7-106 (2)(a)(III), C.R.S.)[59] 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 Section 4 of the *Standards* and has attested to the commitment to comply with these *Standards and Guidelines*;

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 who commit sexual offenses with developmental/intellectual disabilities[60] shall demonstrate compliance with these *Standards* and submit an application demonstrating competency specific to working with this population.

4.310 Continued Placement of Full Operating Level Juvenile Treatment Providers 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, Licensed Psychologist, Licensed Clinical Social Worker, Licensed Professional Counselor, Licensed Marriage and Family Therapist, Clinical Psychiatric Nurse Specialist or Licensed Addiction Counselor, and not be under current disciplinary action that the ARC determines would impede the applicants' ability to practice as an SOMB listed provider;

OR

[59] Colorado Revised Statutes 16-11.7-106(2) **(III)** The board shall require a person who applies for placement, including a person who applies for continued placement, on the list of persons who may provide sex-offender-specific evaluation, treatment, and polygraph services pursuant to this article to submit to a current background investigation that goes beyond the scope of the criminal history record check described in subparagraph (I) of this paragraph (a). In conducting the current background investigation required by this subparagraph (III), the board shall obtain reference and criminal history information and recommendations that may be relevant to the applicant's fitness to provide sex offender-specific evaluation, treatment, and polygraph services pursuant to this article.

[60] Colorado Revised Statutes 16-11.7-103(4)(b)(I) The board shall develop, implement, and revise, as appropriate, guidelines and standards to treat adult sex offenders, including adult sex offenders with intellectual and developmental disabilities, incorporating in the guidelines and standards the concepts of the risk-need-responsivity or another evidence-based correctional model, which guidelines and standards can be used in the treatment of offenders who are placed on probation, incarcerated with the department of corrections, placed on parole, or placed in community corrections. Programs implemented pursuant to the guidelines and standards developed pursuant to this subsection (4)(b) must be as flexible as possible so that the programs may be accessed by each adult sex offender to prevent the offender from harming victims and potential victims. Programs must include a continuing monitoring process and a continuum of treatment options available to an adult sex offender as he or she proceeds through the criminal justice system. Treatment options must be determined by a current risk assessment and evaluation and may include, but need not be limited to, group counseling, individual counseling, family counseling, outpatient treatment, inpatient treatment, shared living arrangements, or treatment in a therapeutic community. Programs implemented pursuant to the guidelines and standards developed pursuant to this subsection (4)(b) must, to the extent possible, be accessible to all adult sex offenders in the criminal justice system, including those offenders with behavioral, mental health, and co-occurring disorders. The procedures for evaluation, identification, treatment, and monitoring developed pursuant to this subsection (4) must be implemented only to the extent that money is available in the sex offender surcharge fund created in section 18-21-103 (3).

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

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

C. Every three (3) years the provider shall complete forty (40) hours of training which includes the SOMB Introductory training to the Standards or the SOMB Standards Booster 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 adults 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 any conviction for any municipal ordinance violation, misdemeanor, felony, or court-martial conviction if the municipal ordinance violation, misdemeanor, felony or court-martial conviction is related to the ability of the approved applicant to practice under these Standards as reviewed and determined by the Application Review Committee. The term "conviction," as it is used in Section 4.000 of these Standards & Guidelines, is defined in Appendix A ("Sex Offender Management Board Administrative Policies"). A certified copy of the judgment from a court of competent jurisdiction of such conviction shall be conclusive evidence of such a record;

E. The provider shall submit to a current administrative background investigation (Section 16-11.7-106 (2) (a) (III), C.R.S.)[61] 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 Section 4 of the *Standards* and has attested to the commitment to comply with these *Standards and Guidelines*;

[61] Colorado Revised Statutes 16-11.7-106(2) (III) The board shall require a person who applies for placement, including a person who applies for continued placement, on the list of persons who may provide sex-offender-specific evaluation, treatment, and polygraph services pursuant to this article to submit to a current background investigation that goes beyond the scope of the criminal history record check described in subparagraph (I) of this paragraph (a). In conducting the current background investigation required by this subparagraph (III), the board shall obtain reference and criminal history information and recommendations that may be relevant to the applicant's fitness to provide sex offender-specific evaluation, treatment, and polygraph services pursuant to this article.

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

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

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

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

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

C. Notify the SOMB in writing within 10 days upon the issuance of any summons and within 10 days of any arrest. You must also notify the SOMB in writing within 10 days upon sustaining any, conviction, entering a nolo contender plea, or entering into any deferred judgment or deferred prosecution agreement for a municipal ordinance violation, misdemeanor, or felony; however, no such notification needs to be made if the underlying offense (or alleged offense) is for a traffic violation involving 7 points or less. Finally, the SOMB must be notified in writing within 10 days of a provider becoming the restrained party in either a criminal or a civil order of protection. The SOMB will be updated by the Colorado Bureau of Investigation of any of the above, and will consider such information, including proper and timely 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 commit 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 any conviction for any municipal ordinance violation, misdemeanor, felony, or court-martial conviction if the municipal ordinance violation, misdemeanor, felony or court-martial conviction is related to the ability of the approved applicant to practice under these Standards as reviewed and determined by the Application Review Committee. The term "conviction," as it is used in Section 4.000 of these Standards & Guidelines, is defined in Appendix A ("Sex Offender Management Board Administrative Policies"). A certified copy of the judgment from a court of competent jurisdiction of such conviction shall be conclusive evidence of such a record;

D. The applicant shall submit to a current administrative background investigation (Section 16-11.7-106 (2)(a)(III), C.R.S.);[62]

E. The applicant shall demonstrate compliance with Section 4 of the *Standards* and has attested to the commitment to comply with these *Standards and Guidelines*;

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 who commit sexual offenses with developmental/intellectual disabilities[63] shall

[62]Colorado Revised Statutes 16-11.7-106(2) **(III)** The board shall require a person who applies for placement, including a person who applies for continued placement, on the list of persons who may provide sex-offender-specific evaluation, treatment, and polygraph services pursuant to this article to submit to a current background investigation that goes beyond the scope of the criminal history record check described in subparagraph (I) of this paragraph (a). In conducting the current background investigation required by this subparagraph (III), the board shall obtain reference and criminal history information and recommendations that may be relevant to the applicant's fitness to provide sex offender-specific evaluation, treatment, and polygraph services pursuant to this article.

[63] Colorado Revised Statutes 16-11.7-103(4)(b)(I) The board shall develop, implement, and revise, as appropriate, guidelines and standards to treat adult sex offenders, including adult sex offenders with intellectual and developmental disabilities, incorporating in the guidelines and standards the concepts of the risk-need-responsivity or another evidence-based correctional model, which guidelines and standards can be used in the treatment of offenders who are placed on probation, incarcerated with the department of corrections, placed on parole, or placed in community corrections. Programs implemented pursuant to the guidelines and standards developed pursuant to this subsection (4)(b) must be as flexible as possible so that the programs may be accessed by each adult sex offender to prevent the offender from harming victims and potential victims. Programs must include a continuing monitoring process and a continuum of treatment options available to an adult sex offender as he or she proceeds through the criminal justice system. Treatment options must be determined by a current risk assessment and evaluation and may include, but need not be limited to, group counseling, individual counseling, family counseling, outpatient treatment, inpatient treatment, shared living arrangements, or treatment in a therapeutic community. Programs implemented pursuant to the guidelines and standards developed pursuant to this subsection (4)(b) must, to the extent possible, be accessible to all adult sex offenders in the criminal justice system, including those offenders with behavioral, mental health, and co-occurring disorders. The procedures for evaluation, identification, treatment, and monitoring developed pursuant to this subsection (4) must be implemented only to the extent that money is available in the sex offender surcharge fund created in section 18-21-103 (3).

demonstrate compliance with these *Standards* and submit an application demonstrating competency specific to working with this population.

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

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

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

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

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

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

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

A. Notify the SOMB in writing within two (2) weeks of changes to contact information. In such cases where a change in agency affiliation has occurred, individuals shall be required to provide updated information, where applicable on the treatment provider/client contract, https://drive.google.com/drive/folders/1u8HPf0Is6YtqxL6WmZQyQ9cmvnaytbdW?usp=sharing description of program services, supervision agreement, and any other information pertinent to the change of employment Changes to contact information include any of the following:

1. Name

2. Treatment agency

3. Address

4. Phone number

5. Email address

6. Supervisor

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

C. Notify the SOMB in writing within 10 days upon the issuance of any summons and within 10 days of any arrest. You must also notify the SOMB in writing within 10 days upon sustaining any, conviction, entering a nolo contender plea, or entering into any deferred judgment or deferred prosecution agreement for a municipal ordinance violation, misdemeanor, or felony; however, no such notification needs to be made if the underlying offense (or alleged offense) is for a traffic violation involving 7 points or less. Finally, the SOMB must be notified in writing within 10 days of a provider becoming the restrained party in either a criminal or a civil order of protection. The SOMB will be updated by the Colorado Bureau of Investigation of any of the above, and will consider such information, including proper and timely 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 commit 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 commit 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 forty (40) hours of training which includes the SOMB Introductory training to the Standards or the SOMB Standards Booster 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 adult 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 any conviction for any municipal ordinance violation, misdemeanor, felony, or court-martial conviction if the municipal ordinance violation, misdemeanor, felony or court-martial conviction is related to the ability of the approved applicant to practice under these Standards as reviewed and determined by the Application Review Committee. The term "conviction," as it is used in Section 4.000 of these Standards & Guidelines, is defined in Appendix A ("Sex Offender Management Board Administrative Policies"). A certified copy of the judgment from a court of competent jurisdiction of such conviction shall be conclusive evidence of such a record;

F. The applicant shall submit to a current administrative background investigation (Section 16-11.7-106 (2) (a) (III), C.R.S.)[64] 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 who commit sexual offenses with developmental/intellectual disabilities[65] shall demonstrate compliance with these *Standards* and submit an application demonstrating competency specific to working with this population.

[64] Colorado Revised Statutes 16-11.7-106(2) **(III)** The board shall require a person who applies for placement, including a person who applies for continued placement, on the list of persons who may provide sex-offender-specific evaluation, treatment, and polygraph services pursuant to this article to submit to a current background investigation that goes beyond the scope of the criminal history record check described in subparagraph (I) of this paragraph (a). In conducting the current background investigation required by this subparagraph (III), the board shall obtain reference and criminal history information and recommendations that may be relevant to the applicant's fitness to provide sex offender-specific evaluation, treatment, and polygraph services pursuant to this article.

[65] Colorado Revised Statutes 16-11.7-103(4)(b)(I) The board shall develop, implement, and revise, as appropriate, guidelines and standards to treat adult sex offenders, including adult sex offenders with intellectual and developmental disabilities, incorporating in the guidelines and standards the concepts of the risk-need-responsivity or another evidence-based correctional model, which guidelines and standards can be used in the treatment of offenders who are placed on probation, incarcerated with the department of corrections, placed on parole, or placed in community corrections. Programs implemented pursuant to the guidelines and standards developed pursuant to this subsection (4)(b) must be as flexible as possible so that the programs may be accessed by each adult sex offender to prevent the offender from harming victims and potential victims. Programs must include a continuing monitoring process and a continuum of treatment options available to an adult sex offender as he or she proceeds through the criminal justice system. Treatment options must be determined by a current risk assessment and evaluation and may include, but need not be limited to, group counseling, individual counseling, family counseling, outpatient treatment, inpatient treatment, shared living arrangements, or treatment in a therapeutic community. Programs implemented pursuant to the guidelines and standards developed pursuant to this subsection (4)(b) must, to the extent possible, be accessible to all adult sex offenders in the criminal justice system, including those offenders with behavioral, mental health, and co-occurring disorders. The procedures for evaluation, identification, treatment, and monitoring developed pursuant to this subsection (4) must be implemented only to the extent that money is available in the sex offender surcharge fund created in section 18-21-103 (3).

4.510 Continued Placement of Associate Level Juvenile Evaluators 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 sexual offending;

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 forty (40) hours of training which includes the SOMB Introductory training to the Standards or the SOMB Standards Booster 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 adult and juveniles, training must reflect both populations. Please reference the list of specialized training categories.

D. The applicant shall not have any conviction for any municipal ordinance violation, misdemeanor, felony, or court-martial conviction if the municipal ordinance violation, misdemeanor, felony or court-martial conviction is related to the ability of the approved applicant to practice under these Standards as reviewed and determined by the Application Review Committee. The term "conviction," as it is used in Section 4.000 of these Standards & Guidelines, is defined in Appendix A ("Sex Offender Management Board Administrative Policies"). A certified copy of the judgment from a court of competent jurisdiction of such conviction shall be conclusive evidence of such a record;

E. The evaluator shall submit to a current administrative background investigation (Section 16-11.7-106 (2) (a) (III), C.R.S.)[66] 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;

[66] Colorado Revised Statutes 16-11.7-106(2) **(III)** The board shall require a person who applies for placement, including a person who applies for continued placement, on the list of persons who may provide sex-offender-specific evaluation, treatment, and polygraph services pursuant to this article to submit to a current background investigation that goes beyond the scope of the criminal history record check described in subparagraph (I) of this paragraph (a). In conducting the current background investigation required by this subparagraph (III), the board shall obtain reference and criminal history information and recommendations that may be relevant to the applicant's fitness to provide sex offender-specific evaluation, treatment, and polygraph services pursuant to this article.

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 who commit sexual offenses with developmental/intellectual disabilities[67] shall demonstrate compliance with these *Standards* and submit an application providing information related to experience and knowledge of working with this population.

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

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

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

[67] Colorado Revised Statutes 16-11.7-103(4)(b)(I) The board shall develop, implement, and revise, as appropriate, guidelines and standards to treat adult sex offenders, including adult sex offenders with intellectual and developmental disabilities, incorporating in the guidelines and standards the concepts of the risk-need-responsivity or another evidence-based correctional model, which guidelines and standards can be used in the treatment of offenders who are placed on probation, incarcerated with the department of corrections, placed on parole, or placed in community corrections. Programs implemented pursuant to the guidelines and standards developed pursuant to this subsection (4)(b) must be as flexible as possible so that the programs may be accessed by each adult sex offender to prevent the offender from harming victims and potential victims. Programs must include a continuing monitoring process and a continuum of treatment options available to an adult sex offender as he or she proceeds through the criminal justice system. Treatment options must be determined by a current risk assessment and evaluation and may include, but need not be limited to, group counseling, individual counseling, family counseling, outpatient treatment, inpatient treatment, shared living arrangements, or treatment in a therapeutic community. Programs implemented pursuant to the guidelines and standards developed pursuant to this subsection (4)(b) must, to the extent possible, be accessible to all adult sex offenders in the criminal justice system, including those offenders with behavioral, mental health, and co-occurring disorders. The procedures for evaluation, identification, treatment, and monitoring developed pursuant to this subsection (4) must be implemented only to the extent that money is available in the sex offender surcharge fund created in section 18-21-103 (3).

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 upon the issuance of any summons and within 10 days of any arrest. You must also notify the SOMB in writing within 10 days upon sustaining any, conviction, entering a nolo contender plea, or entering into any deferred judgment or deferred prosecution agreement for a municipal ordinance violation, misdemeanor, or felony; however, no such notification needs to be made if the underlying offense (or alleged offense) is for a traffic violation involving 7 points or less. Finally, the SOMB must be notified in writing within 10 days of a provider becoming the restrained party in either a criminal or a civil order of protection. The SOMB will be updated by the Colorado Bureau of Investigation of any of the above, and will consider such information, including proper and timely notification of the SOMB, in its decision making related to whether an individual should continue to be listed with the SOMB.

4.600 EVALUATOR: <u>Juvenile Full Operating Level</u>: Associate Level evaluators wanting to move to Full Operating Level status shall complete the application and submit documentation of all of the requirements listed below, as well as a letter from the approved SOMB Clinical Supervisor indicating the evaluator's readiness and demonstration of required competencies to move to Full Operating Level Evaluator. A Full Operating Level Evaluator may evaluate juveniles who commit 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, Licensed Psychologist, Licensed Clinical Social Worker, Licensed Professional Counselor, Licensed Marriage and Family Therapist, Clinical Psychiatric Nurse Specialist or Licensed Addiction Counselor, and not be under current disciplinary action that the ARC determines would impede the applicants' ability to practice as an SOMB listed provider;

OR

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

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

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

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

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

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

E. Within the past five (5) years, the applicant shall have taken forty (40) hours of training which includes the SOMB Introductory training to the Standards or the SOMB Standards Booster training (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 sex offenders and adults, 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 applicant shall not have any conviction for any municipal ordinance violation, misdemeanor, felony, or court-martial conviction if the municipal ordinance violation, misdemeanor, felony or court-martial conviction is related to the ability of the approved applicant to practice under these Standards as reviewed and determined by the Application Review Committee. The term "conviction," as it is used in Section 4.000 of these Standards & Guidelines, is defined in Appendix A ("Sex Offender Management Board Administrative Policies"). A certified copy of the judgment from a court of competent jurisdiction of such conviction shall be conclusive evidence of such a record;

H. The evaluator shall submit to a current administrative background investigation (Section 16-11.7-106 (2) (a) (III), C.R.S.)[68] 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;

[68] Colorado Revised Statutes 16-11.7-106(2) **(III)** The board shall require a person who applies for placement, including a person who applies for continued placement, on the list of persons who may provide sex-offender-specific evaluation, treatment, and polygraph services pursuant to this article to submit to a current background investigation that goes beyond the scope of the criminal history record check described in subparagraph (I) of this paragraph (a). In conducting the current background investigation required by this subparagraph (III), the board shall obtain reference and criminal history information and recommendations that may be relevant to the applicant's fitness to provide sex offender-specific evaluation, treatment, and polygraph services pursuant to this article.

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 who have committed sexual offenses with developmental/intellectual disabilities[69] 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 Full Operating Level Juvenile Evaluators 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, Licensed Psychologist, Licensed Clinical Social Worker, Licensed Professional Counselor, Licensed Marriage and Family Therapist, Clinical Psychiatric Nurse Specialist or Licensed Addiction Counselor, and not be under current disciplinary action that the ARC determines would impede the applicants' ability to practice as an SOMB listed provider;

OR

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

B. The evaluator shall demonstrate continued competency related to sex offending 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.

[69] Colorado Revised Statutes 16-11.7-103(4)(b)(I) The board shall develop, implement, and revise, as appropriate, guidelines and standards to treat adult sex offenders, including adult sex offenders with intellectual and developmental disabilities, incorporating in the guidelines and standards the concepts of the risk-need-responsivity or another evidence-based correctional model, which guidelines and standards can be used in the treatment of offenders who are placed on probation, incarcerated with the department of corrections, placed on parole, or placed in community corrections. Programs implemented pursuant to the guidelines and standards developed pursuant to this subsection (4)(b) must be as flexible as possible so that the programs may be accessed by each adult sex offender to prevent the offender from harming victims and potential victims. Programs must include a continuing monitoring process and a continuum of treatment options available to an adult sex offender as he or she proceeds through the criminal justice system. Treatment options must be determined by a current risk assessment and evaluation and may include, but need not be limited to, group counseling, individual counseling, family counseling, outpatient treatment, inpatient treatment, shared living arrangements, or treatment in a therapeutic community. Programs implemented pursuant to the guidelines and standards developed pursuant to this subsection (4)(b) must, to the extent possible, be accessible to all adult sex offenders in the criminal justice system, including those offenders with behavioral, mental health, and co-occurring disorders. The procedures for evaluation, identification, treatment, and monitoring developed pursuant to this subsection (4) must be implemented only to the extent that money is available in the sex offender surcharge fund created in section 18-21-103 (3).

OR

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 provider shall complete forty (40) hours of training which includes the SOMB Introductory training to the Standards or the SOMB Standards Booster 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 adults who have committed sexual offenses.
If the applicant is reapplying to be an evaluator for adult and juvenile, the training needs to reflect both populations. Please see the list of training categories.

E. The applicant shall not have any conviction for any municipal ordinance violation, misdemeanor, felony, or court-martial conviction if the municipal ordinance violation, misdemeanor, felony or court-martial conviction is related to the ability of the approved applicant to practice under these Standards as reviewed and determined by the Application Review Committee. The term "conviction," as it is used in Section 4.000 of these Standards & Guidelines, is defined in Appendix A ("Sex Offender Management Board Administrative Policies"). A certified copy of the judgment from a court of competent jurisdiction of such conviction shall be conclusive evidence of such a record;

F. The evaluator shall submit to a current administrative background investigation (Section 16-11.7-106 (2)(a)(III), C.R.S.)[70] 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

[70] Colorado Revised Statutes 16-11.7-106(2) **(III)** The board shall require a person who applies for placement, including a person who applies for continued placement, on the list of persons who may provide sex-offender-specific evaluation, treatment, and polygraph services pursuant to this article to submit to a current background investigation that goes beyond the scope of the criminal history record check described in subparagraph (I) of this paragraph (a). In conducting the current background investigation required by this subparagraph (III), the board shall obtain reference and criminal history information and recommendations that may be relevant to the applicant's fitness to provide sex offender-specific evaluation, treatment, and polygraph services pursuant to this article.

pertinent to the change of employment Changes to contact information include any of the following:

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

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

C. Notify the SOMB in writing within 10 days upon the issuance of any summons and within 10 days of any arrest. You must also notify the SOMB in writing within 10 days upon sustaining any, conviction, entering a nolo contender plea, or entering into any deferred judgment or deferred prosecution agreement for a municipal ordinance violation, misdemeanor, or felony; however, no such notification needs to be made if the underlying offense (or alleged offense) is for a traffic violation involving 7 points or less. Finally, the SOMB must be notified in writing within 10 days of a provider becoming the restrained party in either a criminal or a civil order of protection. The SOMB will be updated by the Colorado Bureau of Investigation of any of the above, and will consider such information, including proper and timely 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. juveniles, DD, treatment, evaluation.)

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

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

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

D. 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;

E. 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;

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

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

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

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

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

G. 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.

H. Within the past five (5) years, the applicant shall have taken forty (40) hours of training which includes the SOMB Introductory training to the Standards or the SOMB Standards Booster training (these hours are in addition to the 40 hours required for Full Operating level for a total of 80 hours) of training. Applicants shall also obtain (as a part of the required 80 hours) training specific to Clinical Supervision consistent with any requirements of their respective licensing board of the Department of Regulatory Agencies (DORA).

It is recommended that applicants be approved as Full Operating Level provider for a minimum of 6 months prior to applying to be listed as an SOMB Clinical Supervisor. The current supervisor has the discretion to shorten this time frame when the applicant has previous supervisory experience or demonstrates advanced competency in clinical supervision.

I. APPLICATION FOR APPROVAL AS AN SOMB CLINICAL SUPERVISION

Applicants may apply for approval as an SOMB Clinical Supervisor once they have met the required qualifications and completed the following;

1. Receive supervision from an approved SOMB clinical supervisor for assessment of their supervisory competence.

2. Be assessed as competent in SOMB clinical supervisor Competency #1.

3. Provide supervision, when deemed appropriate, under the oversight of their SOMB clinical supervisor.

4.750 Continued Placement of Clinical Supervisors on the Provider List:

Clinical Supervisors shall continue to attend training as required by their respective licensing board(s) of the Department of Regulatory Agencies (DORA)

4.800

A. Period of Compliance
A listed treatment provider or evaluator, who is applying or reapplying, may receive up to one year or as deemed by the Application Review Committee 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.

B. Grace Period for Renewal
Providers who do not submit an application for renewal of their approved provider status by the date of expiration of their status will have a 30-day grace period in order to submit their application materials without having to start over with an Application One. Failure to submit application materials within 30 days after the date of expiration for approved provider status will require providers to begin the application process over by submitting Application One.

C. Eligibility for Future Renewal Once Provider Approval has Expired
Providers who allow their approved provider status to expire may be considered for return to listing status within 1 year of the expiration of their status. The Application Review Committee will consider whether to reinstate a provider to the approved provider list without having to begin the Application process over based on factors such as history of listing status, the reason for the expiration of the status, and what work the provider has been doing since the approved provider status ended to remain competent in the field.

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 juveniles who commit sexual offenses 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 juveniles who commit sexual offenses shall submit the required application outlining relevant competency with the application criteria as identified in these *Standards*, and identify any experience or training that may be considered for equivalency to these criteria. The Application Review Committee (ARC) shall determine if the submitted documentation substantially meets the application criteria or not, and will provide written notification of any additional needed experience or training.

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

A. A listed provider who wishes to move to not currently practicing status needs to inform the SOMB in writing of this change in status. The listed provider will be moved to the administrative inactive side on the approved provider list under not currently practicing status.

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 adults 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: Associate Level (First Application): Individuals who have not previously applied to the SOMB Approved Provider List as a Polygraph Examiner, and are seeking their initial approval 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 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. To qualify to administer post-conviction sex offender polygraph tests at the Associate Level, an applicant shall meet all of the following requirements:

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

OR

For examiners approved prior to June 5, 2023, the examiner shall have graduated from an accredited American Polygraph Association (APA) school and, have a minimum of a high school diploma,

B. The applicant shall demonstrate competency according to the individual's respective professional standards (American Polygraph Association) and ethics consistent with the accepted standards of practice of sex offense specific examinations;

C. The applicant shall submit to a current administrative background investigation (Section 16-11.7-106(2)(a)(III), C.R.S.).[71]

D. The applicant shall not have any conviction for any municipal ordinance violation, misdemeanor, felony, or court-martial conviction if the municipal ordinance violation, misdemeanor, felony or court-martial conviction is related to the ability of the approved applicant to practice under these Standards as reviewed and determined by the Application

[71] Colorado Revised Statutes 16-11.7-106(2) **(III)** The board shall require a person who applies for placement, including a person who applies for continued placement, on the list of persons who may provide sex-offender-specific evaluation, treatment, and polygraph services pursuant to this article to submit to a current background investigation that goes beyond the scope of the criminal history record check described in subparagraph (I) of this paragraph (a). In conducting the current background investigation required by this subparagraph (III), the board shall obtain reference and criminal history information and recommendations that may be relevant to the applicant's fitness to provide sex offender-specific evaluation, treatment, and polygraph services pursuant to this article.

Review Committee. The term "conviction," as it is used in Section 4.000 of these Standards & Guidelines, is defined in Appendix A ("Sex Offender Management Board Administrative Policies"). A certified copy of the judgment from a court of competent jurisdiction of such conviction shall be conclusive evidence of such a record;

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

4.900 DD/ID

Individuals wanting to provide polygraph services to juveniles who commit sexual offenses with developmental/ intellectual disabilities[72] shall demonstrate compliance with and submit an application providing information related to experience and knowledge of working with this population.

4.910 All Applicants Begin at the Associate Level (First Application):

All applicants shall apply for, and be approved at, the Associate Level polygraph examiner status prior to applying for Full Operating Level.

A. Out-of-State Applicants: Individuals who have the required credentials and education, that reside outside Colorado may seek 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 Supervisor as defined in these Standards. At the time of approval, out-of-state applications shall be supervised by a Full Operating Polygraph Examiner to ensure compliance with the Standards and Guidelines. Length of supervision shall be determined by the supervising examiner. Out-of-state applications will be reviewed on a case-by-case basis.

B. Equivalency Applications: Individuals who have prior experience conducting polygraphs may apply and be reviewed on a case by case basis for approval. This experience may be conducting polygraphs for a law enforcement or any other governmental agency.

4.920 Professional Supervision of Associate Level Polygraph Examiners:

A supervision agreement shall be signed by both the polygraph examiner and their supervisor. The supervision agreement shall specify supervision occurring at a minimum of two (2) hours of

[72] Colorado Revised Statutes 16-11.7-103(4)(b)(I) The board shall develop, implement, and revise, as appropriate, guidelines and standards to treat adult sex offenders, including adult sex offenders with intellectual and developmental disabilities, incorporating in the guidelines and standards the concepts of the risk-need-responsivity or another evidence-based correctional model, which guidelines and standards can be used in the treatment of offenders who are placed on probation, incarcerated with the department of corrections, placed on parole, or placed in community corrections. Programs implemented pursuant to the guidelines and standards developed pursuant to this subsection (4)(b) must be as flexible as possible so that the programs may be accessed by each adult sex offender to prevent the offender from harming victims and potential victims. Programs must include a continuing monitoring process and a continuum of treatment options available to an adult sex offender as he or she proceeds through the criminal justice system. Treatment options must be determined by a current risk assessment and evaluation and may include, but need not be limited to, group counseling, individual counseling,

family counseling, outpatient treatment, inpatient treatment, shared living arrangements, or treatment in a therapeutic community. Programs implemented pursuant to the guidelines and standards developed pursuant to this subsection (4)(b) must, to the extent possible, be accessible to all adult sex offenders in the criminal justice system, including those offenders with behavioral, mental health, and co-occurring disorders. The procedures for evaluation, identification, treatment, and monitoring developed pursuant to this subsection (4) must be implemented only to the extent that money is available in the sex offender surcharge fund created in section 18-21-103 (3).

one-to-one direct supervision monthly, and that the supervisor is ultimately responsible for the test results.

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

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

A. Additional components of supervision may include, but are not limited to:

B. Preparation for a polygraph examination;

C. Review/live observation of an examination;

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

E. Review of other data collected during an examination.

4.920 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.

4.925 Required notifications to SOMB:

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

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

   1. Name

   2. Treatment agency

   3. Address

4. Phone number

5. Email address

6. Supervisor

B. Notify the SOMB in writing within 10 days upon the issuance of any summons and within 10 days of any arrest. You must also notify the SOMB in writing within 10 days upon sustaining any, conviction, entering a nolo contender plea, or entering into any deferred judgment or deferred prosecution agreement for a municipal ordinance violation, misdemeanor, or felony; however, no such notification needs to be made if the underlying offense (or alleged offense) is for a traffic violation involving 7 points or less. Finally, the SOMB must be notified in writing within 10 days of a provider becoming the restrained party in either a criminal or a civil order of protection. The SOMB will be updated by the Colorado Bureau of Investigation of any of the above, and will consider such information, including proper and timely notification of the SOMB, in its decision making related to whether an individual should continue to be listed with the SOMB.

4.930 POLYGRAPH EXAMINER - Associate Level (Initial 3 years):

An Associate Level polygraph examiner may administer post-conviction or post-adjudication polygraph tests under the supervision of a Full Operating Level Polygraph Examiner under the *Standards and Guidelines*. To qualify to administer post-conviction or post-adjudication polygraph tests at the Associate Level, an applicant shall meet all of the following requirements:

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

OR

For examiners approved prior to June 5, 2023, the examiner shall have graduated from an accredited American Polygraph Association (APA) school, have a minimum of a high school diploma, and shall have maintained SOMB listing, in good standing, as an associate level Polygraph Examiner since the initial approval.

B. The applicant shall complete a minimum of fifty (50) polygraph exams, on post-conviction or post-adjudication individuals while operating under the Associate Level status;

C. The applicant shall demonstrate competency according to the individual's respective professional standards (American Polygraph Association) and ethics consistent with the accepted standards of practice of sex offense specific examinations;

D. The applicant shall complete the American Polygraph Association (APA) approved forty (40) hour training specific to post-conviction sexual offending (PCSOT).

E. The applicant shall complete the SOMB Introductory or Standards Booster Training

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

F. The applicant shall submit to a current administrative 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 submit quality assurance protocol forms from three (3) separate examinations submitted to three Full Operating Level Polygraph Examiners from outside the examiner's agency. When possible, exams of each type shall be submitted to different examiners. If an examiner is not conducting a particular type of exam, this should be discussed with the applicable supervisor and identified within the application. Peer review must be conducted by the Polygraph Examiner annually at a minimum.

DD/ID

Individuals wanting to provide polygraph services to juveniles who commit sexual offenses with developmental/intellectual disabilities, shall ensure one (1) of the quality assurance examinations submitted is on a DD/ID individual. There is no requirement to what type of exam needs to be submitted.

H. The applicant shall not have any conviction for any municipal ordinance violation, misdemeanor, felony, or court-martial conviction if the municipal ordinance violation, misdemeanor, felony or court-martial conviction is related to the ability of the approved applicant to practice under these Standards as reviewed and determined by the Application Review Committee. The term "conviction," as it is used in Section 4.000 of these Standards & Guidelines, is defined in Appendix A ("Sex Offender Management Board Administrative Policies"). A certified copy of the judgment from a court of competent jurisdiction of such conviction shall be conclusive evidence of such a record;

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

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

DD/ID

Individuals wanting to provide polygraph services to juveniles who commit sexual offenses with developmental/ intellectual disabilities[73] shall demonstrate compliance with and submit an application providing information related to experience and knowledge of working with this population.

[73] Colorado Revised Statutes 16-11.7-103(4)(b)(I) The board shall develop, implement, and revise, as appropriate, guidelines and standards to treat adult sex offenders, including adult sex offenders with intellectual and developmental disabilities, incorporating in the guidelines and standards the concepts of the risk-need-responsivity or another evidence-based correctional model, which guidelines and standards can be used in the treatment of offenders who are placed on probation, incarcerated with the department of corrections, placed on parole, or placed in community corrections. Programs implemented pursuant to the guidelines and standards developed pursuant to this subsection

4.940 Continued Placement of Polygraph Examiner Associate Level on the Provider List:

Polygraph examiners at the Associate Level shall apply for continued placement on the list every three (3) years by the date provided by the SOMB. Requirements are as follows:

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

OR

For examiners approved prior to June 5, 2023, the examiner shall have graduated from an accredited American Polygraph Association (APA) school, have a minimum of a high school diploma, and shall have maintained SOMB listing, in good standing, as an associate level Polygraph Examiner since the initial approval.

B. The applicant shall complete a minimum of fifty (50) polygraph exams, on post-conviction or post-adjudication individuals while operating under the Associate Level status;

C. The applicant shall demonstrate competency according to the individual's respective professional standards (American Polygraph Association) and ethics consistent with the accepted standards of practice of sex offense specific examinations;

D. The examiner shall complete a minimum of forty (40) hours (which includes SOMB Introductory of Boosters Training) of continuing education every three (3) years as determined by the supervisor and examiner based upon individual training needs in order to maintain proficiency in the field of polygraph testing and to remain current on any developments in the assessment, treatment, and monitoring of sex offenders.

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

E. The examiner shall submit to a current administrative background investigation (Section 16-11.7-106(2)(a)(III), C.R.S.)[74] that includes satisfactory references as requested by the SOMB. The SOMB may also solicit such additional references as necessary to determine compliance

(4)(b) must be as flexible as possible so that the programs may be accessed by each adult sex offender to prevent the offender from harming victims and potential victims. Programs must include a continuing monitoring process and a continuum of treatment options available to an adult sex offender as he or she proceeds through the criminal justice system. Treatment options must be determined by a current risk assessment and evaluation and may include, but need not be limited to, group counseling, individual counseling, family counseling, outpatient treatment, inpatient treatment, shared living arrangements, or treatment in a therapeutic community. Programs implemented pursuant to the guidelines and standards developed pursuant to this subsection (4)(b) must, to the extent possible, be accessible to all adult sex offenders in the criminal justice system, including those offenders with behavioral, mental health, and co-occurring disorders. The procedures for evaluation, identification, treatment, and monitoring developed pursuant to this subsection (4) must be implemented only to the extent that money is available in the sex offender surcharge fund created in section 18-21-103 (3).

[74] Colorado Revised Statutes 16-11.7-106(2) **(III)** The board shall require a person who applies for placement, including a person who applies for continued placement, on the list of persons who may provide sex-offender-specific evaluation, treatment, and polygraph services pursuant to this article to submit to a current background investigation that goes beyond the scope of the criminal history record

check described in subparagraph (I) of this paragraph (a). In conducting the current background investigation required by this subparagraph (III), the board shall obtain reference and criminal history information and recommendations that may be relevant to the applicant's fitness to provide sex offender-specific evaluation, treatment, and polygraph services pursuant to this article.

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

F. The applicant shall submit quality assurance protocol forms from one (1) examination [Sex History preferred] for each population submitted to a Full Operating Level Polygraph Examiner from outside the examiner's agency. When possible, exams of each type shall be submitted to different examiners Peer review must be conducted annually at a minimum.

DD/ID

Individuals wanting to provide polygraph services to juveniles who commit sexual offenses with developmental/intellectual disabilities, shall submit an additional quality assurance protocol form from a separate exam, to a full operating examiner with the DD/ID listing.

G. The applicant shall not have any conviction for any municipal ordinance violation, misdemeanor, felony, or court-martial conviction if the municipal ordinance violation, misdemeanor, felony or court-martial conviction is related to the ability of the approved applicant to practice under these Standards as reviewed and determined by the Application Review Committee. The term "conviction," as it is used in Section 4.000 of these Standards & Guidelines, is defined in Appendix A ("Sex Offender Management Board Administrative Policies"). A certified copy of the judgment from a court of competent jurisdiction of such conviction shall be conclusive evidence of such a record;

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

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

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

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

OR

For examiners approved prior to June 5, 2023, the examiner shall have graduated from an accredited American Polygraph Association (APA) school, have a minimum of a high school diploma, and shall have maintained SOMB listing, in good standing, as an associate level Polygraph Examiner for at least 10 years (initial listing plus three renewal cycles);

B. The examiner shall have conducted at least two hundred (200) post-conviction, fifteen (15) juvenile post-adjudication polygraph exams.

C. The applicant shall demonstrate competency according to the individual's respective professional standards (American Polygraph Association) and ethics consistent with the accepted standards of practice of sex offense specific examinations;

D. The examiner shall submit a letter from their supervisor indicating the examiner's readiness to move to Full Operating Level status, including documentation of having completed the professional supervision components, and the examiner's adherence and compliance with standards.

E. The applicant shall submit quality assurance protocol forms from one (1) examination for each population submitted to a Full Operating Level Polygraph Examiner from outside the examiner's agency. Peer review must be conducted annually at a minimum.

DD/ID

Individuals wanting to provide polygraph services to juveniles who commit sexual offenses with developmental/intellectual disabilities, shall submit an additional quality assurance protocol form from a separate exam, to a full operating examiner with the DD/ID listing.

4.955 Required notifications to SOMB:

Providers listed under section 4.950 shall provide the following notifications to SOMB as applicable:

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

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

C. Notify the SOMB in writing within 10 days upon the issuance of any summons and within 10 days of any arrest. You must also notify the SOMB in writing within 10 days upon sustaining any, conviction, entering a nolo contender plea, or entering into any deferred judgment or deferred prosecution agreement for a municipal ordinance violation, misdemeanor, or

felony; however, no such notification needs to be made if the underlying offense (or alleged offense) is for a traffic violation involving 7 points or less. Finally, the SOMB must be notified in writing within 10 days of a provider becoming the restrained party in either a criminal or a civil order of protection. The SOMB will be updated by the Colorado Bureau of Investigation of any of the above, and will consider such information, including proper and timely notification of the SOMB, in its decision making related to whether an individual should continue to be listed with the SOMB.

4.960 POLYGRAPH EXAMINER - Full Operating Level:

Polygraph examiners who administer post-conviction and post-adjudication 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 administer post-conviction and post-adjudication polygraph exams shall adhere to best practices as recommended within the polygraph profession.

To qualify at the Full Operating Level, 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;

OR

For examiners approved prior to June 5, 2023, the examiner shall have graduated from an accredited American Polygraph Association (APA) school, have a minimum of a high school diploma, and shall have maintained SOMB listing, in good standing, as an associate level Polygraph Examiner for at least 10 years (initial listing plus three renewal cycles);

B. The examiner shall have conducted at least two hundred (200) post-conviction polygraph exams. The applicant shall ensure to complete both adult and juvenile exams in order meet the qualifications and provide services for both populations.

Discussion: Post-adjudication polygraph tests completed for juveniles and/or tests completed for approval as an Associate Level polygraph examiner status may be included for Full Operating Level polygraph examiner approval.

C. The applicant shall demonstrate competency according to the individual's respective professional standards (American Polygraph Association) and ethics consistent with the accepted standards of practice of sex offense specific examinations;

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

1. Pre-test interview procedures and formats.

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

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

Ten (10) of the forty (40) hours shall be specific to the treatment of adult sex offenders. These training hours may be utilized to meet the qualifications for both adult and juvenile polygraph examiners. Training hours must include the SOMB Introductory training to the Standards or the SOMB Standards Booster training.

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;

DD/ID

Individuals wanting to provide polygraph services to juveniles who commit sexual offenses with developmental/ intellectual disabilities shall demonstrate compliance with and submit an application providing information related to experience and knowledge of working with this population.

E. The examiner shall submit to a current administrative background investigation (Section 16-11.7-106(2)(a)(III), C.R.S.)[75] 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 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 contendere 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 not have any conviction for any municipal ordinance violation, misdemeanor, felony, or court-martial conviction if the municipal ordinance violation, misdemeanor, felony or court-martial conviction is related to the ability of the approved applicant to practice under these Standards as reviewed and determined by the Application Review Committee. The term "conviction," as it is used in Section 4.000 of these Standards & Guidelines, is defined in Appendix A ("Sex Offender Management Board Administrative Policies"). A certified copy of the judgment from a court of competent jurisdiction of such conviction shall be conclusive evidence of such a record;

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

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

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

OR

For examiners approved prior to June 5, 2023, the examiner shall have graduated from an accredited American Polygraph Association (APA) school, have a minimum of a high school diploma, and shall have maintained SOMB listing, in good standing, as an associate level Polygraph Examiner for at least 10 years (initial listing plus three renewal cycles);

[75] Colorado Revised Statutes 16-11.7-106(2) **(III)** The board shall require a person who applies for placement, including a person who applies for continued placement, on the list of persons who may provide sex-offender-specific evaluation, treatment, and polygraph services pursuant to this article to submit to a current background investigation that goes beyond the scope of the criminal history record check described in subparagraph (I) of this paragraph (a). In conducting the current background investigation required by this subparagraph (III), the board shall obtain reference and criminal history information and recommendations that may be relevant to the applicant's fitness to provide sex offender-specific evaluation, treatment, and polygraph services pursuant to this article.

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

   Ten (10) of the forty (40) hours shall be specific to the treatment of adult sex offenders. These training hours may be utilized to meet the qualifications for both adult and juvenile polygraph examiners. Training hours must include the SOMB Introductory training to the Standards or the SOMB Standards Booster training.

   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;

C. The examiner shall conduct a minimum of one hundred (100) post-conviction polygraph examinations in the three (3) year listing period;
D. The applicant shall demonstrate competency according to the individual's respective professional standards (American Polygraph Association) and ethics consistent with the accepted standards of practice of sex offense specific examinations;

E. The examiner shall submit to a current administrative background investigation (Section 16-11.7-106(2)(a)(III), C.R.S.)[76] 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 applicant shall submit quality assurance protocol forms from one (1) examination [Sex History preferred] for each population submitted to a Full Operating Level Polygraph Examiner from outside the examiner's agency. Peer review must be conducted annually at a minimum.

DD/ID

Individuals wanting to provide polygraph services to sex offenders with developmental/intellectual disabilities, shall submit an additional quality assurance protocol form from a separate exam, to a full operating examiner with the DD/ID listing.

G. The applicant shall not have any conviction for any municipal ordinance violation, misdemeanor, felony, or court-martial conviction if the municipal ordinance violation, misdemeanor, felony or court-martial conviction is related to the ability of the approved applicant to practice under these Standards as reviewed and determined by the Application Review Committee. The term "conviction," as it is used in Section 4.000 of these Standards & Guidelines, is defined in Appendix A ("Sex Offender Management Board Administrative

[76] Colorado Revised Statutes 16-11.7-106(2) **(III)** The board shall require a person who applies for placement, including a person who applies for continued placement, on the list of persons who may provide sex-offender-specific evaluation, treatment, and polygraph services pursuant to this article to submit to a current background investigation that goes beyond the scope of the criminal history record check described in subparagraph (I) of this paragraph (a). In conducting the current background investigation required by this subparagraph (III), the board shall obtain reference and criminal history information and recommendations that may be relevant to the applicant's fitness to provide sex offender-specific evaluation, treatment, and polygraph services pursuant to this article.

Policies"). A certified copy of the judgment from a court of competent jurisdiction of such conviction shall be conclusive evidence of such a record;

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

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

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

K. DD/ID

Individuals wanting to provide polygraph services to juveniles who commit sexual offense with developmental/ intellectual disabilities[77] shall demonstrate compliance with and submit an application providing information related to experience and knowledge of working with this population.

4.975

A. Period of Compliance:

A listed treatment provider or evaluator, who is applying or reapplying, may receive up to one year or as deemed by the Application Review Committee 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.

B. Grace Period for Renewal

Providers who do not submit an application for renewal of their approved provider status by the date of expiration of their status will have a 30-day grace period in order to submit their application materials without having to start over with an Application One. Failure to submit application materials within 30 days after the date of expiration for approved provider status will require providers to begin the application process over by submitting Application One.

[77] Colorado Revised Statutes 16-11.7-103(4)(b)(I) The board shall develop, implement, and revise, as appropriate, guidelines and standards to treat adult sex offenders, including adult sex offenders with intellectual and developmental disabilities, incorporating in the guidelines and standards the concepts of the risk-need-responsivity or another evidence-based correctional model, which guidelines and standards can be used in the treatment of offenders who are placed on probation, incarcerated with the department of corrections, placed on parole, or placed in community corrections. Programs implemented pursuant to the guidelines and standards developed pursuant to this subsection (4)(b) must be as flexible as possible so that the programs may be accessed by each adult sex offender to prevent the offender from harming victims and potential victims. Programs must include a continuing monitoring process and a continuum of treatment options available to an adult sex offender as he or she proceeds through the criminal justice system. Treatment options must be determined by a current risk assessment and evaluation and may include, but need not be limited to, group counseling, individual counseling, family counseling, outpatient treatment, inpatient treatment, shared living arrangements, or treatment in a therapeutic community. Programs implemented pursuant to the guidelines and standards developed pursuant to this subsection (4)(b) must, to the extent possible, be accessible to all adult sex offenders in the criminal justice system, including those offenders with behavioral, mental health, and co-occurring disorders. The procedures for evaluation, identification, treatment, and monitoring developed pursuant to this subsection (4) must be implemented only to the extent that money is available in the sex offender surcharge fund created in section 18-21-103 (3).

C. Eligibility for Future Renewal Once Provider Approval Has Expired

Providers who allow their approved provider status to expire may be considered for return to listing status within 1 year of the expiration of their status. The Application Review Committee will consider whether to reinstate a provider to the approved provider list without having to begin the Application process over based on factors such as history of listing status, the reason for the expiration of the status, and what work the provider has been doing since the approved provider status ended to remain competent in the field.

4.980 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.

4.985 Not Currently Practicing: When a listed examiner is not currently providing any court ordered or voluntary sex offense specific treatment, evaluation, or polygraph services, including not performing peer consultation or 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 moved to the administrative inactive side on the approved provider list under not currently practicing status.

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

C. The listed provider may not remain under not currently practicing status longer than 2 reapplication cycles (6 years). Following completion of the second reapplication submission

timeframe, the listed provider must either relinquish listing status completely or submit reapplication to resume providing listed services.

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

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

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

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

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

B. Notify the SOMB in writing within 10 days of any arrest, conviction, nolo contender plea, or deferred 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.

Research Citations

Section 4.000 is primarily focused on provider qualification-related procedures. There were no footnotes in this section based on this reason. However, this does not mean that Section 4.000 is not evidence-based. On the contrary, Section 4.000 was heavily guided by primary research that the SOMB did between 2012 and 2014 in addition to statutory requirements. The SOMB started discussing qualifications of treatment providers, evaluators, and polygraph examiners of different levels, including Clinical Supervisor and competence-based training in 2012 at the Best Practices Committee meetings. Many of the initial discussions were guided by the book *The Fundamentals of Clinical Supervision and the Standards for Counseling Supervisors* by the American Association of Counseling. The SOMB carried out a survey and focus group study in 2014 before drafting relevant standards for Section 4.000. Several trainings on the Competence-Based Model occurred between 2014 and 2016. The Competence-Based Model training covered the entirety of Section 4.000.

The following qualifications of Treatment Providers, Evaluators, and Polygraph Examiners Working with adult sex offenders and juveniles who have committed sexual offenses have research support (the Standards are supported by a review of the literature): 4.100, 4.200, 4.300, 4.310, 4.600, 4.610, 4.700, 4.900, 4.960; 4.120, 4.700, 4.920, 4.950; and DD/ID Standards in 4.100, 4.120, 4.200, 4.300, 4.400, 4.500, 4.510,4.600, 4.900, 4.920, 4.930, 4.940, and 4.970. All research references in these Standards were evaluated by the staff researcher and presented to the SOMB regarding the revisions being discussed. Not all research considered directly supported the revisions; however, the research was reviewed in its totality to inform the revisions process regardless of whether it supported the standard revision or not. This research was then incorporated into the Standards and presented to the SOMB for ratification by the Board. The research in these Standards was evaluated based on the quality of the research design and the quality/strength of their findings as it related to the revisions being discussed. The research reviewed and utilized in this revision can be found in the SOMB's online repository at: https://dcj.colorado.gov/dcj-offices/domestic-violence-and-sex-offender-management/domestic-violence-and-sex-offender

The following Standards and Guidelines in Section 4.000 were revised but do not have research support given their procedural nature: 4.110, 4.130, 4.210, 4.220, 4.310, 4.320, 4.410, 4.510, 4.520, 4.610, 4.620, 4.810, 4.820, 4.830, 4.840, 4.910 (Out-of-State Applicants), 4.925, 4.940, 4.950, 4.955, 4.970 (Continued Placement), 4.985 (Movement between Adult and Juvenile Listing Status; Not Currently Practicing; Original Waiver Clause; Movement to Full Operating Level), 4.990 (Required notifications to SOMB). The SOMB staff did a search for research applicable to the Standards noted above. Research was not found applicable to these Standards, so in absence of research the Standards are based on best practices procedures, professional association guidelines, and the professional expertise of the members of the Board. Should research become available in the future pertaining to the topic of these Standards it will be evaluated and incorporated, should it be of sound quality.

Pursuant 16-11.7-106 of the Colorado Revised Statutes, the SOMB "shall develop an application and review process for treatment providers, evaluators, and polygraph examiners who provide services pursuant to this article to adult sex offenders and to juveniles who have committed sexual offenses." The Following Standards and Guidelines in Section 4.00 were revised to ensure compliance with the statute:

1. Requirement for Background check: 4.100(E), 4.200(G), 4.210(D), 4.300(H), 4.310(E), 4.400(D), 4.500(F), 4.510(E), 4.600(H), 4.610(F), 4.900(D), 4.930(E), 4.940(E), 4.960(F), 4.970,(D),
2. Listing of Providers with DD/ID Qualifications 2: 4.100 (H), 4.300(K), 4.400(G), 4.500(I), 4.510(I), 4.600(K), 4.900(A), 4.930(J), 4.940(K), 4.970(J),

List of Specialized Training Categories

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

▪ Impact of sex offenses ▪ Assessing treatment progress ▪ Supervision techniques with sex offenders ▪ Offender's family stability, support systems and parenting skills ▪ Sex offender attachment styles ▪ Knowledge of laws, policies and ethical concerns relating to confidentiality, mandatory reporting, risk management and offender participation in treatment ▪ Ethics ▪ Philosophy and Principles of the SOMB. ▪ Trauma and vicarious Trauma		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	▪ Co-morbid conditions, differential diagnosis ▪ Investigations ▪ Addictions and substance abuse ▪ Partner Violence ▪ Any of the topics in the above sex offense specific category that is also specific to juveniles who sexually offend	

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5.000 Establishment of a Multidisciplinary Team for the Management and Supervision of Juveniles Who Have Committed Sexual Offenses

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.[78,79,80,81] 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

[78] 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.

[79] 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).

[80] 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.

[81] 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).

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, 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[82,83,84,85] In some rare cases a juvenile may fit into a category identified in the Young Adult Modification Protocol and teams may consider this when making treatment and supervision decisions. (Please refer to Appendix C, "Young Adult Modification Protocol."

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 or agent, if assigned, which may include but is not limited to probation, parole, diversion, etc.

[82] 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.

[83] 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.

[84] 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.

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

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

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.[86,87,88,89,90,91]

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.

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

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

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

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

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

[91] 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.

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

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).[92] 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.

[92] Colorado Revised Statutes (2020) 16-11.7-105 Each adult sex offender or juvenile who has committed a sexual offense sentenced by the court for an offense committed on or after January 1, 1994, shall be required, as a part of the any sentence t probation, commitment to the department of human services, sentence to community corrections, incarceration with the department of corrections, placement on parole, or out-of-home placement to undergo treatment to the extent appropriate to such offender based upon the recommendations of the evaluation and identification made pursuant to section 16-11.7-104 or based upon any subsequent recommendations by the department of corrections, the judicial department, the department of human services, or the division of criminal justice in the department of public safety, whichever is appropriate. The treatment and monitoring shall be provided by an approved provider pursuant to section 1611.7-106, and the offender shall pay for the treatment to the extent the offender is financially able do so.

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.[93] 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

[93] Colorado Revised Statutes (2020) C.R.S. 12-245-220 Disclosure of confidential communications - definitions. (1) A licensee, registrant, or certificate holder shall not disclose, without the consent of the client, any confidential communications made by the client, or advice given to the client, in the course of professional employment. A licensee's, registrant's, or certificate holder's employee or associate, whether clerical or professional, shall not disclose any knowledge of the communications acquired in that capacity. Any person who has participated in any therapy conducted under the supervision of a licensee, registrant, or certificate holder, including group therapy sessions, shall not disclose any knowledge gained during the course of the therapy without the consent of the person to whom the knowledge relates.

information to be disclosed, and should keep in mind applicable mandatory reporting and confidentiality laws.

E. 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.

Discussion: A goal of treatment is to help juveniles who have committed sexual offenses to gain an increased understanding of healthy, non-abusive sexuality. To achieve this goal, treatment providers and supervising officers must engage the juvenile in non-judgmental discussion of sexual topics and materials. The MDT should support the development of healthy sexual relationships, when appropriate, that involve consent, reciprocity, and mutuality. Please refer to Appendix D "Guidelines for the use of Sexually Stimulating Materials" for additional information.

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

G. 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 and, if contact has been restricted by a court order, a court order allowing contact. Please refer to Section 9.000 for further information related to victims.

Discussion: In response to the Family First Prevention Services Act (FFPSA) there may be circumstances, outside the control of the MDT, in which the juvenile and the victim have contact due to the juvenile remaining in the home. In these circumstances the treatment provider and MDT should document any concerns and any known circumstances that prevent contact from being restricted, such as but not limited to; not qualifying for a Qualified Residential Treatment Program (QRTP) by a qualified individual. In these cases, the treatment provider and MDT, in collaboration with the victim representative, should discuss and establish plans regarding ongoing treatment and safety considerations to ensure both psychological and physical safety of the victim. Treatment providers have the right not to accept a referral based on the provider's determination they cannot meet the needs of the client. In the event new information that was not known at the time the juvenile was placed back in the home becomes known to the team, the team should bring this information to the referral source or court for possible reconsideration of placement or assessment under FFSPA.

H. 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).

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

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

K. 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.

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

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

N. 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).

O. 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.

5.150 Responsibilities of the Supervising Agency

The primary responsibility of the supervising officer or agency is to ensure the juvenile is in compliance with the conditions of supervision.

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 or agency shall make a referral for the required service.

5.151 For juveniles who have committed a sexual offense who begin community supervision on or after June 5, 2023, the supervising agency of each juvenile who has committed a sexual offense shall provide the juvenile with access to a complete list of treatment providers who are approved pursuant to section 16-11.7-106 and who have the expertise to work with the specific risks and needs of that particular juvenile.

5.152 The supervising agency shall also make specific recommendations to the juvenile. When making a list of referrals, the supervising agency shall consider the individual risks and treatment needs of the particular juvenile, ability of the treatment provider to accept new clients, geographic proximity of the provider, and the nature of the programs, and tailor referrals to those considerations and any other factor relevant to the treatment needs of the juvenile, capability of the provider, and safety of the community.

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

5.152 DD/ID

For juveniles with intellectual and/or developmental disabilities, as described in section 25.5-10-202, the supervising agency shall refer that juvenile to a provider approved by the SOMB to work with that population.

5.153 For juveniles who prefer to do treatment in a language other than English, referrals must be offered, when possible, to providers who are fluent in the target language.

5.154 Once selected, the treatment provider or agency may not be changed by the juvenile without the approval of the multidisciplinary team, or the court, except the juvenile may change the treatment provider or agency once within ninety days of the court imposing sentence or the juvenile's release on parole.

Discussion: The MDT should be mindful of the role a juvenile can serve in selecting their own treatment provider. Juveniles should be allowed to share information, provide their input, and share their opinion. It may also be necessary to defer to a juvenile's legal guardian for a decision. The MDT should be mindful that juveniles subject to this statutory provision represent a continuum of ages/developmental levels, and the juvenile's capacity, cognitive abilities, and general understanding should be considered by the team.

A. These requirements above (5.151 through 5.154) do not apply to the Division of Youth Services based on the nature of the program, the complex needs of the juveniles served, and the placements and approved treatment providers available to work with juveniles from the Division of Youth Services.

B. The Division of Youth Services shall assign juveniles who have committed a sexual offense to a treatment provider based on the individual risks and needs of the juvenile and have procedures in place to allow for a juvenile or family to request a change in treatment providers based on responsivity factors.

5.155 The MDT for the juvenile shall review all requests for changes in treatment providers and approve requests if the MDT determines the juvenile's risks, needs, and responsivity factors can be better served by an alternate treatment provider.

5.200 Responsibilities of the supervising probation officer

5.201 The Supervising Probation Department shall comply with standard 5.150, Responsibilities of the Supervising Agency, above.

5.202 In addition to the responsibilities as outlined in the section, the duties of the supervising probation officer are defined by statute, Chief Justice Directives, Probation Standards, and local departmental policies (C.R.S. 16-11-209).[94]

5.203 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.).[95] If optimal resources are not available refer to Section 5.100

5.203 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.[96]

5.204 Shall notify juveniles who have committed sexual offenses and their parent/caregiver that they must register with local law enforcement if ordered by the court in accordance with Section

[94] Colorado Revised Statutes. (2020). C.R.S. 16-11.-209 – Duties of Probation Officers - (1) It is the duty of a probation officer to investigate and report upon any case referred to him or her by the court for investigation. The probation officer shall furnish to each person released on probation under his or her supervision a written statement of the conditions of probation and shall instruct the person regarding the same. The officer shall keep informed concerning the conduct and condition of each person on probation under his or her supervision and shall report thereon to the court at such times as it directs. Such officers shall use all suitable methods, not inconsistent with the conditions imposed by the court, to aid persons on probation and to bring about improvement in their conduct and condition. Each officer shall keep records of his or her work; shall make such reports to the court as are required; and shall perform such other duties as the court may direct.

[95] Colorado Revised Statutes (2020) 16-11.7-105 Each adult sex offender or juvenile who has committed a sexual offense sentenced by the court for an offense committed on or after January 1, 1994, shall be required, as a part of the any sentence t probation, commitment to the department of human services, sentence to community corrections, incarceration with the department of corrections, placement on parole, or out-of-home placement to undergo treatment to the extent appropriate to such offender based upon the recommendations of the evaluation and identification made pursuant to section 16-11.7-104 or based upon any subsequent recommendations by the department of corrections, the judicial department, the department of human services, or the division of criminal justice in the department of public safety, whichever is appropriate. The treatment and monitoring shall be provided by an approved provider pursuant to section 1611.7-106, and the offender shall pay for the treatment to the extent the offender is financially able do so

[96] Colorado Revised Statutes (2020) 16-11.7-105 Each adult sex offender or juvenile who has committed a sexual offense sentenced by the court for an offense committed on or after January 1, 1994, shall be required, as a part of the any sentence t probation, commitment to the department of human services, sentence to community corrections, incarceration with the department of corrections, placement on parole, or out-of-home placement to undergo treatment to the extent appropriate to such offender based upon the recommendations of the evaluation and identification made pursuant to section 16-11.7-104 or based upon any subsequent recommendations by the department of corrections, the judicial department, the department of human services, or the division of criminal justice in the department of public safety, whichever is appropriate. The treatment and monitoring shall be provided by an approved provider pursuant to section 1611.7-106, and the offender shall pay for the treatment to the extent the offender is financially able do so.

18-3-412.5, C.R.S.[97] 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.

5.205 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.

5.206 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.[98]

5.207 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.

5.208 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.

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

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

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

5.212 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.

5.213 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.

[97] Colorado Revised Statutes (2020) C.R.S. 18-3-412.5 – Failure to Register as a Sex Offender. A person who is required to register pursuant to article 22 of title 16 and who fails to comply with any of the requirements placed on registrants by said article 22, including but not limited to committing any of the acts specified in this subsection (1), commits the offense of failure to register as a sex offender:
[98] Interstate Commission for Adult Offender Supervision: Rule 4.101 - Manner and degree of supervision in receiving state: A receiving state shall supervise offenders consistent with the supervision of other similar offenders sentenced in the receiving state, including the use of incentives, corrective actions, graduated responses, and other supervision techniques.

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

5.214 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. Alternatives 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.

5.215 Shall complete all training as required by the Probation Standards.

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.

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).[99]

5.470 The polygraph examiner must have training as specified in Section 4.0.[100]

5.500 Responsibilities of the Department of Human Services/ County Child Welfare Agencies

5.505 The Department of Human Services/County Child Welfare Agencies shall comply with standard 5.150, Responsibilities of the Supervising Agency, above.

5.510 In cases when the Department of Human Services is involved, and in accordance with Volume 7[101] 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.

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.

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

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[99] Colorado Revised Statutes (2020) 19-1-304 (1) (d) Except as otherwise authorized by section 19-1-303, any social and clinical studies, including all formal evaluations of the juvenile completed by a professional, whether or not part of the court file or any other record, are not open to inspection, except to the juvenile named in the record; to the juveniles parent, guardian, legal custodian, or attorney; or by order of the court, upon a finding of legitimate interest in and need to review the social and clinical studies.

[100] Colorado Revised Statutes (2020) 16-11.7-105 Each adult sex offender or juvenile who has committed a sexual offense sentenced by the court for an offense committed on or after January 1, 1994, shall be required, as a part of the any sentence t probation, commitment to the department of human services, sentence to community corrections, incarceration with the department of corrections, placement on parole, or out-of-home placement to undergo treatment to the extent appropriate to such offender based upon the recommendations of the evaluation and identification made pursuant to section 16-11.7-104 or based upon any subsequent recommendations by the department of corrections, the judicial department, the department of human services, or the division of criminal justice in the department of public safety, whichever is appropriate. The treatment and monitoring shall be provided by an approved provider pursuant to section 1611.7-106, and the offender shall pay for the treatment to the extent the offender is financially able do so.

[101] 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

Discussion: These Standards and Guidelines are offered as guidance with juveniles and families who are seeking intervention regarding sexually abusive behavior that has been disclosed through self-report or evaluation who are not under the statutory purview of the SOMB. 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.

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. Monitoring and updates to the supervision, safety, or support plan on the basis of the individualized evaluation, ongoing assessments, and reports of current behavioral observations by the MDT.

F. Recommendations to the court as appropriate about the treatment plan to maintain consistency between any parallel dependency and neglect, and delinquency court proceedings.

G. Inclusion of sex-offense specific treatment needs in the DHS service plans.

H. 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.[102] 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

5.605 The Division of Youth Services (DYS) shall comply with standard 5.150, Responsibilities of Supervising Agency, above.

[102] 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

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.[103] 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 DYS and programs or facilities contracting with DYS 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. DYS shall only refer juveniles to whom these standards apply for evaluation, assessment, and treatment only to providers listed with the Sex Offender Management Board.[104]

5.610 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.

The responsibilities of the DYS 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.[105]

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[103] Colorado Revised Statutes (2020) 19-2-922 – Juveniles Committed to the Department of Human Services – Evaluation and Placement - Each juvenile committed to the custody of the department of human services shall be examined and evaluated by the department prior to institutional placement or other disposition.

(b) Such evaluation and examination shall be conducted at a detention facility and shall be completed within thirty days. The department of human services may, by rule, determine the extent and scope of the evaluation and examination. To the extent possible and relevant, the evidence, reports, examination, studies, and other materials utilized in a sentencing hearing conducted under section 19-2-906 shall also be utilized in evaluation and examination conducted under this section. The provisions of this paragraph (b) shall not apply to examination and evaluation conducted pursuant to section 19-2-923 (1).

(c) The examination and evaluation shall include the use of an objective risk assessment that is based upon researched factors that correlate to a risk to the community. The results of the objective risk assessment shall be used to help identify treatment services for the juvenile during his or her commitment and the period of parole supervision.

[104] Colorado Revised Statutes (2020) 16-11.7-105 Each adult sex offender or juvenile who has committed a sexual offense sentenced by the court for an offense committed on or after January 1, 1994, shall be required, as a part of the any sentence t probation, commitment to the department of human services, sentence to community corrections, incarceration with the department of corrections, placement on parole, or out-of-home placement to undergo treatment to the extent appropriate to such offender based upon the recommendations of the evaluation and identification made pursuant to section 16-11.7-104 or based upon any subsequent recommendations by the department of corrections, the judicial department, the department of human services, or the division of criminal justice in the department of public safety, whichever is appropriate. The treatment and monitoring shall be provided by an approved provider pursuant to section 1611.7-106, and the offender shall pay for the treatment to the extent the offender is financially able do so.

[105] Colorado Revised Statutes (2020). 19-2-1003 – Parole Officers – powers – duties - Under the direction of the director of the division of youth services, the juvenile parole officer or officers in each region established in section 19-2-209 (3) shall supervise all juveniles living in the region who, having been committed to the department of human services, are on parole from one of its facilities.

(2) The juvenile parole officer shall give to each juvenile granted parole a written statement of the conditions of his or her parole, shall explain such conditions fully, and shall aid the juvenile to observe them. He or she shall have periodic conferences with and reports from the juvenile. The juvenile parole officer may conduct such investigations or other activities as may be necessary to determine whether the conditions of parole are being met and to accomplish the rehabilitation of the juvenile.

(3) All juvenile parole officers shall have the powers of peace officers, as described in sections 16-2.5-101 and 16- 2.5-138, C.R.S., in performing the duties of their position.

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 5.000, shall make recommendations for placement in accordance with Section 19-2-403, C.R.S.[106]

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.[107] 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.[108]

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.[109]

5.670 A discharge summary shall be completed on all juveniles who have been committed to DYS 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

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[106] Colorado Revised Statutes (2020) 19-2-403 – Human service facilities – authority - The department of human services shall establish and operate facilities necessary for the care, education, training, treatment, and rehabilitation of those juveniles legally committed to its custody under section 19-2-601 or 19-2-907. As necessary and when funds are available for such purposes, such facilities may include but shall not be limited to:

(a) Group care facilities and homes, including halfway houses, nonresidential transition programs, day reporting and day treatment centers, and staff secure facilities; **(b)** Training schools;

(c) Conservation camps;

(d) Diagnostic and evaluation centers and receiving centers; and

(e) Any programs necessary to implement the purposes of this section for juveniles in community placement.

[107] Colorado Revised Statutes (2020) 19-2-1002 – Juvenile parole - Juvenile parole board - hearing panels authority.

(a) The juvenile parole board, referred to in this part 10 as the "board", established pursuant to section 19-2-206, may grant, deny, defer, suspend, revoke, or specify or modify the conditions of any parole for any juvenile committed to the department of human services as provided in sections 19-2-601 and 19-2-907. In addition to any other conditions, the board may require, as a condition of parole, any adjudicated juvenile to attend school or an educational program or to work toward the attainment of a high school diploma or the successful completion of a high school equivalency examination, as that term is defined in section 22-33-102 (8.5), C.R.S.; except that the board shall not require any such juvenile to attend a school from which he or she has been expelled without the prior approval of that school's local board of education. The board may modify any of its decisions, or those of the hearing panel, except an order of discharge.

[108] Colorado Revised Statutes (2020) 19-2-1003 – Parole officers – powers – duties - Under the direction of the director of the division of youth services, the juvenile parole officer or officers in each region established in section 19-2-209 (3) shall supervise all juveniles living in the region who, having been committed to the department of human services, are on parole from one of its facilities; and 19-2-209 – Juvenile parole – organization - Juvenile parole services are administered by the division of youth services in the department of human services, under the direction of the director of the division of youth services, appointed pursuant to section 19-2-203.

[109] Colorado Revised Statutes (2020) 19-2-921 – Commitment to the Department of Human Services - When a juvenile is committed to the department of human services, the court shall transmit, with the commitment order, a copy of the petition, the order of adjudication, copies of the social study, any clinical or educational reports, and other information pertinent to the care and treatment of the juvenile.

(b) The department of human services shall provide the court with any information concerning a juvenile committed to its care that the court at any time may require.

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.[110]

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

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

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"). In circumstances where multiple victim professionals are involved in the case, the MDT, including the victim professionals, should determine and clarify what role and function each victim professional will serve. 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.

[110] Colorado Revised Statutes (2020) 18-3-412.5 – Failure to register as a sex offender - A person who is required to register pursuant to article 22 of title 16 and who fails to comply with any of the requirements placed on registrants by said article 22, including but not limited to committing any of the acts specified in this subsection (1), commits the offense of failure to register as a sex offender:

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 outlines 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.[111]

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.

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

[111] 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.

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, caregivers, and other natural support systems to help them meet these Standards.

5.910 Responsibilities of Schools/School Districts

The responsibilities of the school representative on the MDT[112] 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[113,114]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 all safety factors are taken into account.

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

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.

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[112] Colorado Revised Statutes (2020) 16-11.7-103 – Sex Offender Management Board – creation – duties – repeal - Educational materials**.** The board, in collaboration with law enforcement agencies, victim advocacy organizations, the department of education, and the department of public safety, shall develop and revise, as appropriate, for use by schools, the statement identified in section 22-1-124, C.R.S., and educational materials regarding general information about adult sex offenders and juveniles who have committed sexual offenses, safety concerns related to such offenders, and other relevant materials. The board shall provide the statement and materials to the department of education, and the department of education shall make the statement and materials available to schools in the state.

[113] 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.

[114] 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.

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:
https://cdpsdocs.state.co.us/somb/RRP/REPORTS/REFERENCEGUIDEFORSCHOOLPERSONNELFINAL.pdf

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 (GAL) representing a juvenile who has committed a sex offense in either a delinquency or dependency and neglect matter. [115]*Current law requires that the court terminate the appointment of a GAL in a delinquency case when sentencing occurs unless a youth is sentenced to residential or community out-of-home placement as a condition of probation. The court must also terminate the appointment of a GAL in a delinquency case once a youth turns eighteen years of age, unless the youth has a developmental disability. The involvement of the guardian ad litem on the MDT is important in properly meeting the needs of the juvenile, the victim, families and the community and should be encouraged when the law allows.*

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[116] 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 meetings. The guardian ad litem should advocate for elements

[115]Colorado Revised Statutes (2020) 13-91-102 – Legislative Declaration - The general assembly hereby finds that the legal representation of and non-legal advocacy on behalf of children is a critical element in giving children a voice in the Colorado court system. The general assembly further finds that the representation of children is unique in that children often have no resources with which to retain the services of an attorney or advocate, they are unable to efficiently provide or communicate to such an attorney or advocate the information needed to effectively serve the best interests or desires of that child, and they lack the ability and understanding to effectively evaluate and, if necessary, complain about the quality of representation they receive. Accordingly, the general assembly finds that the representation of children necessitates significant expertise as well as a substantial investment in time and fiscal resources. The general assembly finds that, to date, the state has been sporadic, at best, in the provision of qualified services and financial resources to this disadvantaged and voiceless population.

(b) Accordingly, the general assembly hereby determines and declares that it is in the best interests of the children of the state of Colorado, in order to reduce needless expenditures, establish enhanced funding resources, and improve the quality of representation and advocacy provided to children in the Colorado court system, that an office of the child's representative be established in the state judicial department.

[116] Colorado Revised Statutes (2020) 13-91-103 – Definitions - "Court-appointed special advocate" or "CASA volunteer" means a trained volunteer appointed by the court pursuant to the provisions of part 2 of article 1 of title 19, C.R.S., section 14-10-116, C.R.S., or title 15, C.R.S., in a judicial district to aid the court by providing independent and objective information, as directed by the court, regarding children involved in actions brought pursuant to section 14-10-116, C.R.S., or title 15 or 19, C.R.S.; and 13-91-106 – Guardian ad Litem fund – court appointed special advocate (CASA) fund – created - There is hereby created in the state treasury the guardian ad litem fund, referred to in this subsection (1) as the "fund". The fund shall consist of such general fund moneys as may be appropriated thereto by the general assembly and any moneys received pursuant to section 13-91-105 (1)(a)(IX). The moneys in the fund shall be subject to annual appropriation by the general assembly to the state judicial department for allocation to the office of the child's representative for the purposes of funding the work of the office of the child's representative relating to the provision of guardian ad litem services and for the provision of guardian ad litem services in Colorado. All interest derived from the deposit and investment of moneys in the fund shall be credited to the fund. Any moneys not appropriated shall remain in the fund and shall not be transferred or revert to the general fund of the state at the end of any fiscal year.

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.

Research Citations

The following Juvenile Standards and Guidelines in Section 5.000 have research support (the Standards are either footnoted or are supported by a review of the literature): 5.100, 5.110 and 5.110 DD/ID, 5.130 (92), 5.140 (93) and 5.140 DD/ID, 5.200 (will add statutory footnote), 5.201 and 5.201 DD/ID (will add statutory footnote), 5.202 and 5.202 DD/ID (94), 5.203, 5.204 (97), 5.207, 5.209, 5.310, 5.440, 5.460 (99), 5.470 (100), 5.510, 5.610 (104), 5.620 (105), 5.630, 5.640 (106), 5.650 (107, 108), 5.660 (109), 5.670 (110), 5.700, 5.900, 5.910 (111), 5.920 (115), and 5.922 (will add statutory footnote). All footnotes and research references in these Standards were evaluated by the staff researcher and presented to the SOMB regarding the revisions being discussed. Not all research considered directly supported the revisions; however, the research was reviewed in its totality to inform the revisions process regardless of whether it supported the standard revision or not. This research was then incorporated into the Standards and presented to the SOMB for ratification by the Board. The research in these Standards was evaluated based on the quality of the research design and the quality/strength of their findings as it related to the revisions being discussed. The research reviewed and utilized in this revision can be found in the SOMB's online repository at: https://dcj.colorado.gov/dcj-offices/domestic-violence-and-sex-offender-management/domestic-violence-and-sex-offender

The following Juvenile Standards and Guidelines in Section 5.000 were revised but do not have research support given their procedural nature: 5.120, 5.121, 5.205, 5.206, 5.208, 5.210-5.213, 5.410-5.430, 5.450, 5.680, 5.810-5.830, and 5.921. The SOMB staff did a search for research applicable to the Standards noted above. Research was not found applicable to these Standards, so in absence of research the Standards are based on best practices procedures, professional association guidelines, and the professional expertise of the members of the Board. Should research become available in the future pertaining to the topic of these Standards it will be evaluated and incorporated, should it be of sound quality.

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6.000 Polygraph Examination of Juveniles Who Have Committed Sexual Offenses

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[117]. The polygraph can be used to add incremental validity to treatment planning and risk management decisions. The concept of "incremental validity" refers to improvements in decision making through the use of additional information sources. Polygraph test results shall not be used as the sole determining factor in the supervision and treatment decision-making process. 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.

There is limited research on the effectiveness of polygraph testing with juveniles; however, some studies show improved access to information related to risk and need that might otherwise not be obtained.[118] Polygraph testing is a tool available to MDTs that may be helpful in specific cases to; promote honesty and accountability, help a juvenile progress past any barriers of denial, and corroborate progress in treatment and supervision.[119] If used, MDTs shall follow the standards outlined within this section.

Discussion: The SOMB considered all available research in developing standards related to the use of polygraph testing with juveniles and recognizes the current limitations of the research. The SOMB also understands that the Association for the Treatment of Sexual Abusers (ATSA) has published a statement[120] recommended against the use of polygraph testing with juveniles based on this same

[117] Stovering, J., Nelson, W. M. & Hart, K. J. (2013). Timeline of victim disclosures by juvenile sex offenders. The Journal of Forensic Psychiatry & Psychology, 24(6), 728-739; Van Arsdale, A., Shaw, T., Miller, P., & Parent, M. C. (2012). Polygraph testing for juveniles in treatment for sexual behavior problems: An exploratory study. Journal of Juvenile Justice, 68-79;

[118] Chaffin, M. (2010). The case of juvenile polygraphy as a clinical ethics dilemma. *Sexual Abuse: A Journal of Research and Treatment, 23(3),* 314-328;

[119] Elliot, E. & Vollm, B. (2018). The utility of post-conviction polygraph testing among sexual offenders. *Sexual Abuse, 30(4),* 367-392; Jensen, T. M., Shafer, K., Roby, C. Y., & Roby, J. L. (2015). Sexual history disclosure polygraph outcomes: Do juvenile and adult sex offenders differ? *Journal of Interpersonal Violence, 30(6),* 928-944. Spruin, E., Wood, J. L., Gannon, T. A., & Tyler, N. (2018). Sexual offender's experiences of polygraph testing: A thematic study in three probation trusts. *Journal of Sexual Aggression, 24(1),* 12-24.

[120] *"Polygraph testing is a physiological measurements designed for use with adults. The use was extended to adolescents and younger children without establishing scientific validity and without full consideration of potential for harm. In particular, no research has subjected*

currently available research. However; the SOMB continues to support the limited use of polygraph testing as an adjunct tool with juveniles as identified above in keeping with the SOMB's Guiding Principles.

6.050 If utilized, Polygraph testing shall be based on a specific rationale based on individual risk and need, such as in cases with high or difficult to manage risk. When considering the use of polygraph testing for a juvenile the MDT shall review the following factors:

A. What information is being sought by the polygraph and how will this information inform treatment and supervision?

B. Are there alternate methods, which can be utilized to obtain the information being sought?

C. What current behavior(s), risk factors(s), need(s) is the MDT concerned with and how is this addressed by polygraph testing?

If after review of the above factors the MDT has concluded the polygraph will be utilized, the rationale for use shall be documented.

6.100 Suitability Criteria/Exclusionary Factors for Polygraph Testing:

A. The multidisciplinary team shall review the following suitability criteria when considering a referral for polygraph examination:

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.

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the measurement to controlled evaluation with relevant comparison groups including adolescents who have not offended sexually. There are, therefore, no "norms" against which to compare measurement results, which severely limits the interpretability. More generally, polygraph testing has not been shown to improve treatment outcomes, reduce recidivism, or enhance community safety. Polygraph testing has not been regularly used outside of the United States. Indeed, some countries have banned the use with minors. Ethical concerns raised for polygraph testing the potential for coercion and for engendering fear, shame and other negative responses in adolescent clients. Further ethical concerns relate to the prospect of basing impactful decisions (including those relevant to such things as legal restrictions and/or family reunification) on the results of measurements that are largely unsupported, empirically. Without a clearly identified benefit and with a potential for harm, ATSA recommends against using polygraph with adolescents under age 18" (p. 33 ATSA Practice Guidelines 2017)

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. Presence of acute pain or illness
5. Presence of acute distress
6. Recent medication changes that negatively impact functioning
7. Mean Age Equivalency (MAE) or Standard Age Score (SAS) is below 12 years (per standardized psychometric testing)
8. Clear indicators exist that results would be invalid

6.110 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. Polygraph examiners shall utilize the American Polygraph Association Suitability Criteria (see Appendix L-2) in making decisions related to suitability for testing. Polygraph examiners shall not test juveniles who present as clearly unsuitable for polygraph testing at the time of the examination. In cases where the juvenile is determined to be unsuitable for polygraph testing, the MDT shall consider other forms of behavioral monitoring.

If the MDT determines that it is appropriate to use a polygraph examination with a juvenile who presents with suitability considerations, the examiner shall conduct the examination in a manner that is sensitive to the juvenile's physical, mental, or emotional condition. The

examiner shall note in the examination report those conditions that may have affected the juvenile's suitability for testing, and indicate the test results as "qualified."

Discussion: In this context, "qualified" means that the test results may not have the same level of validity as test results that are not complicated by suitability considerations.

6.120 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.

6.121 If the MDT determines a juvenile should not take a polygraph 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 6.100*.

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.

Discussion: For juveniles not suitable for polygraph testing the Sex History Disclosure Packet (Refer to Appendix N) can be a valuable tool for treatment providers in determining past behavior, understanding of various sexual behaviors, understanding consensual sexual behaviors, and identifying potential areas of focus.

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.

6.130 Formulation of test questions:

A. 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 (Refer to Appendix M, "Polygraph Examination" and Appendix N "Sexual History Disclosure Packet" for further details) shall be referred to the polygraph examiner so that the examiner can formulate suitable questions for the exam based on input from the MDT.

B. The examiner shall make the final determination of questions used, and determine whether to administer a broader or more narrowly focused examination within the scope of the requested polygraph exam. The examiner shall note the reasons for the change in focus of the examination in the exam report, if such a change is made.

6.140 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.

6.150 Polygraph Testing of Juveniles:

A. The MDT shall set the expectation for honesty and complete disclosure from the juvenile. Such openness will contribute to community safety, the development of an appropriate treatment plan and successful progression through treatment.

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

C. 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.

D. 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.

E. 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.

6.160 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.

6.170 Polygraph testing shall only 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.

6.171 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," "no significant reactions," 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, no significant reaction, and inconclusive (no opinion). The terms deception indicated and no deception indicated are provided only to provide context to significant reaction and no significant reaction but should not be used when reporting results.

6.172 The multidisciplinary team after receiving input from the polygraph examiner, shall review the results of polygraph exams and share relevant information in order to respond to polygraph testing results with the juvenile.

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

6.180 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 abusive, illegal, harmful 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 6.100*.

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 6.100 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

6.200 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. The examiner shall conduct a thorough pre-test interview, including a detailed discussion regarding areas of concern.

D. 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. Before proceeding to the in-test phase of an examination, the examiner shall review and explain all test questions to the juvenile. The examiner shall not proceed until satisfied with the juvenile's understanding of all test questions.

a. Question construction shall be:

i. Simple, direct, easily understood by the examinee, and tailored to the juvenile;
ii. Behaviorally descriptive of the juvenile's involvement in an issue of concern;

Discussion: Questions about knowledge, truthfulness, or another person's behavior are considered less desirable but may be utilized;

iii. Time limited (date of incident or timeframe);
iv. Absent of assumptions about guilt or deception;
v. Free of legal terms and jargon;
vi. Avoid the use of mental state or motivational terminology.

2. While the MDT members shall communicate all issues of concern to the examiner in advance of the examination date, the exact language of the test questions shall be determined by the examiner at the time of the examination.

E. Each examination shall be scheduled for a minimum of 90 minutes in length. Examiners shall not conduct more than five examinations per day.

Discussion: Time periods for polygraph examinations may vary depending upon the type of exam being conducted and the individual being tested. Some exams may last less than 90 minutes and others may exceed 90 minutes, however, all exams shall be scheduled for a minimum of 90 minutes.

F. Recording (audio and video) of polygraph examinations shall be required. Audio and video recording of the entire examination and the written report shall be maintained for a minimum of three years from the date of the examination.

G. All testing data shall be hand scored by the examiner. Computerized scoring algorithms may be used for comparative purposes and quality assurance in the field. The computer algorithm shall never be the sole determining factor in any examination. The examiner shall issue a written report to the supervising officer and treatment provider within fourteen days of the examination. The report shall include factual and objective accounts of the pertinent information developed during the examination, including statements made by the examinee during the pre-test and post-test interviews.

Discussion: If there are any disclosures during the polygraph exam related to violations of the treatment contract or the terms and conditions of supervision, or of a previously unknown sexual assault victim that create a significant risk either to the community or juvenile, then the examiner should contact the supervising officer and treatment provider

as soon as possible and prior to completing the written report. Each report shall include information regarding:

1. The date of examination
2. Beginning and ending times of examination
3. Reason for examination
4. Name of person requesting examination
5. Name of examinee
6. Birth date of examinee
7. Type of court supervision
8. Case background (instant offense and adjudication)
9. Statement attesting to the juvenile's suitability for polygraph testing (medical/psychiatric/developmental)
10. Date of last clinical polygraph examination (if known)
11. Examination questions and answers
12. Any additional information deemed relevant by the polygraph examiner (e.g. behavioral observations or verbal statements)
13. Brief demographic information (relationship status, children, living arrangements, employment/education status, etc.)
14. Reasons for inability to complete the examination
15. Summary of pre-test and post-test interviews, including disclosures or other relevant information provided by the juvenile
16. Examination results

    The examiner shall render an opinion based on an empirically-supported scoring technique regarding the offender's reactions to each test question:

    a. No significant reactions, indicative of non-deception;
    b. Significant reactions, indicative of deception;
    c. No opinion/inconclusive;
    d. The examiner shall note in the examination report and communicate with the MDT regarding suspected attempts to manipulate the test results.

H. 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.

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

J. In order to avoid a conflict of interest with an in-house polygraph examiner, the integrity of the distinct roles/perspectives of the MDT must be preserved. The polygraph examiner and therapist or supervising officer must never be the same person. In community settings, the juvenile shall not be mandated to test with the in-house examiner.

K. Polygraph examiners shall be sensitive to ethnic or cultural characteristics when conducting examinations. Polygraph examiners shall attempt to elicit information regarding ethnic or cultural characteristics in advance of the examination date and shall conduct the examination in a manner that is sensitive to those ethnic or cultural characteristics.

L. The need for language translation, including both foreign languages and sign languages, shall be assessed by the MDT on a case-by-case basis.

When needed, the polygraph examiner shall utilize a court certified interpreter, whenever possible. It is important that idiomatic language usage be done accurately and consistently across each successive test chart. A Juvenile's relatives or friends shall not serve as interpreters for polygraph examinations. The examiner shall inform the interpreter in advance about the process of the polygraph test. The examiner shall obtain from the interpreter a written translation, including a mirror translation, of each question presented during the in-test phase of an examination. This translation shall be prepared prior to the in-test phase and shall be maintained as part of the polygraph examination record.

Discussion: Polygraph examinations completed with the aid of a language interpreter should be regarded as "qualified" and the test results should be viewed with caution.

M. All numerical and computer scores shall be considered raw data and therefore shall not be disclosed in written examination report

N. Written polygraph reports and related work products shall be released only to the supervising officer and treatment provider, the court, parole board or other releasing agency, or other professionals as directed by the supervising officer and treatment provider

Discussion: In order to ensure that the written polygraph report can only be released by the examiner, a statement of sole proprietorship should be included with the report.

O. The examiner shall seek peer review of at least two examinations per year using the protocol. Peer reviews shall consist of a systematic review of the examination report, test data, test questions, scored results, computer score (if available), audio/video recording (upon request), and collateral information. The purpose of the peer review shall be to

facilitate a second professional opinion regarding a particular examination, to gain professional consensus whenever possible, and to formulate recommendations for the community supervision team.

P. The examiner is required to submit quality assurance reviews using the protocol form as part of the application and reapplication process (for more information, see Section 4.100).

Q. When a quality control review is requested by the supervising officer or treatment provider, the examiner shall provide the required exam information to the polygraph examiner who will complete the quality control review.

Discussion: Quality control reviews may be initiated in response to a variety of circumstances, including but not limited to, when separate examinations yield differing test results regarding the same issue(s) and/or time period. This review would then be completed by the two examiners whose examinations yielded differing results. The purpose of this review is to clarify the reasons for the differing test results and formulate a recommendation for the MDT. If consensus cannot be reached, the team shall consult with a third, independent, SOMB listed full operating level polygraph examiner, agreed upon by both polygraph examiners, to review the conflicting information and offer an opinion regarding the issue. If differences in test results remain unsolved, both examinations shall be set aside and a new polygraph examination shall be conducted. Whenever consensus cannot be reached, the MDT must err on the side of community safety when considering their response.

Discussion: If a juvenile would like to initiate a quality control review, the juvenile must first discuss the concern with the supervising officer and treatment provider in an attempt to resolve the concern within the context of a case staffing. If, after having reported the concern to the supervising officer and treatment provider, and attempting to resolve the concern, the juvenile still wishes to proceed with a quality control review, then the juvenile may contract with a SOMB listed full operating level polygraph examiner to complete the review. The juvenile is responsible for all costs associates with the quality control review in such circumstances.

R. When initiating a quality control review, the supervising officer and treatment provider shall contact the original examiner and, together with the original examiner, select an independent, full-operating level polygraph examiner to complete an objective peer review.

The reviewing examiner shall contact the original examiner with any questions and feedback, and shall complete the quality control review and the one-page Quality Control Summary Report together with the original examiner.

Discussion: It should not be assumed that a reviewer or reviewers present more expertise than the original examiner. Studies have found that results obtained by original examiners have outperformed those of subsequent reviewers. Quality control reviews serve only to offer an additional professional opinion to further advise MDT members regarding a polygraph test whose decisions may be affected by the information and results obtained.

S. The polygraph examiner shall complete the one-page Quality Control Summary Report, and the supervision officer and treatment provider shall include the Report in the offender's treatment and supervision files. Quality control reviewers shall refrain from making global or generalized conclusions regarding an examiner's work or competence (which cannot be done based upon a single examination). If the original results are not endorsed by the reviewer, a specific empirical flaw must be identified, and the reviewing examiner shall limit professional opinions to the following conclusions:
    a. Examination is supported - results shall be accepted;
    b. Examination is not supported - results shall be set aside;

        Discussion: Setting aside an examination result does not include removal of the examination report from the offender's supervision and treatment files, but should include the addition of documentation regarding the community supervision team's response.

    c. Examination is supported but qualified by identifiable empirical limitations - results may be set aside or accepted with reasonable caution. Such qualifying limitations may include identifiable empirical limitations pertaining to offender suitability, data quality, and clarity of the issue/s under investigation, and are often noted by the original examiner in the examination report.

T. In addition to the SOMB Standards, polygraph examiners shall adhere to the established ethics, standards, examination techniques, and practices of the American Polygraph Association (APA) for Post-Conviction Sex Offender Testing (PCSOT), and the American Society for Testing and Materials (ASTM).

Research Citations

For the following Standards: 6.000-6.050
All footnotes and research references in these Standards were evaluated by the staff researcher and presented to the Standards Revision Committee regarding the revisions being discussed. Not all research considered directly supported the revisions; however, the research was reviewed in its totality to inform the revisions process regardless of whether it supported the standard revision or not. This research was then incorporated into the revisions and presented to the SOMB for discussion and a 20-day public comment period, allowing for stakeholder review of research incorporated, before being ratified by the Board on the aforementioned date. The research in these Standards was evaluated based on the quality of the research design and the quality/strength of their findings as it related to the revisions being discussed. The research reviewed and utilized in this revision can be found in the SOMB's online repository at: https://dcj.colorado.gov/dcj-offices/domestic-violence-and-sex-offender-management/domestic-violence-and-sex-offender

For the following Standards: 6.100-6.200

The Staff Researcher did a search for research applicable to the revisions being discussed, along with a solicitation for research from members of the Board's Committees and members of the public. Research was not found applicable to the revisions being discussed, so in absence of research the Committee moved forward with evaluating the revisions primarily utilizing the American Polygraph Association's guidelines along with best practices, statutory requirements, and the professional expertise of the members of the Committees and the Board. Should research become available in the future pertaining to the topic of these Standards it will be evaluated and incorporated, should it be of sound quality.

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7.000 Continuity of Care and Information Sharing

Continuity of care is the process of delivering seamless service through integration, coordination and the sharing of information between MDT 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) to collaborate with one another to avoid disruption to the continuity of care, keeping in mind continuity of care pertains to those clients beginning treatment, those returning to treatment, as well as those in aftercare programs. Continuity of care values the progress a client has achieved in treatment and supervision, and increases the client's investment in treatment by aligning services with individual needs.

7.000 Continuity of Care

7.010 Value and benefit of continuity of care

A. Continuity increases a client's investment in treatment and supervision, and leads to improved outcomes.

B. Continuity values and recognizes progress that has been achieved.

C. Continuity emphasizes the value of ongoing assessment of current needs.

D. Continuity prevents unwarranted repetition of services.

E. Continuity contributes to rapport building and aids in the therapeutic alliance.

7.020 Members of the MDT/CST should prioritize continuity of care through collaboration with past and present service providers. Examples include, but are not limited to, a client being sentenced to the Department of Corrections after a period of community supervision, transitions between judicial districts, and clients in the custody of the Department of Human Services stepping down to community providers

7.030 Upon initiating services with a client, the MDT/CST should determine how to ensure continuity.

A. Treatment Providers shall obtain signed releases and request previous treatment records.[121]

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 O for an example.

Discussion: Treatment decisions shall be based on individualized risks, needs and responsivity factors, and requirements to repeat previously completed work (e.g. non-deceptive polygraph examination results, completed treatment components) should only be required with documented rationale for why repetition is needed.

D. Treatment Providers shall use this information to determine current treatment needs and as a basis for initiating communication with MDT/CST members regarding treatment needs.

E. Other members of the MDT/CST (including polygraph examiners and supervising officers) should communicate with previous providers to determine service needs; this may include the continuation of services or implementation of new services.

7.040 MDT/CST members, including treatment providers, should determine the level of service that is needed in relationship to what has already been completed.

A. Previously approved conditions should not be modified solely based on a change in MDT/CST membership.

B. Treatment Providers shall have an identified system to gather information through collateral reports and client interviews, which gives them the ability to assess the treatment content areas outlined in the Standards. Treatment Providers shall use this information to determine level of progress, treatment areas of continued focus, and treatment areas that have been completed. A sample intake assessment form can be found in Appendix "O."

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

[121] Colorado Revised Statute (2020) 12-245-220. Disclosure of confidential communications - definitions. (1) A licensee, registrant, or certificate holder shall not disclose, without the consent of the client, any confidential communications made by the client, or advice given to the client, in the course of professional employment. A licensee's, registrant's, or certificate holder's employee or associate, whether clerical or professional, shall not disclose any knowledge of the communications acquired in that capacity. Any person who has participated in any therapy conducted under the supervision of a licensee, registrant, or certificate holder, including group therapy sessions, shall not disclose any knowledge gained during the course of the therapy without the consent of the person to whom the knowledge relates.

contact with minors. MDT/CST members should use this information to determine level of progress, service areas of continued focus, and level of community access.

Discussion: This process should include individuals who can provide information related to previous services, community access, previously approved conditions and/or restrictions. This can include, but is not limited to: support persons, family members, professionals, and previous providers. MDT/CST members, including treatment providers, should be mindful of the impacts to clients, family, and the community, when previously approved conditions are modified. Rationale for such a modification should be documented and connected to risk, need, and responsivity.

7.100 Transition Points and continuity of care consideration

Throughout the continuum of services there may be a variety of transition points. The following sections are intended to provide guidance regarding some transition points, but this is not intended to be an exhaustive list of all possible transition points.

A. Clients changing treatment providers.

1. Clients who have been granted permission for community activities should not have these privileges removed solely based on a change in treatment providers, unless compelling circumstances are present.
2. Current treatment providers may continue previously achieved conditions (e.g. contact with children) when such approval is documented by the previous treatment provider, and there is no new information to indicate such condition should be restricted.

   Discussion: For example, a previously granted condition, such as visitation with children, may need to be continued in the community with comparable safeguards (e.g. allowing supervised contact with children for an individual who previously had visitation within a structured environment).

3. Members of the MDT/CST should discuss current privileges and activities and determine if these privileges and activities can be maintained in a manner in which community and victim safety is not compromised.

B. Clients being released from the Department of Corrections (DOC) facilities who have been receiving treatment in the Sex Offender Treatment and Monitoring Program (SOTMP):

1. Members of the CST should review basic needs that the client will need to access in the community and develop an interim safety plan to meet these needs while the client is waiting to begin treatment in the community. A sample interim safety plan can be found in Appendix "N" of the Adult Standards and Guidelines."

2. Clients who have been granted permission for privileges or activities should not have these privileges or activities removed solely based on a change in living environment, unless compelling circumstances are present.

3. Members of the CST should discuss current privileges and activities and determine how these privileges and activities can be maintained in a manner in which community and victim safety is not compromised.

Discussion: For example, a previously granted condition such as visitation with children may need to be continued in the community with comparable safeguards (e.g. allowing supervised contact with children for an individual who previously had visitation within a structured environment).

4. When a client is released from the DOC SOTMP on parole or accepted into Community Corrections, the SOTMP treatment provider shall send all records, including a discharge summary and Risk Management Plan/Personal Change Contract, which:

    a. Describe the level of cooperation and institutional behavior.

    b. Describe participation in treatment, including treatment objectives addressed, completed, and left to complete.

    c. Suggest specific conditions of parole, including adjunct treatment recommendations.

    d. Indicate ongoing risk and protective factors

    e. Identify any Approved support person(s)

    f. Indicate length of time and engagement in treatment

C. Clients returning to treatment/supervision after a period of time out of treatment/supervision:

1. Members of the MDT/CST, including the treatment provider and evaluator should have an identified system to gather information through collateral reports and client interviews, which gives them the ability to assess and determine privileges, activities and the level of treatment needs. See Appendix E for sample recommendations.

7.200 Information Sharing

A. Importance of Information Sharing

1. Current provider: Treatment Provider shall request all relevant and applicable previous records and will complete an assessment in the absence of such records. See Appendix "F" for a sample intake assessment.

2. Previous provider(s): Upon receipt of a signed release of information the Treatment Provider shall release past treatment records to include: Individual Treatment Plan, Progress Summaries, summary of polygraph results, Discharge Summaries, and additional adjunct services provided.

3. Supervising officer: Facilitate the exchange of relevant and applicable records.

B. Releases of Information

1. Treatment providers, evaluators, polygraph examiners, and supervising officers shall be aware of and comply with all applicable laws and rules related to confidentiality and releasing of information (e.g. HIPAA, FERPA, 42 CFR, Mental Health Practice Act, Professional and Ethical codes of conduct).[122]

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 "P."

   b. A court filing document for submitting information regarding participation in treatment for adults can be found in Appendix "N" of the Adult Standards and Guidelines.

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

[122] Colorado Revised Statute (2020) 12-245-220. Disclosure of confidential communications - definitions. (1) A licensee, registrant, or certificate holder shall not disclose, without the consent of the client, any confidential communications made by the client, or advice given to the client, in the course of professional employment. A licensee's, registrant's, or certificate holder's employee or associate, whether clerical or professional, shall not disclose any knowledge of the communications acquired in that capacity. Any person who has participated in any therapy conducted under the supervision of a licensee, registrant, or certificate holder, including group therapy sessions, shall not disclose any knowledge gained during the course of the therapy without the consent of the person to whom the knowledge relates.

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.

Research Citations

The following Juvenile Standards and Guidelines in Section 7.000 have research support (the Standards are either footnoted or are supported by a review of the literature): 7.010, 7.030 (121), and 7.200 (122).

All footnotes and research references in these Standards were evaluated by the staff researcher and presented to the SOMB regarding the revisions being discussed. Not all research considered directly supported the revisions; however, the research was reviewed in its totality to inform the revisions process regardless of whether it supported the standard revision or not. This research was then incorporated into the Standards and presented to the SOMB for ratification by the Board. The research in these Standards was evaluated based on the quality of the research design and the quality/strength of their findings as it related to the revisions being discussed. The research reviewed and utilized in this revision can be found in the SOMB's online repository at: https://dcj.colorado.gov/dcj-offices/domestic-violence-and-sex-offender-management/domestic-violence-and-sex-offender

The following Juvenile Standards and Guidelines in Section 7.000 were revised but do not have research support given their procedural nature: 7.020, 7.040, and 7.100.

The SOMB staff did a search for research applicable to the Standards noted above. Research was not found applicable to these Standards, so in absence of research the Standards are based on best practices procedures, professional association guidelines, and the professional expertise of the members of the Board. Should research become available in the future pertaining to the topic of these Standards it will be evaluated and incorporated, should it be of sound quality.

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8.000 Victim Impact and a Victim Centered Approach

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.[123] 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.[124]

Sexual crimes violate victims. Victims may experience chronic and severe mental and physical health symptoms, as well as social, familial, economic and spiritual harm. These symptoms cross over into all aspects of victims' lives, and victims often face long term impact and continue to struggle for recovery over the course of their lifetimes. Trauma from sexual assault changes the victim's world view, self-perception and sense of power and control. Family members of victims and communities as a whole are also negatively impacted by sexual offenses. While the effects of sexual assault on victims are unique and may vary over time, common consequences of sexual assault include:

- Fear
- Anxiety
- Hypervigilance
- Self-blame
- Guilt
- Shame
- Depression
- Anger
- Irritability
- Avoidance

[123] 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.

[124] 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.

- 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.

8.000 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 juveniles who have committed sexual offenses. Individuals and programs working with juveniles who have committed sexual offenses 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 juveniles to internalize and demonstrate long term behavioral change. The impact to the victim informs and guides the decision making process and assists professionals in prioritizing the safety and needs of victims of sexual crimes.

8.010 The MDT 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 MDT members and required by these standards to be an approved evaluator, polygraph examiner or treatment provider. Teams shall include a victim representative on the MDT 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 and juveniles who have committed sexual offenses, 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."[125]

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

[125] Colorado Revised Statutes (2020) 16-11.7-103 (4) (i) Standards for identification and evaluation of juvenile offenders. The board shall develop, prescribe, and revise, as appropriate, a standard procedure to evaluate and identify juveniles who have committed sexual offenses, including juveniles with developmental disabilities. The procedure shall provide for an evaluation and identification of the juvenile offender and recommend behavior management, monitoring, treatment, and compliance and shall incorporate the concepts of the risk-need-responsivity or another evidence-based correctional model based upon the knowledge that all unlawful sexual behavior poses a risk to the community and that certain juveniles may have the capacity to change their behavior with appropriate intervention and treatment. The board shall develop and implement methods of intervention for juveniles who have committed sexual offenses, which methods have as a priority the physical and psychological safety of victims and potential victims and that are appropriate to the needs of the particular juvenile offender, so long as there is no reduction in the safety of victims and potential victims.

afforded criminal defendants.[126] (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.[127]

For more information regarding victim considerations in the school environment, please see the **SOMB Reference Guide for School Personnel.**[128]

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 MDT can support victims and contribute to their healing and recovery:

Needs:

1. Caring, compassionate response
2. Physical and psychological safety/protection
3. Being believed
4. Therapy and other resources
5. Opportunities for input
6. Information regarding the management, supervision and treatment of the juvenile.
7. Accurate information being provided to the juvenile's and victim's support systems

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[126] Colorado Revised Statutes (2020) 24-4.1-301 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.

[127] Colorado Revised Statutes (2020) 24-4.1-302.5 In order to preserve and protect a victim's rights to justice and due process, each victim of a crime has the following rights:

(a) The right to be treated with fairness, respect, and dignity, and to be free from intimidation, harassment, or abuse, throughout the criminal justice process;

(b) The right to be informed of and present for all critical stages of the criminal justice process as specified in section 24-4.1-302 (2); except that the victim shall have the right to be informed of, without being present for, the critical stages described in section 24-4.1-302 (2)(a), (2)(a.5), (2)(a.7), (2)(e.5), (2)(k.3), (2)(n), (2)(p), (2)(q), and (2)(u);

(b.5) Repealed.

(b.7) For a victim of a sex offense, the right to be informed of the filing of a petition by the perpetrator of the offense to terminate sex offender registration pursuant to section 16-22-113 (2) and (2.5);

(b.9) The right to receive a free copy of the initial incident report from the investigating law enforcement agency; except that the release of a document associated with the investigation is at the discretion of the law enforcement agency based on the status of the case or security and safety concerns in a correctional facility, local jail, or private contract prison as defined in section 17-1-102, C.R.S.

[128] Colorado Revised Statutes (2020) 16-11.7.103 (4) (l) Educational materials. The board, in collaboration with law enforcement agencies, victim advocacy organizations, the department of education, and the department of public safety, shall develop and revise, as appropriate, for use by schools, the statement identified in section 22-1-124, C.R.S., and educational materials regarding general information about adult sex offenders and juveniles who have committed sexual offenses, safety concerns related to such offenders, and other relevant materials. The board shall provide the statement and materials to the department of education, and the department of education shall make the statement and materials available to schools in the state.

Support:

1. Listen to victims and allow them to be heard
2. Provide information about team members' roles and responsibilities
3. Reassure victims that the abuse was not their fault
4. Hold the juvenile fully accountable
5. Validate the victims' experience
6. Acknowledge victims' strengths and ability to heal/recover
7. Be clear regarding what information can and cannot be shared
8. Be willing to repeat information
9. Be sensitive to where victims are in their recovery process
10. Advocate, as needed, for therapy for victims
11. Recognize the impact of the trauma on the victims' behaviors, beliefs and emotions, and how those may be expressed
12. Thank victims for reporting and going through the very difficult criminal justice process
13. Recognize the importance of how clarification, contact or reunification are implemented (refer to section 8.000)

Common Victim Concerns and Safety Issues

1. Location of the juvenile
2. The negative impact of the victim encountering the juvenile in the community, especially in intra-familial cases, such as family functions
3. The juvenile being able to manipulate the MDT members in the same ways he/she manipulated the victim and victim's family
4. Lack of trust that information regarding the juvenile's treatment and supervision is being provided
5. The conditions of supervision, such as allowing contact with minors
6. The juvenile continuing to deny, minimize or blame the victim for the abuse
7. Whether or not the juvenile is demonstrating engagement in treatment and changing their behavior
8. Whether or not the juvenile is telling the truth, demonstrating honesty through polygraphs or other means, and compliant on supervision
9. Whether or not the juvenile is expressing genuine remorse for the abuse

Research Citations

The following Juvenile Standards and Guidelines in Section 8.000 have research support (the Standards are either footnoted or are supported by a review of the literature): 8.000 and 8.010 (127, 128) were supported by a review of the literature but they were not cited. All footnotes and research references in these Standards were evaluated by the staff researcher and presented to the Standards Revisions Committee regarding the revisions being discussed. Not all research considered directly supported the revisions; however, the research was reviewed in its totality to inform the revisions process regardless of whether it supported the standard revision or not. This research was then incorporated into the Standards and presented to the SOMB for ratification by the Board. The research in these Standards was evaluated based on the quality of the research design and the quality/strength of their findings as it related to the revisions being discussed. The research reviewed and utilized in this revision can be found in the SOMB's online repository at:

https://dcj.colorado.gov/dcj-offices/domestic-violence-and-sex-offender-management/domestic-violence-and-sex-offender

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9.000 Victims and Potential Victims: Clarification, Contact and Reunification

9.100 Victim Clarification[129]

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.[130]

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.

[129] 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.

[130] 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.

9.110 Victim clarification procedures[131]

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:

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 shall be written in a manner assuming the victim will receive the letters, regardless of whether or not the letters will actually be sent. With the clarification process designed to primarily benefit the victim, if the victim, the parent or guardian of a child victim, the victim's therapist, or victim representative requests the completed letter, it shall be provided in a manner that best meets the needs of the victim. Per Section 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.

   Discussion point: If there are concerns that releasing the letter could result in harm to the victim or juvenile, or there are disagreements regarding releasing

[131] 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)

the letter, the MDT should discuss these concerns and develop a plan for how to mitigate the concerns while still meeting the needs of the victim.

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 abusive, illegal and/or harmful 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 B, "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 affect 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, illegal and/or harmful 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.

9.200 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.

9.210 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 11.000 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.

9.300 Family Reunification[132],[133]

9.310 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.

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.

Discussion: In response to the Family First Prevention Services Act (FFPSA) there may be circumstances, outside the control of the MDT, in which the juvenile and the victim have contact due to the juvenile remaining in the home. In these circumstances the treatment provider and MDT should document any concerns and any known circumstances that prevent contact from being restricted, such as but not limited to; not qualifying for a Qualified Residential Treatment Program (QRTP) by a qualified individual. In these cases, the treatment provider and MDT, in collaboration with the victim representative, should discuss and establish plans regarding ongoing treatment and safety considerations to ensure both psychological and physical safety of the victim. See section 9.320 for additional information. In the event new information that was not known at the time the juvenile was placed back in the home becomes

[132] 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.

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

known to the team, the team should bring this information to the referral source or court for possible reconsideration of placement or assessment under FFSPA.

9.320 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 9.110 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 11.000) 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.

Discussion: In response to the Family First Prevention Services Act (FFPSA) there may be circumstances, outside of the control of the MDT, in which the juvenile and the victim have contact due to the juvenile remaining in the home. In these circumstances the treatment provider and MDT should document any concerns and any known circumstances that prevent contact from being restricted, such as but not limited to; not qualifying for a Qualified Residential Treatment Program (QRTP) by a qualified individual. In these cases, the treatment provider and MDT, in collaboration with the victim representative, should discuss and establish plans regarding ongoing treatment and safety considerations to ensure both psychological and physical safety of the victim. See Section 9.320 A-C, 2 for additional information. In the event new information that was not known at the time the juvenile was placed back in the home becomes known to the team, the team should bring this information to the referral source or court for possible reconsideration of placement or assessment under FFSPA.

9.330 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.

Research Citations

The following Juvenile Standards and Guidelines in Section 9.000 have research support (the Standards are either footnoted or are supported by a review of the literature): 9.100, 9.110, and 9.300. All footnotes and research references in these Standards were evaluated by the staff researcher and presented to the SOMB regarding the revisions being discussed. Not all research considered directly supported the revisions; however, the research was reviewed in its totality to inform the revisions process regardless of whether it supported the standard revision or not. This research was then incorporated into the Standards and presented to the SOMB for ratification by the Board. The research in these Standards was evaluated based on the quality of the research design and the quality/strength of their findings as it related to the revisions being discussed. The research reviewed and utilized in this revision can be found in the SOMB's online repository at: https://dcj.colorado.gov/dcj-offices/domestic-violence-and-sex-offender-management/domestic-violence-and-sex-offender

The following Juvenile Standards and Guidelines in Section 9.000 were revised but do not have research support given their procedural nature: 9.200 and 9.210. The SOMB staff did a search for research applicable to the Standards noted above. Research was not found applicable to these Standards, so in absence of research the Standards are based on best practices procedures, professional association guidelines, and the professional expertise of the members of the Board. Should research become available in the future pertaining to the topic of these Standards it will be evaluated and incorporated, should it be of sound quality.

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10.000 Additional Conditions of Community Supervision

Additional conditions for community supervision may be imposed by the court or parole board and enforced by supervising agencies, i.e. probation[134], parole[135], DYS, DHS, etc. Juveniles under supervision for a sexual offense shall comply with the specific terms and conditions that may be imposed. MDT members shall refer to the supervising agency/officer for the terms and conditions specific to the juvenile.

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

[134] C.R.S. 19-2-925 Probation - terms - release - revocation. (1) (a) The terms and conditions of probation shall be specified by rules or orders of the court. The court, as a condition of probation for a juvenile who is ten years of age or older but less than eighteen years of age on the date of the sentencing hearing, may impose a commitment or detention. The aggregate length of any such commitment or detention, whether continuous or at designated intervals, shall not exceed forty-five days; except that such limit shall not apply to any placement out of the home through a county department of social services. Each juvenile placed on probation shall be given a written statement of the terms and conditions of his or her probation and shall have such terms and conditions fully explained to him or her

[135] C.R.S 19-2-921 (6) Parole supervision of juveniles committed to the department of human services undersection 19-2-601 or 19-2-907, as determined by the juvenile parole board, shall not exceed six months, except as otherwise provided by statute.

Research Citations

The following Juvenile Standards and Guidelines in Section 10.000 have research support (the Standards are either footnoted or are supported by a review of the literature and the statute): 10.000.

All footnotes and research references in these Standards were evaluated by the staff researcher and presented to the SOMB regarding the revisions being discussed. Not all research considered directly supported the revisions; however, the research was reviewed in its totality to inform the revisions process regardless of whether it supported the standard revision or not. This research was then incorporated into the Standards and presented to the SOMB for ratification by the Board. The research in these Standards was evaluated based on the quality of the research design and the quality/strength of their findings as it related to the revisions being discussed. The research reviewed and utilized in this revision can be found in the SOMB's online repository at: https://dcj.colorado.gov/dcjoffices/domestic-violence-and-sex-offender-management/domestic-violence-and-sex-offender

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11.000 Informed Supervision Protocol

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[136]. 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[137].

Discussion: 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[138]. 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.

[136] 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.

[137] 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.

[138] 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*,

11.100 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;

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[139].

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: 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.

[139] 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.

11.200 Responsibilities of the Informed Supervisor

A. Respect victim's confidentiality[140].

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[141].

D. Directly observes and monitors approved contact between the juvenile, victim(s), siblings and other potential victims as defined by the MDT[142].

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[143].

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[144].

G. Understands the conditions of community supervision and treatment.

H. Can design, implement and monitor safety plans for daily activities[145]. (Refer to Appendix O, "Informed Supervision" and Appendix L, "Safety Planning" for further details).

I. Is able to hold the juvenile accountable for his/her behavior[146].

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[140] 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.

[141] 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.

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

[143] 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.

[144] 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.

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

[146] 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*.

J. Has the skill to intervene in and interrupt high risk patterns[147].

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

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 11.200 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[148]. MDTs will need to address problems that surface in regards to informed supervisors such as;

- Learning curves
- Training or retraining requirements
- Family Dynamics[149]
- 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.

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[148] 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.

[149] 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.

Research Citations

The following Juvenile Standards and Guidelines in Section 11.000 have research support (the Standards are either footnoted or are supported by a review of the literature): 11.000, 11.100 A., B., and C., and 11.200 A., B., C., D., E., F., G., H., I., J., K. and L.

All footnotes and research references in these Standards were evaluated by the staff researcher and presented to the SOMB regarding the revisions being discussed. Not all research considered directly supported the revisions; however, the research was reviewed in its totality to inform the revisions process regardless of whether it supported the standard revision or not. This research was then incorporated into the Standards and presented to the SOMB for ratification by the Board. The research in these Standards was evaluated based on the quality of the research design and the quality/strength of their findings as it related to the revisions being discussed. The research reviewed and utilized in this revision can be found in the SOMB's online repository at: https://dcj.colorado.gov/dcj-offices/domestic-violence-and-sex-offender-management/somb/about-the-sex-offender-management

The following Juvenile Standards and Guidelines in Section 11.000 were revised but do not have research support given their procedural nature: 11.100 C-1 thru C-11, 11.100 D., and 11.200 M.

The SOMB staff did a search for research applicable to the Standards noted above. Research was not found applicable to these Standards, so in absence of research the Standards are based on best practices procedures, professional association guidelines, and the professional expertise of the members of the Board. Should research become available in the future pertaining to the topic of these Standards it will be evaluated and incorporated, should it be of sound quality.

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Appendix A: Sex Offender Management Board Administrative Policies

This appendix is designed for listed treatment providers, evaluators, and polygraph examiners pursuant to section 16-11.7-101-09, C.R.S., 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, Standards Compliance Reviews, appeals and other administrative actions.

The Executive Director of the Department of Public Safety may suspend or modify any of these procedures in the interest of justice to avoid irreparable harm to crime victims or to the citizens of Colorado. If the situation warrants, the SOMB may exercise the option of seeking guidance from the Office of the Attorney General for possible legal action.

A. LISTING AS A PROVIDER

1. This appendix applies to treatment providers, evaluators, and polygraph examiners who are listed in the following categories:

    a. Associate level provider status
    b. Full Operating level provider status
    c. Clinical Supervisor status
    d. Not currently practicing status

2. For the purposes of Section 4 and the Administrative Policies of these Standards and Guidelines, “conviction” means a conviction by a jury or by a court and shall also include a deferred judgment and sentence agreement, a deferred prosecution agreement, a deferred adjudication agreement, an adjudication, and a plea of guilty or nolo contendere (sometimes referred to as an “Alford” plea). For the purposes of Section 4 and the Administrative Policies of these Standards and Guidelines, “conviction” also includes any criminal record which has since been expunged and/or sealed except that "conviction" does not include any juvenile record which has been expunged pursuant to 19-1-306 or another state's equivalent.

3. Failure to disclose a criminal conviction, as “conviction” is defined in these Standards and Administrative Policies, may result in the denial of an individual’s application to the SOMB Approved Provider List. Should such a failure to disclose be discovered after an applicant’s approval to the Approved Provider List, such a failure may be used by the SOMB in its decision making related to whether an individual should continue to be listed with the SOMB.

4. The applicant/provider shall:
   - Not have any conviction for any municipal ordinance violation, misdemeanor, felony or court-martial conviction if the municipal ordinance violation, misdemeanor, felony or court-martial conviction is related to the ability of the 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, as "conviction" is defined in paragraph 2, above, shall be conclusive evidence of such a record.
   - Not be a party to any civil dispute that has resulted in the applicant/provider being the restrained party in any order of protection, if such dispute is related to the ability of the applicant/provider to practice under these Standards and Guidelines, as reviewed and determined by the ARC. Such civil disputes may result in the denial of an applicant's application, or in the removal of a provider from the Approved Provider List.
   - Not abuse drugs or alcohol, nor shall an applicant/provider use drugs and/or alcohol in a way that compromises their ability to practice under these Standards and Guidelines, as determined by the ARC. Such drug/alcohol use or abuse may result in the denial of an applicant's application, or in the removal of a provider from the Approved Provider List.
   - Notify the SOMB in writing within 10 days upon the issuance of any summons and within 10 days of any arrest. You must also notify the SOMB in writing within 10 days upon sustaining any, conviction, entering a nolo contender plea, or entering into any deferred judgment or deferred prosecution agreement for a municipal ordinance violation, misdemeanor, or felony; however, no such notification needs to be made if the underlying offense (or alleged offense) is for a traffic violation involving 7 points or less. 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.

5. Providers not on the SOMB approved provider list, including any provider who is denied placement or removed from the Provider List, shall not provide any sex offense specific services pursuant to statute in Colorado to convicted adult sex offenders or juveniles who have committed sexual offenses. No referral source shall use any provider not on the approved provider list, denied placement or removed from the provider list per 16-11.7-106 C.R.S.

6. 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.

7. **Confidentiality of SOMB Files:** The following information in the SOMB files, including application materials, for applicants, and individuals on the provider list, 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, unfounded complaints, Standards Compliance Reviews (SCR) with no founded Standards violations, or any

supplemental documentation, 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.).

Records related to violations and the outcome of a complaint or a For Cause SCR are part of the Approved Provider's file and can be made available to members of the public upon request through the Colorado Open Records Act (Section 24-72-201, C.R.S.).

8. **Period of Compliance:** A listed treatment provider or evaluator, who is applying or reapplying, may receive up to one year or as deemed by the Application Review Committee 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.

9. **Grace Period for Renewal:** Providers who do not submit an application for renewal of their approved provider status by the date of expiration of their status will have a 30-day grace period in order to submit their application materials without having to start over with an Application One. Failure to submit application materials within 30 days after the date of expiration for approved provider status will require providers to have to begin the application process over by submitting Application One.

10. **Eligibility for Future Renewal once Provider Approval has Expired**: Providers who allow their approved provider status expire may be considered for return to listing status within 1 year of the expiration of their status. The Application Review Committee will consider whether to reinstate a provider to the approved provider list without having to begin the Application One process over based on factors such as history of listing status, the reason for the expiration of the status, and what work the provider has been doing since the approved provider status ended to remain competent in the field.

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, REDUCTION IN APPROVAL STATUS OR ANY SPECIFIC LISTING STATUS ON THE PROVIDER LIST

Any applicant who is denied placement on the Provider List, receives a reduction in approval status or any specific status (e.g., 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 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. The SOMB will consider the basis for denial or reduction in approval status, as well as information presented by the applicant or provider regarding the denial or reduction in status.

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 E of this Appendix A.

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 submitted online or made in writing to the SOMB and signed by the complainant. Anonymous complaints will be accepted and reviewed in the same manner as all other complaints submitted to the SOMB. 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 and investigate 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, 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 were on the Provider List at the time of the alleged violation. Complaints against a listed provider regarding actions of unlisted persons under the supervision of that individual, are also appropriate for SOMB intervention. Complaints filed against supervising officers should be sent directly to the agency/entity that employs the

supervising officer (i.e., Probation, Parole, Human Services, etc.). Information on where to file a complaint against a supervising officer is available on the SOMB website.

Per 16-11.7-106 (7) (b) C.R.S., complaints will be reviewed and investigated 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 and complainant to determine if the complaint can be resolved informally through mutual agreement between the identified provider and complainant. Complaints and corrective actions that may be suitable for an offer to the complainant and provider for a mutual agreement may include but are not limited to required release of treatment records with a suitable release, a continuing education class, seeking consultation or supervision, or voluntary relinquishment of provider status, among other. Decisions related to use of mutual agreement will be made on a case-by-case basis. If mutual agreement can be reached as agreed upon by the complainant and provider, the complaint will be determined to be unfounded. The complainant will be notified in writing of the mutual agreement and the complaint will be unfounded. The information that a mutual agreement or the letter containing the terms of the mutual agreement will be available upon request. 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 founded complaint 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 details of the complaint remain confidential. The information that a mutual agreement or the letter containing the terms of the mutual agreement will be available upon request. 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 founded complaint will appear on file for this identified provider regarding this complaint.

e. Request for SOMB Staff to further investigate the information contained in the complaint either directly or through 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 A.

E. APPEAL PROCESS

Any complainant or identified provider who wishes to appeal a finding on a complaint, denial for placement on the Provider List for a specific listing status, the involuntary removal from the Approved Provider List, a reduction in approved listing status, or a Standards Compliance Review with a findings of a Standards violation may appeal the decision to the SOMB. Appeals 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, application or standards compliance review 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 a verbal presentation by the complainant; 20 minutes for presentation by the ARC; 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:

    a. Accept the finding of the ARC.
    b. Reject the finding of the ARC.
    c. Modify the finding or sanction of the 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 A is the sole SOMB remedy for a provider denied placement on or any specific status on the Provider List, a resolution of a complaint(s), or Standards Compliance Review with a finding of a Standards violation. The decision of the SOMB is final.

    Contact information and relevant forms related to Appendix A may be found on the SOMB website at https://www.colorado.gov/pacific/dcj/form/file-complaint-somb.

F. STANDARDS COMPLIANCE REVIEWS

Implementation of the *Standards and Guidelines* is an important part of the work of the SOMB. Mechanisms to verify compliance with the *Standards and Guidelines* serve as a way of promoting victim safety and the successful assessment, evaluation, and treatment of convicted adult sex offenders or juveniles who have committed sexual offenses.

Inquiries about the Standards and Guidelines may be screened by SOMB program staff using the Standards Compliance Review Criteria (per Application Review Committee Standard Operating Procedure) when providing training and technical assistance (TTA) to Approved Providers.

The purpose of Standard Compliance Reviews (SCR) is to review a provider's compliance with these ***Standards and Guidelines***, and to identify innovative and exceptional practices in areas related to offender evaluation, assessment, and treatment. The ARC may conduct a SCR at any time. Once a provider has successfully completed an SCR, the provider will be exempt from random selection for six years.

A. Technical Assistance

SOMB staff are authorized to answer questions, provide clarification, and provide support pertaining to the application and interpretation of the Standards as needed and applicable, on a case by case basis. SOMB Approved Providers and other individuals who use the Standards and Guidelines are encouraged to contact SOMB staff with questions when technical issues arise.

B. Standards Compliance Reviews

The Application Review Committee (ARC) is authorized to initiate a Standards Compliance Review (SCR) for an Approved Provider at random, voluntarily or For-Cause under the authority of the SOMB. An SCR is the process wherein the ARC conducts a review of an Approved Provider's compliance with the Standards and Guidelines. This process may identify violations of standards, concerns with practices, opportunities for technical assistance, innovative approaches and/or best practices in areas related to client evaluation, assessment, and treatment. Pursuant to C.R.S. 16-11.7-103(4)(h.5), the ARC must perform compliance reviews on at least ten percent of treatment providers on the Approved Provider List every two years.

1. Types of Standards Compliance Reviews:

a) Voluntary - An individual Approved Provider may contact SOMB staff and volunteer to participate in a Standards Compliance Review (SCR). Self-selection for an SCR may offer the Approved Provider an opportunity to review aspects of their practice to determine if there are any areas that should be modified to ensure compliance with the Standards and Guidelines. This voluntary request will meet the SOMB requirements to receive a random SCR within required time parameters, but does not preclude the individual from receiving a for-cause SCR in the future.

b) Random – The ARC may conduct periodic SCRs of treatment providers on the Approved Provider List on a randomized basis to determine if a Provider is following the requirements of the Standards and Guidelines. Selection of Approved Providers subject to a random SCR will be drawn based on the Provider Identification Number in the Provider Data Management System (PDMS). The SOMB, on behalf of the ARC, will determine what services, documentation, or aspects of the Standards and Guidelines need to be reviewed as part of randomized SCRs.

c) For Cause – The ARC may vote to initiate an SCR for cause when information is obtained through technical assistance, processing of an application, or an anonymous complaint sufficiently alleges that an Approved Provider may not be complying with the Standards and Guidelines. The ARC, in conjunction with the SOMB staff, will evaluate the information received to determine the scope, credibility, and severity of the alleged circumstances. The SOMB staff and the ARC Chair shall determine the most appropriate method for investigating and resolving compliance issues or concerns.

2. The ARC may select one of the following Response Levels based on the information available concerning the Standards Compliance Review:

a) Level 1 – Implementation Verification

A Level 1 SCR evaluates and determines whether an Approved Provider has implemented requirements of the Standards and Guidelines related to administrative, training, or MTT consultation actions.

b) Level 2 – Work Product Review

In addition to the requirements of Level 1, a Level 2 SCR evaluates and determines whether an Approved Provider is adhering to the requirements of the Standards and Guidelines related to written work product (e.g., offender evaluation summary report, treatment plans, monthly progress reports, Community Supervision Team/Multidisciplinary Team communications, treatment contracts, discharge summaries, etc.).

c) Level 3 – Site Visit & File Review

In addition to the requirements of Level 2, a Level 3 SCR is a comprehensive audit to determine if an Approved Provider is adhering to the requirements of the Standards and Guidelines. This may include a review of client files, attendance in group or individual therapy sessions, evaluations, or other services provided under the Standards and Guidelines.

For Level 3 reviews proper consents and/or releases shall be in place to ensure compliance with confidentiality requirements. In the instances of providers within an agency, the ARC will coordinate with the agency to implement the appropriate consents and approvals required by the agency in order to complete the review.

3. Provider Notification - Providers will receive a notification letter when they have been selected for an SCR and the type of SCR being administered. The notification letter will also include instructions regarding how to respond to the ARC. The Provider must submit all requested materials by the deadline identified in the notification letter. If multiple Providers within a single organization are subject to an SCR, the ARC may initiate one SCR process that incorporates the investigation of all Providers within the organization or agency.

4. SCR Review – Once information has been received, the ARC will review the Approved Provider's response to the SCR and any other relevant information concerning the Approved Provider in order to identify any Standard violations, as well as opportunities to implement innovations or incorporate best practices. Information related to the type of SCR, documentation request, and the response from the Approved Provider will remain confidential during the pendency of the SCR investigation and evaluation period.

5. ARC Determination – The ARC will notify the Approved Provider who is the subject of the SCR of the outcome of the review within 7 days of the ARC rendering a decision. The

notification of the outcome will be provided in writing and will include any required follow up actions that the ARC deems necessary. The SCR will identify at least one or more of the following outcomes:

a) The Approved Provider is approved for continued placement on the Approved Provider List, and no further action is required at that time.

Outcome: The Approved Provider retains their level and their status is maintained. The ARC may provide general feedback for the Approved Provider for their consideration.

b) An innovative practice is identified as a best practice.

Outcome: The Approved Provider retains their level and their status is maintained. If an Approved Provider demonstrates skills, competencies, and abilities of a higher practice level, the ARC has the discretion of awarding an increase in practice level.

c) Standards violations are founded.

Outcome: The Approved Provider may be offered a Compliance Action Plan (CAP) to resolve the founded violations identified in the SCR. The ARC will determine whether the Approved Provider may retain their practice level or whether the practice level will be reduced while the CAP is in effect. The CAP will specify the timeframes, actions, and documentation needed by the Approved Provider to demonstrate that the founded violations have been resolved. The Approved Provider must demonstrate to the ARC that the founded violations have been resolved systemically. Once the Approved Provider has completed the CAP to the satisfaction of the ARC, the Approved Provider will retain their practice level. For Voluntary and Random SCRs, records related to resolved violations, the supplemental documentation, and the outcome of the SCR remains part of the Approved Provider's confidential file and not available to the public. The records related to violations and the outcome of a For Cause SCR are part of the Approved Provider's file and can be made available to members of the public upon request.

The ARC has the discretion to administer any action listed in Section IV of these Administrative Policies if:

i. The Approved Provider subject to a CAP declines, refuses, or fails to participate in the CAP required to resolve the founded violations.

ii. The Approved Provider subject to a CAP cannot resolve the founded violations or the Approved Provider is unable to demonstrate skills, competencies, and abilities consistent with the Provider's practice level.

d) A formal complaint will be opened by the SOMB and also forwarded to the Department of Regulatory Agencies (DORA), on behalf of the ARC.

Outcome: The ARC may determine that the SCR has resulted in founded violations that rise to the level of initiation of a formal complaint against the Approved Provider. The ARC will notify the Approved Provider that it will proceed with a formal complaint based on the findings of the

SCR. A complaint will also be provided to the Department of Regulatory Agencies based on the findings of the SCR.

G. VARIANCES

The purpose of the Standards Variance Process is to allow for a SOMB Approved Provider or applicant to seek approval for a temporary suspension of a specific Standard. The reasons for suspending a requirement of the Standards vary, but modifications to requirements of the Standards are limited to rare circumstances that are reviewed on a case-by-case basis. Variance requests can be related to the treatment of an individual under the purview of the ***Standards*** or to request a modification to the approval process.

A. Submitting A Variance Request – A Provider who is unable to comply with the requirements of the Standards may submit a variance proposal to the ARC for review. The proposal should be identified as a Standard Variance Request and must include the following components:

1. Identification of each Standard that is subject to the variance;

2. An overview of the unusual circumstances and documentation why compliance with the Standards is not possible;

3. A plan developed for the proposed variance of outlining the following:

    a) Victim safety including re-offense

    b) Ongoing assessment of risk and need

    c) Timeframe

    d) Written verification of CST/MDT consensus

B. Preliminary Review – SOMB Staff will perform an initial review of the request. If the request is not acceptable, the Staff will work with the Provider to modify and address any questions or concerns.

C. ARC Review – The ARC will review the Standards Variance Request. If the request is acceptable and does not pose a safety risk, the ARC may authorize preliminary approval of the Variance Request. A review of the approved Variance Request will be scheduled and presented at the SOMB. Variances that are not granted preliminary approval by the ARC will be scheduled for formal review by the Board at the next meeting. If approved, the ARC will ratify the Standards Variance Request and create a plan for conducting periodic reviews and any necessary documentation required for those reviews. The Provider will be notified in writing of the decision to approve or deny the variance.

D. If a variance is in place for more than two years, the Board may consider if a standards revision is necessary.

Contact information and relevant forms related to this appendix may be found on the SOMB website at https://www.colorado.gov/pacific/dcj/form/file-complaint-somb

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Appendix B: Considerations for MDTs/CSTs: Working with Victims When Facilitating Contact, Clarification, and/or Reunification

Purpose

The purpose of this Appendix is to provide guidance to victim representatives as well as other CST/MDT professionals in the facilitation and considerations for Clarification and Reunification work.

This information is intended to be supplemental to the Standards in the Adult Standards and Guidelines 5.700 and 8.000 and the Juvenile Standards and Guidelines Sections 8.000 and 9.000

These considerations are not to be construed as expectations that the victim must meet in order to move forward with the clarification process.

Background

As a required component of offense-specific treatment outlined by both the SOMB Adult and Juvenile Standards & Guidelines, clarification work can be a multi-step process intended to promote client accountability and offer an opportunity for victims to participate and provide input into the treatment process, in the event they would like to participate. Clarification work is designed to primarily benefit the victim and also serves to promote accountability and healing for the client. Victim participation is never required, and clarification sessions should only occur based on the direction or in the best interest of the victim(s), not the individual who caused harm. Clarification is always victim-centered and based on victim need. The following are considerations for MDTs/CSTs in working with victims and secondary victims who have requested contact, clarification, or reunification. It is important to consider the following areas as a means of ensuring that the victim is able to benefit from the positive effects and healing nature of clarification, and is not placed in a situation that could result in further victimization or could compromise their physical or emotional safety or well-being.

The terms 'victim', 'survivor', or 'person harmed' are commonly used to describe someone who has experienced sexual violence. It is common for individuals to vary in which term they prefer or use to describe themselves. Depending on someone's culture, race, religion, gender, or other lived circumstances, all individuals have the right to choose which term they prefer. Although this document

uses all of the above-listed terms, it is recommended that professionals interacting with those who have experienced sexual violence ask, and use whichever term each individual person prefers.

Ethical Client Care and Considerations for Victim Impact

The clarification process can be difficult, as can many aspects of treatment, and involves a wide range of emotional responses. Clarification work and/or sessions provide an opportunity for growth and healing to both the person harmed and the person who caused harm, and should not be avoided on the basis that it could be uncomfortable or difficult for the client to experience. Professionals working with the individual who has caused harm and the victim or individual harmed should have open communication to review potential dynamics that could result in harm.

A therapist is ethically obligated to protect their client and "do no harm". However, the discomfort and difficult situations some clients may experience in sex offense specific treatment does not necessarily constitute a violation of this ethical tenet to general mental health practices. Part of the treatment process is to help clients navigate difficult situations and respond in non-abusive ways. If there are concerns that releasing the letter could result in harm to the victim or individual who caused harm, or there are disagreements regarding releasing the letter or the content of the letter, the CST/MDT should discuss these concerns and develop a plan for how to mitigate the concerns while still meeting the needs of the victim.

Victim-Centered Care for Clarification and Reunification Work

Each case where clarification occurs will be different. In order to best meet the needs of the victim, teams will need to individualize their approach to each clarification process. Since this process is victim-driven, teams should prioritize any requests made by the victim. Teams are encouraged to be creative during this process. It is important for all members of the CST/MDT to collaborate during the clarification process. The victim representative's involvement in this process is essential to ensuring the team remains victim-centered. The victim representative should be considered the subject matter expert regarding victim needs and information, and teams should defer to their expertise when making decisions that impact the victim. Decisions to determine if a victim is prepared for contact and/or clarification should be based on the input from the victim representative and the victim.

Team Considerations for Gaining Victim Contact Information

Victim contact information may not be initially known. If the MDT/CST does not have victim contact information at the time they are considering contact/clarification, the following are considerations regarding how to obtain the contact information. The MDT/CST should also keep in mind that victim representative contact information can be provided directly to the victim. The preferred point of contact is the victim representative on the team unless the victim has indicated otherwise. Professionals must obtain the victim's permission to release their contact information.

Considerations for Probation Cases:

- The Victim Service Officer (VSO) with the supervising agency will likely be the best initial contact for gaining victim contact information.
- In the event the VSO does not have the victim's contact information or is unable to provide the information in a timely manner, another avenue the MDT/CST can utilize is reaching out to the District Attorney's Office.

Considerations for Department of Corrections (DOC)/Youthful Offender System (YOS) and Parole Cases:

- The SOTMP Victim Liaison will be the best initial contact for gaining victim contact information if the client is in DOC/YOS. The MDT/CST can contact the SOTMP Victim Liaison at doc_sotmp_vl@state.co.us.

Considerations for Division of Youth Services (DYS) cases:

- Contact the DYS Victim Services Coordinator to gain victim contact information if the client is in DYS.

Considerations for DHS/Child Welfare Cases:

- The Caseworker will likely be the best initial contact for gaining victim contact information is the client is in out-of-home placement and being supervised by DHS/Child Welfare.
- In the event that DHS has closed the case at the point of clarification, the CST/MDTs should discuss the appropriate victim advocate of representative to reach out to.

Considerations for Community Corrections Cases:

- In the case that the client is in Community Corrections as a DOC client, the SOTMP Victim Liaison will be the best initial contact for gaining victim contact information.
- In the case that the client is in Community Corrections as a Diversion client, the Case Manager will be the best initial contact for gaining victim contact information.
- CST/MDTs should check with their specific jurisdiction as the above considerations may differ by jurisdiction

Guidance Regarding Protection Orders and Other Court Orders

There is the potential that a court order may prevent contact, clarification, or reunification. When the victim/survivor wants to engage in clarification and/or reunification, the MDT/CST should consider any and all court orders that may prohibit contact to avoid any violations. In every criminal case, there is an initial criminal protection order put in place which prohibits contact, among other thing, with the victim and witnesses. These are often modified during the court proceedings or at a sentencing hearing. A criminal protection order is in place until the complete and final resolution of a case, including the duration of the sentence. Not every criminal protection order contains a no-contact provision. If there is an active criminal protection order in place which contains a no-contact provision with the victim, this must be modified by the Court prior to contact by the client or on the client's behalf (as third-party contact may be considered contact).

A victim may also have obtained a civil protection order via a civil process, which, if granted, automatically contacts a no-contact provision and is permanent, unless the victim has moved the Court to modify or dismiss the civil protection order. This would have to be modified by the victim by filing a motion to modify or dismiss the civil protection order.

A judge may also issue orders concerning contact in divorce or custody proceedings. The client and victim would have knowledge of whether such an order exists at the time either person is seeking contact, clarification, or reunification. If so, they would need to move the issuing Court or modify or dismiss any no-contact provisions of such court orders.

Guidance for Clarification Processes and Contact

A victim/survivor's wishes for clarification work may change as the process progresses. It is important for the professionals to ensure open channels of communication at the beginning of the work to ensure the victim/survivor feels comfortable expressing their needs and sharing if those needs shift. Below is a non-exhaustive list of considerations professionals should discuss with the victim/survivor while preparing for Clarification and check in on the status of throughout the process.

Considerations for discussion with survivor when preparing for Clarification work:

- Desired level of contact with the team and any requests for changes as the process progresses.
- Any concerns that arise as a result of contact.
- Support systems available.
- Previous and ongoing grooming patterns.
- Identify and practice healthy boundaries.
- Non-verbal signs to be aware of.

Clarification Letters

Considerations for discussion with survivor when preparing for clarification letters directly to the victim:

- Willingness to acknowledge and talk about the abuse to a degree that they are able to express what they need in a letter.
- Identifying the impact reading a letter and indirect contact with the offender could have on them.
- Identifying opportunities and avenues for them to advocate for their needs in regards to a clarification letter and indirect contact.

Considerations for discussion with secondary victims and/or family members or representative of the victim when preparing for clarification letter:

- Willingness to acknowledge the secondary harm caused.
- Willingness to acknowledge that the secondary harm is separate from the harm to the victim.
- Identifying the impact reading a letter and indirect contact with the offender could have on them.
- Identifying how they can advocate for their needs in regards to a clarification letter and indirect contact.
- Identifying and talking about any direct harm that was cause through the grooming process or harm caused by the offender to gain access to the victim.

Clarification Sessions

Considerations for discussion with the person victimized when preparing for a clarification session:

- Willingness to express their needs regarding:
    - To what extent would they like to discuss the harm that has occurred.
        - Previous and ongoing grooming patterns.
        - Non-verbal signals for facilitators to be aware of.

- What behaviors they may be seeking accountability for in the event they do not want to discuss the sexually abusive behaviors that occurred in the initial session.
- Logistical considerations of the meeting (platform/location, seating arrangement, etc.).
  - How they would like the meeting to begin and end.
  - How they would like professionals to intervene if they decide to end the meeting unexpectedly (code words, etc.).
- Desired level of contact with the person who harmed them to the team, and any requests for changes as the process progresses.
- What self-care will look like before, during, and after a clarification session.
  - Identify and practice healthy boundaries
  - Support systems available
    - What external resources may be lacking that would further support them in the process (therapy, etc.).
- Opportunities and avenues to express external impacts, pressures, or considerations impacting their ability to clearly express individual needs from clarification session.

Reunification

Family reunification is when the person who caused harm will be residing in the same residence with the victim as defined in the Standards. Reunification may also include other situations in which individuals are not family and/or will not be living in the same home and are still wishing to be reunified. The reunification process does not minimize or ignore the harm that has been caused, but rather recognizes the work that has been completed and systems that have been put in place to ensure safety of the person harmed. Reunification should only occur after careful review of all potential risks and a determination that any clarification work and/or sessions has been completed based on the needs of the person harmed. The MDT/CST should continue to monitor reunification and make adjustments as needed based on information gained, especially considering any external pressures for reunification. The MDT/CST should recommend services based on identified needs and should adjust services based on the needs of the person harmed. It is important to note that reunification does not indicate that completion of treatment and/or services. Please refer to Juvenile Standards Section 9.300 and Adult Standards 5.700.

Considerations for discussion with the person victimized when preparing for reunification:

- Preference for boundaries or parameters of interactions.
- What does safety planning entail?
  - Identifying support systems available.
  - Ability of victim to self-advocate.
  - Ability of victim to identify grooming and boundary testing behaviors

Considerations for discussion with the family system when preparing for family reunification (Refer to the Approved Supervision and Informed Supervision requirements):

- What does safety planning entail?
  - Willingness of the caregiver to engage in ongoing safety planning

  - Willingness of the caregiver to report any future abusive behaviors
  - Ability of victim to self-advocate
  - How will previous grooming behaviors or unhealthy boundaries that contributed to the initial harm be addressed moving forward?
- Identifying support systems available
- Awareness of authority dynamics between adults and children
  - How to navigate when or if pressure is placed on children from family regarding reunification?

Guidance for Secondary Victims and Clarification

While the intention of clarification is to primarily benefit the victim and to promote accountability and healing for the client, it is also important to acknowledge that there may be secondary victims that can benefit from engaging in the clarification process.

Secondary victims may experience traumatic impact due to their loved one's experiences of abuse/assault. These impacts may mirror those of the victim, including feelings of helplessness, anger, a loss of a sense of control, altered world view, increased fear/hypervigilance, and many others. Secondary survivors, especially parents/guardians, may have been subject to grooming, manipulation, and abuse tactics from the client, which can exacerbate traumatic impact. Additionally, abuse can impact family systems, disrupt intrafamilial relationships and may cause disturbances to overall family functioning. Given that secondary survivor's experiences of the trauma will be unique from those of the index victim, it may be important for these experiences to be acknowledged and addresses in the clarification process. In this way, the needs of all those who have been victimized are being addressed, and the client can better demonstrate accountability for the breadth and complexity of harm cause by their abusive behavior.

Discussion Point: The non-offending parent or lawful guardian of minor victims are statutorily defined as victims in the Colorado Victims Rights Act.

Especially in cases that involve a pre-existing relationship and/or prolonged grooming behaviors, it is important for professionals guiding clarification work to proactively engage in conversations with both the offender and victim to identify behaviors or dynamics that may have played a part in the abuse that has occurred but than any external party may not be aware of.

Additionally, in the event the victim's support system may be directly impacted by the outcome of clarification/reunification (i.e. guardian, family member, etc.), it is important to ensure that the victim's needs are directly identified. The victim representative should have conversations within the support system about the importance of clarification needs being clearly communicated by the victim as to uphold the intention of clarification for the offender to address the victim's needs. In some cases, there may be added benefit by offering a separate clarification with the support system to ensure each party's needs are being addressed.

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Appendix C: Young Adult Modification Protocol

Young Adult Modification Protocol[150]

The SOMB recognizes that due to responsivity[151] 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.[152,153,154,155,156,157,158,159]

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

[150] 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

[151] 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.

[152] Teicher, M., Anderson, S., Polcari, A., Anderson, C., & Navalta, C. (2002). Developmental

neurobiology of childhood stress and trauma. *Psychiatric Clinics of North America,* 25, 397-426.

[153] 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).

[154] Siegel, D.J. (2006). Brain, mind, and behavior. In D. Wedding & M. Stuber (Eds.), *Behavior and Medicine, Fourth Edition*. Cambridge, MA: Hogrefe & Huber.

[155] 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.

[156] 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

[157] Steinberg, L. (2008). A social neuroscience perspective on adolescent risk-taking. *Developmental Review, 28,* 78-106.

[158] 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.

[159] 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.

and manages risks. Such assessment should include strengths and protective factors.[160] 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.[161]

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.

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[160] 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.

[161] 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[162] 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.

[162] 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.

Further, participants' response to treatment will be enhanced by effortful attendance to their individual learning style, abilities and culture."[163]

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.

[163] 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.

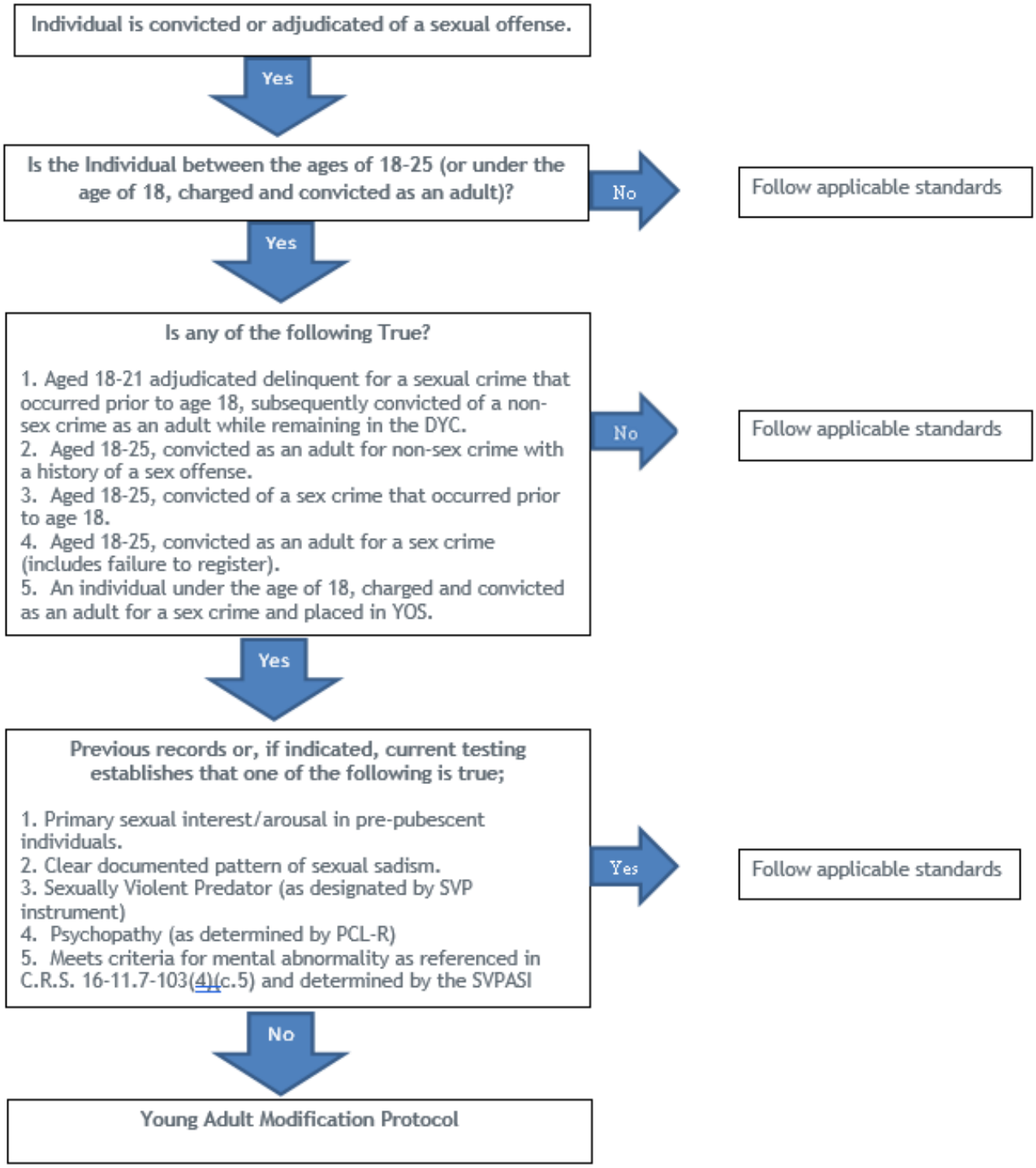
Yes___ No___ _ Clear and documented pattern of sexual sadism.

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.

Young Adult Modification Protocol Criteria Flow Chart



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Appendix D: Guidelines for the Use of Sexually Stimulating Materials

Applicable Standards from the *Standards and Guidelines for the Assessment, Evaluation, Treatment and Behavioral Monitoring of Adult Sex Offenders (Adult Standards):*

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

A. Offenders shall not access, possess, utilize, or subscribe to any sexually oriented material or material related to their offending behavior to include, but not limited to, mail, computer, television, or telephone, nor patronize any place where such material or entertainment is available

5.110 As soon as possible after the conviction and referral of a sex offender to probation, parole, or community corrections, the supervising officer should convene a Community Supervision Team (CST) to manage the offender during his/her term of supervision.

A. Community and victim safety, and risk management are paramount when making decisions about the management and/or treatment of offenders.

Applicable Standards (i.e., Additional Conditions of Supervision) from the *Standards and Guidelines for the Evaluation, Assessment, Treatment and Supervision of Juveniles Who Have Committed Sexual Offenses (Juvenile Standards):*

Appendix K (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 K (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 abusive, illegal and/or harmful 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 abusive, illegal and/or harmful 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. Abusive, illegal and/or harmful sexual arousal/interest based upon assessment arousal/interest assessment, where appropriate. Materials related to the pattern of offending or that contribute to abusive, illegal and/or harmful sexual arousal/interest should always be prohibited.

E. Engagement in treatment and compliance with supervision, including progress and openness related to sexuality issues and activity, and reported use of sexually oriented or stimulating materials, as verified by monitoring polygraph and other forms of monitoring where appropriate. In addition, the presence or recurrence of denial of the facts of the underlying offense.

The process of approving the use of sexually stimulating materials is fluid in nature and should be discussed with the client throughout the supervision and treatment process, and continued monitoring to assure the goals of promoting healthy sexual and community safety is necessary. The CST/MDT should rescind approval for access to sexually stimulating materials as dictated by the behavior of or any regression in treatment or supervision by the adult or juvenile who has sexually offended.

The conditions of probation and parole as well as the treatment contract may currently contain language prohibiting possession or use of most of the materials pertinent to this Appendix. The conditions of probation are essentially orders of the Court once a judge signs them and cannot be changed or amended without authority of the court. Conditions of parole are similar in

nature to probation and must be approved by the Parole Board. Therefore, any modification must be approved by the judge or parole board. The treatment contract of each agency is probably the easiest to amend of all the documents, as it is signed by the adult or juvenile who has sexually offended at the beginning of treatment. Any approval of the use of sexually stimulating materials must be reflected in a modification to the treatment contract and plan, and if allowable by order of the Court or Parole Board, reflected in the probation or parole file.

Healthy Sexuality:

Many treatment curriculums for adults and juveniles who have sexually offended include a component on the development of healthy sexuality. The following information is offered to approved treatment providers working with this population.

Sexual Expression

Human beings are sexual beings. Sexuality and sexual expression are integrally intertwined and inseparable from other fundamental human characteristics, specifically intimacy, interpersonal connectedness, belonging, and attachment. Healthy humans desire to be involved in relationships. Sexual expression is a part of intimate romantic relationships. Not everyone is capable of the reciprocity or other social skills that relationships entail, and often a sexual intimate relationship is not available to individuals for a number of reasons. However, therapy targets helping people move in the direction of being able to engage in reciprocal and mutual relationships.

Masturbation

Masturbation is often employed as a way to supplement sexual expression in a relationship or in lieu of being able to gratify sexual needs in a relationship. Masturbation (when not compulsive and done privately) is a natural and healthy practice to express sexuality and gratify or relieve sexual needs/tension. Masturbation can serve as a means of reducing sexual needs that could become expressed in less appropriate or more harmful ways. As people do masturbate, stimuli for masturbation need to be based on healthy themes, such as closeness, intimacy, mutuality, reciprocity, and safety. This does not rule out visual stimuli which are ubiquitous. Prohibiting stimulating materials is problematic and impossible. Instead it is a task of treatment to determine which materials are "inappropriate," by not reinforcing the values and principles stated herein (e.g., mutuality, reciprocity, safety, etc.). On the other hand, stimuli that reinforce these values are not problematic. It is not the goal of treatment to eliminate sexuality or sexual expression, rather to direct it to appropriate themes.

Teaching Healthy Sexuality

Treatment providers address healthy sexuality in a number of ways. One way is by discussing sexual needs, preferences and expression in an open nonjudgmental manner. This serves as *modeling* in that the client can observe a therapist discuss sexuality in a mature, open and non-defensive manner; the client learns to do the same. Sexual expression needs to be discussed in a treatment setting.

Sexual Diversity

Cultural, social and individual differences are accepted in healthy sexuality and one shows respect for these differences. As long as it is not harmful activity, a healthy attitude is open to the fact that others have needs that are not like our own. Examples are represented in the G.L.B.T.Q. community; there should be no discrimination on the basis of orientation and preference when they are legal and not harmful to others.

Healthy Boundaries, Roles, and Safe Sex

Consent is quintessential to healthy sexual expression. Consent involves equality of the individuals to make informed decisions. People are always very different from one another but must be equal in their ability to consent to engage in sexual behavior with one another. Consent involves *communication in advance* of what will take place (sexual activity) between two individuals. It involves mutuality and reciprocity. Large disparities in power and influence are antithetical to these principles. Likewise, the needs and desires of both parties are negotiable and negotiated; an agreement is reached prior to the activity ensuing. Similarly, activities that are not permissible must be communicated and respected. Education related to issues of consent and barriers to consent including impairment due to alcohol or drug consumption, and the intellectual capacity of both parties should be addressed. Safe sexual practices are a requirement of healthy sexuality.

CONCLUSION:

This appendix has attempted to clarify the differences between sexually oriented or explicit materials from sexually stimulating materials. While the former is prohibited by terms and conditions of supervision and the treatment contract, the latter may be allowed at some point in treatment and supervision based upon the suggested criteria in this Appendix. In addition, the exploration of concepts related to healthy sexuality are seen as critical for the therapeutic rehabilitation of the adult or juvenile who has sexually offended.

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Appendix E: Sexual Offense History Decision Aid

Guidelines for Evaluation of Juvenile or Adult Males Who Have Committed Sex Offenses as a Juvenile Only and Have a New Non-Sex Crime

These guidelines are for sex offense-specific evaluations of juvenile or adult males who have a past sex offense as a juvenile only[164] and a new non-sex crime, who meet the statutory definition of a sex offender. These guidelines also apply to juvenile or adult males who have a past sex offense as a juvenile only and who are convicted of Failure to Register.[165]

Per statute, all sex offenders in the state of Colorado "as part of the presentence or probation investigation (are) required pursuant to section 16-11-103, to submit to an evaluation for treatment, an evaluation for risk, procedures required for monitoring of behavior to protect the victims, and potential victims, and an identification developed pursuant to section 16-11.7-103 (4)." Further, all sex offenders in the state of Colorado are required, as part of any sentence to probation, commitment to the Department of Human Services, sentence to community corrections, incarceration with the Department of Corrections, placement on parole, or out-of-home placement to "undergo treatment to the extent appropriate to such offender based upon the recommendations of the evaluation and identified made pursuant to section 16-11.7-104…"[166] Finally, it is noted that sex offenders sentenced to community supervision (probation or parole) may be supervised by specialized sex offender supervision officers and subject to some or all of the specialized terms and conditions of supervision developed for sex offenders.[167]

INTRODUCTION

The ***Guidelines for Evaluation of Juvenile or Adult Males Who Have Committed Sex Offenses as a Juvenile Only and Have a New Non-Sex Crime*** includes a series of protocols and a decision aid. The Guidelines are designed to be used with the applicable Colorado SOMB Standards and Guidelines for the Evaluation, Assessment, Treatment, and Supervision of Juveniles Who Have Committed Sexual Offenses (hereafter referred to as the SOMB Juvenile Standards and Guidelines). The Guidelines are provided to assist Evaluators in meeting the SOMB Juvenile Standards and Guidelines when these evaluations are requested but are not a required protocol.

GUIDELINE PROTOCOLS

[164] The juvenile standards apply when the past sex offending was committed when a juvenile only and no sex offenses have been convicted or adjudicated as an adult.

[165] Failure to register is a new non-sex offense criminal conviction.

[166] 236 See 16-11.7-105 C.R.S.

[167] 237 See 18-1.3-1007 C.R.S.

Use of SOMB Approved Evaluators

A Juvenile Evaluator should be used if both the current non-sex crime, including Failure to Register, and the most recent sex offense are adjudicated as a juvenile (i.e., prior to age 18 years).

An Adult Evaluator should be used if the current non-sex crime, including Failure to Register, occurred as an adult (i.e., when 18 years or older) and the most recent sexual offense was adjudicated as a juvenile. Although the client is an adult, the SOMB Juvenile Standards and Guidelines apply as the past sex offense was adjudicated as a juvenile. Ideally, an Evaluator with both Juvenile and Adult listed provider status is used, but when unavailable, the Adult-listed Evaluator should consult with a Juvenile-listed provider. The consultation should be documented in the client record and evaluation. For young adults aged 18-25 years, Evaluators should also consult the SOMB Young Adult Modification Protocol.

For further discussion and clarification about the correct application of the SOMB Juvenile and Adult Standards and Guidelines see the SOMB Bulletin *Applicability of the Adult or Juvenile Standards for Individuals Meeting the Definition of a Sexual Offender (16-11.7-102)*, dated June 5, 2014.

Multidisciplinary Collaboration

The Evaluator should seek relevant background information, including the discharge summary, from the prior Multi-Disciplinary Team (MDT) and any adjunct treatment providers, if available. Evaluators are encouraged to use judgment in the amount of effort given if the information is difficult to obtain. Evaluations should not be unnecessarily delayed when prior treatment information is unavailable.

The Evaluator should document the information obtained from other sources in the evaluation and document unsuccessful attempts to gain information in the client record.

The Evaluator should be available to consult with the PSI Officer to answer questions about the evaluation and to review the treatment recommendations as needed.

If the evaluation is before the individual enters a plea, the evaluation may need updating following conviction and sentencing. If the Evaluator who completed the pre-plea evaluation is no longer available, a new Evaluator can complete the update.

Evaluator Competency

Evaluators should be familiar with this Appendix and the applicable SOMB Adult and Juvenile Standards and Guidelines.

DECISION AID

The decision aid is to assist Evaluators and for use in conjunction with the applicable Colorado SOMB Juvenile Standards and Guidelines. While available to use, it is not a required protocol. Evaluators should use clinical judgment when determining the most appropriate evaluation of the client and when making recommendations within the requirements of the SOMB Juvenile Standards and Guidelines Section 2.000. The evaluation should give due consideration *within an overall assessment of risk* to the past sexual offending, the amount of time residing sex offense-free in the community, and the new nonsexual offending.

When using the decision aid or other methods, Evaluators should take care to consider individual differences and the potential impact on the suitability of assessment instruments, recidivism risk, and desistance processes. Individual differences include race-ethnicity, immigration status, sexual orientation, gender identity, mental health, developmental-cognitive disabilities, and physical disabilities. Evaluators should also take care to ensure any assessment instruments used are normed and validated for the appropriate age group. For evaluations of adults with a juvenile sex offense, adult sex offending risk instruments are typically not appropriate when the sex offense occurred only as a juvenile.[168] Juvenile sexual offending risk instruments are also typically not appropriate for use with adults.[169]

The decision aid incorporates research on juvenile sexual recidivism risk, desistance, and protective factors, alongside existing research and best practices.[170] Of relevance, research finds the sexual recidivism rate for male juveniles is lower than for male adults. Sexual recidivism estimates typically range from under 3% up to 9% over long follow-up periods (e.g., up to 20 years). Consistent with this, developmental life-course studies show most male juveniles who commit a sex offense are adolescent-limited and desist by adulthood. Nonetheless, that research also shows a small proportion do persist and sexually offend in adulthood. Consequently, a large proportion of male juveniles convicted or adjudicated of a sex offense are low risk, while a small group presents a higher risk.

Research on rates of violent and general offending indicates many males with a juvenile sex offense conviction or adjudication commit other delinquent and non-sex offenses.[171] Developmental life-course studies indicate that for some individuals, non-sexual violent and general offending will persist while sex offending desists. Thus, determining the type of offending trajectory the individual presents can help inform treatment recommendations. In cases where the offending pattern indicates elevated sexual recidivism risk, sex offense-specific treatment is indicated. In cases where the offending pattern indicates low sexual recidivism risk but higher risk for other violence or general offending,

[168] For example, the Static-99R is designed for use with adult males and is not recommended for young male adults less than 18 years old at the time of release. The *Static-99R manual 2016* discusses the limitations of use with adolescents who committed a sexual offense and who are released once 18 or older. The VASOR-2 and SOTIPS are designed for use with adult males who committed a qualifying sexual offense when 18 years or older.

[169] For example, the J-SOAP-II is designed for use with boys aged 12-18 years of age who have been adjudicated for sexual offenses or have a history of sexually coercive behavior.

[170]Caldwell, M. F. (2016). Quantifying the decline in juvenile sexual recidivism rates. *Psychology, Public Policy, & Law, 22*(4), 414-426; Lobanov-Rostovsky, C. (2015). *Recidivism of juveniles who commit sexual offenses*. SOMAP Research Brief: US Department of Justice, Office of Justice Programs; Lussier, P. McCuish, E., & Corrado, R. R. (2015). The adolescence-adulthood transition and desistance from crime: Examining the underlying structure of desistance. *Journal of Life Course Criminology, 1*, 87-117; Lussier, P., Van Den Berg, C., Bijleveld, C., & Hendriks, J. (2012). A developmental taxonomy of juvenile sex offenders for theory, research, and prevention: The adolescent-limited and high-rate slow desister. *Criminal Justice & Behavior, 39*(12), 1559-1581; Ozkan, T., Clipper, S. J., Piquero, A. R., Baglivio, M., & Wolff, K. (2020). Predicting sexual recidivism. *Sexual Abuse: A Journal of Research & Treatment, 32*(4), 375-399; Schwartz-Mette, Righthand, J. H., Dore, G., & Huff, R. (2020). Long-term predictive validity of the Juvenile Sex Offender Assessment Protocol-II: Research and practice implications. *Sexual Abuse: A Journal of Research & Treatment, 32*(5), 499-520; Worling, J. R., Littlejohn, A., & Bookalam, D. (2010). 20-year prospective follow-up study of specialized treatment for adolescents who offended sexually. *Behavioral Sciences and the Law, 26*, 46-57.

[171] Caldwell, M. F. (2016). Quantifying the decline in juvenile sexual recidivism rates. *Psychology, Public Policy, & Law, 22*(4), 414-426; Lussier, P. McCuish, E., & Corrado, R. R. (2015). The adolescence-adulthood transition and desistance from crime: Examining the underlying structure of desistance. *Journal of Life Course Criminology, 1*, 87-117; Lussier, P., Van Den Berg, C., Bijleveld, C., & Hendriks, J. (2012). A developmental taxonomy of juvenile sex offenders for theory, research, and prevention: The adolescent-limited and high-rate slow desister. *Criminal Justice & Behavior, 39*(12), 1559-1581; Ozkan, T., Clipper, S. J., Piquero, A. R., Baglivio, M., & Wolff, K. (2020). Predicting sexual recidivism. *Sexual Abuse: A Journal of Research & Treatment, 32*(4), 375-399; Schwartz-Mette, Righthand, J. H., Dore, G., & Huff, R. (2020). Long-term predictive validity of the Juvenile Sex Offender Assessment Protocol-II: Research and practice implications. *Sexual Abuse: A Journal of Research & Treatment, 32*(5), 499-520; Worling, J. R., Littlejohn, A., & Bookalam, D. (2010). 20-year prospective follow-up study of specialized treatment for adolescents who offended sexually. *Behavioral Sciences and the Law, 26*, 46-57.

interventions to address non-sexual offending may be more appropriate.[172] In some cases, the overall risk may be low, and no treatment recommendations will be indicated. For example, when the client has lived without known offending for many years in the community and the new non-sex crime was due to situational or personal factors that have been sufficiently resolved.

Structured, empirically-informed juvenile risk assessment instruments are available to guide the assessment of risk and protective factors in male *juveniles*. Few have actuarial risk tables and so do not provide recidivism estimates.[173] A contributing factor is that it is technically challenging to distinguish juveniles who sexually recidivate from those who desist when the overall rate of juvenile sexual recidivism is low. Research on specific risk factors supports that deviant sexual interest or preoccupation is associated with higher rates of sexual recidivism and that treatment completion is associated with lower rates of sexual recidivism.[174]

Juvenile sex-offending risk instruments are not appropriate for use with adults, and adult sex-offending risk instruments are typically not appropriate when the sex offense occurred only as a juvenile.[175] Thus, the evaluation of male adults with a past juvenile sex offense primarily involves a clinical assessment.

[172] Kettrey, H. H. & Lipsey, M. W. (2018). The effects of specialized treatment on the recidivism of juvenile sex offenders: A systematic review and meta-analysis. *Journal of Experimental Criminology, 14*(3), 1-27.

[173] Barra, S., Bessler, C., Landolt, M. A., Aebi, M. (2018). Testing the validity of criminal risk assessment tools in sexually abusive youth. *Psychological Assessment, 30*(11), 1430-1443; Caldwell, M. F. (2016). Quantifying the decline in juvenile sexual recidivism rates. *Psychology, Public Policy, & Law, 22*(4), 414-426; Schwartz-Mette, Righthand, J. H., Dore, G., & Huff, R. (2020). Long-term predictive validity of the Juvenile Sex Offender Assessment Protocol-II: Research and practice implications. *Sexual Abuse: A Journal of Research & Treatment, 32*(5), 499-520.

[174] Kettrey, H. H. & Lipsey, M. W. (2018). The effects of specialized treatment on the recidivism of juvenile sex offenders: A systematic review and meta-analysis. *Journal of Experimental Criminology, 14*(3), 1-27; Kim, B., Benekos, P. J., Merlo, A. V. (2015). Sex offender recidivism revisited: Review of recent meta-analyses on the effects of sex offender treatment. *Trauma, Violence, & Abuse, Jan*, 1-13; Olver, M. E., Stockdale, K. C., & Wormith, J. S. (2011). A meta-analysis of predictors of offender treatment attrition and its relationship to recidivism. *Journal of Consulting and Clinical Psychology, 79*(1), 6-21; Ozkan, T., Clipper, S. J., Piquero, A. R., Baglivio, M., & Wolff, K. (2020). Predicting sexual recidivism. *Sexual Abuse: A Journal of Research & Treatment, 32*(4), 375-399; Ralston, C. A., & Epperson, D. L. (2013). Predictive validity of adult risk assessment tools with juveniles who offended sexually. *Psychological Assessment, 25*(3), 905-916; Schwartz-Mette, Righthand, J. H., Dore, G., & Huff, R. (2020). Long-term predictive validity of the Juvenile Sex Offender Assessment Protocol-II: Research and practice implications. *Sexual Abuse: A Journal of Research & Treatment, 32*(5), 499-520; Worling, J. R., Littlejohn, A., & Bookalam, D. (2010). 20-year prospective follow-up study of specialized treatment for adolescents who offended sexually. *Behavioral Sciences and the Law, 26*, 46-57.

[175] One exception is the possible use of the Static-99R when a juvenile committed the sexual offense when 17 years of age and was released when 18 or older. See the *Static-99R manual 2016* for a discussion of the limitations of the use of the Static-99R with juveniles.

Decision Aid Format

The decision aid is illustrated in a flowchart that outlines three main phases.

The first phase involves evaluating the individual's current sexual recidivism risk following the period in the community sex offense-free.

The past evaluation for the most recent sex offense should be obtained, if available. The past evaluation should be updated to be current. When the most recent sex offense was adjudicated as a juvenile, evaluations completed 6 months or more ago should be updated. If the past evaluation is unavailable or unsuitable, a new evaluation of the current sexual recidivism risk should be conducted. The new evaluation should be consistent with the SOMB Juvenile Standards and Guidelines Section 2.000. The evaluation should give due consideration *within an overall assessment of risk* to potential static and dynamic risk factors, protective factors, and strengths. The evaluation should include due consideration of the time sex offense-free in the community and the new nonsexual offending.

For clients who are male juveniles, a structured, empirically informed juvenile risk assessment instrument should be used where suitable. For clients who are male adults, the evaluation will be primarily a clinical assessment of relevant factors. However, other instruments that assess non-sexual recidivism risk or psychological factors that are validated with male adults may be appropriate where relevant.

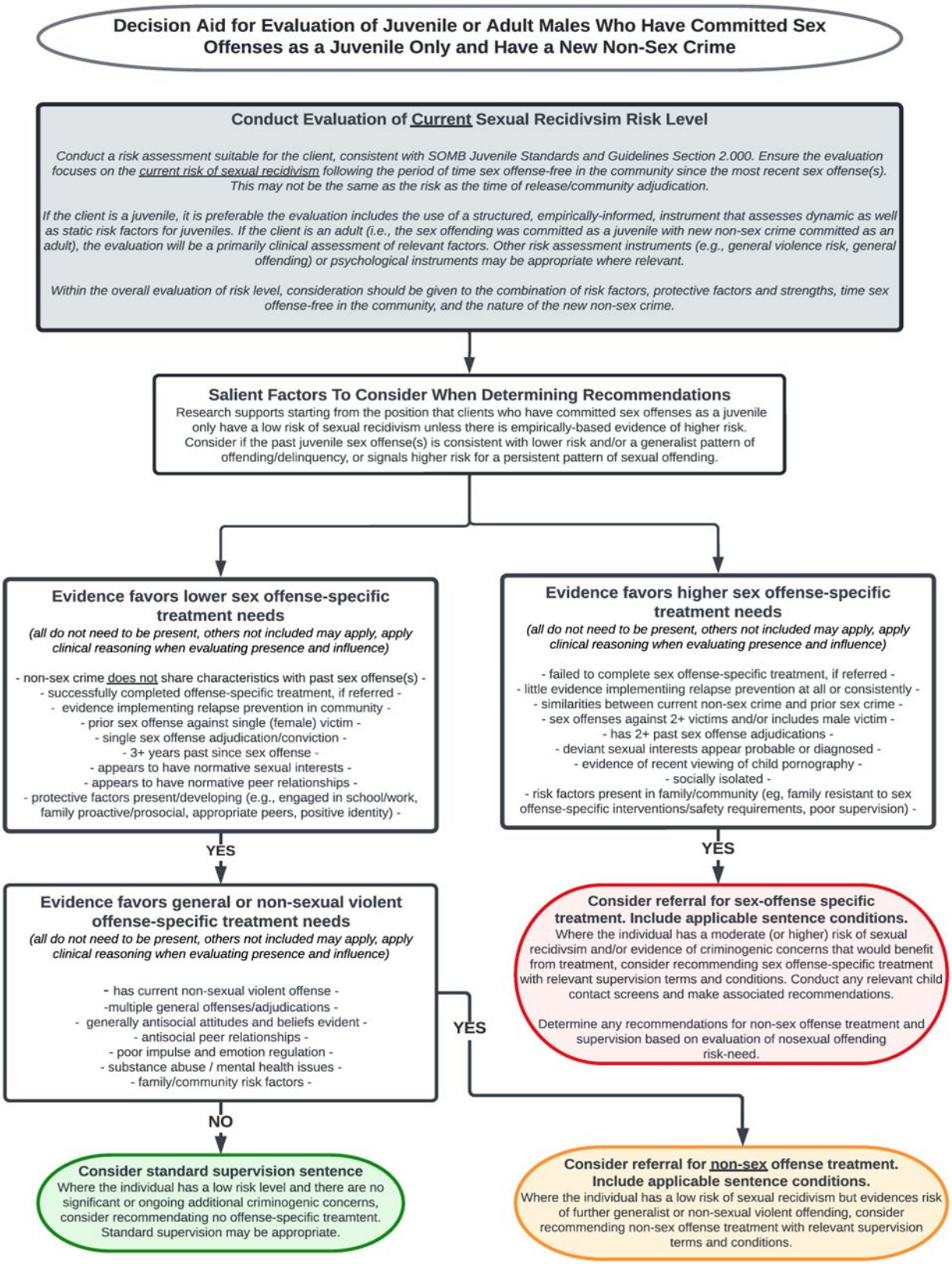
The second phase involves considering additional factors that influence the need for any current sex offense-specific treatment.

Research on base rates supports the position that males with a past juvenile sex offense have a low risk of sexual recidivism unless there is empirically-based evidence of higher risk. The factors listed that favor desistance or low offense-specific intervention needs are not exhaustive. Similarly, the factors listed that favor the presence of offense-specific intervention needs is not exhaustive. Other considerations may apply to specific individuals. Evaluators should use their clinical judgment. The considerations need not be "all present" or "all absent" to proceed through the pathways. Instead, they are factors to consider when determining the best combination of recommendations. Evaluators should apply clinical judgment in determining their significance.

The third phase involves considering the appropriate treatment recommendations.

The intention is for final treatment and sentence recommendations to be matched to the risk-need level of the individual, taking into consideration treatment responsivity and non-sexual offending patterns. The options are recommendations for standard supervision only, non-sex offense treatment (e.g., substance abuse or violence prevention), or sex offense-specific treatment. Any sex offense-specific treatment recommendations shall be consistent with the applicable SOMB Juvenile Standards and Guidelines Section 2.000.

Evaluators may assess other non-sex offending treatment needs. When doing so, Evaluators should use reliable and validated methods appropriate for the client to screen or assess non-sex offending risk, criminogenic needs, and related psychosocial factors. The presence, type, and severity of criminogenic needs associated with non-sex offending may be distinct from, or overlap, those for sex offending. Where sex offense-specific and nonsexual offending treatment needs coexist, Evaluators should consider the combination and sequencing of treatment recommendations.


Decision Aid for Evaluation of Juvenile or Adult Males Who Have Committed Sex Offenses as a Juvenile Only and Have a New Non-Sex Crime
Conduct Evaluation of Current Sexual Recidivsim Risk Level
Conduct a risk assessment suitable for the client, consistent with SOMB Juvenile Standards and Guidelines Section 2.000. Ensure the evaluation focuses on the current risk of sexual recidivism following the period of time sex offense-free in the community since the most recent sex offense(s). This may not be the same as the risk as the time of release/community adjudication.
If the client is a juvenile, it is preferable the evaluation includes the use of a structured, empirically-informed, instrument that assesses dynamic as well as static risk factors for juveniles. If the client is an adult (i.e., the sex offending was committed as a juvenile with new non-sex crime committed as an adult), the evaluation will be a primarily clinical assessment of relevant factors. Other risk assessment instruments (e.g., general violence risk, general offending) or psychological instruments may be appropriate where relevant.
Within the overall evaluation of risk level, consideration should be given to the combination of risk factors, protective factors and strengths, time sex offense-free in the community, and the nature of the new non-sex crime.
Salient Factors To Consider When Determining Recommendations
Research supports starting from the position that clients who have committed sex offenses as a juvenile only have a low risk of sexual recidivism unless there is empirically-based evidence of higher risk. Consider if the past juvenile sex offense(s) is consistent with lower risk and/or a generalist pattern of offending/delinquency, or signals higher risk for a persistent pattern of sexual offending.
Evidence favors lower sex offense-specific treatment needs
(all do not need to be present, others not included may apply, apply clinical reasoning when evaluating presence and influence)
- non-sex crime does not share characteristics with past sex offense(s) -
- successfully completed offense-specific treatment, if referred -
- evidence implementing relapse prevention in community -
- prior sex offense against single (female) victim -
- single sex offense adjudication/conviction -
- 3+ years past since sex offense -
- appears to have normative sexual interests -
- appears to have normative peer relationships -
- protective factors present/developing (e.g., engaged in school/work, family proactive/prosocial, appropriate peers, positive identity) -
YES
Evidence favors general or non-sexual violent offense-specific treatment needs
(all do not need to be present, others not included may apply, apply clinical reasoning when evaluating presence and influence)
- has current non-sexual violent offense -
-multiple general offenses/adjudications -
- generally antisocial attitudes and beliefs evident -
- antisocial peer relationships -
- poor impulse and emotion regulation -
- substance abuse / mental health issues -
- family/community risk factors -
NO
Consider standard supervision sentence
Where the individual has a low risk level and there are no significant or ongoing additional criminogenic concerns, consider recommendating no offense-specific treamtent. Standard supervision may be appropriate.
Evidence favors higher sex offense-specific treatment needs
(all do not need to be present, others not included may apply, apply clinical reasoning when evaluating presence and influence)
- failed to complete sex offense-specific treatment, if referred -
- little evidence implementiing relapse prevention at all or consistently -
- similarities between current non-sex crime and prior sex crime -
- sex offenses against 2+ victims and/or includes male victim -
- has 2+ past sex offense adjudications -
- deviant sexual interests appear probable or diagnosed -
- evidence of recent viewing of child pornography -
- socially isolated -
- risk factors present in family/community (eg, family resistant to sex offense-specific interventions/safety requirements, poor supervision) -
YES
Consider referral for sex-offense specific treatment. Include applicable sentence conditions.
Where the individual has a moderate (or higher) risk of sexual recidivsim and/or evidence of criminogenic concerns that would benefit from treatment, consider recommending sex offense-specific treatment with relevant supervision terms and conditions. Conduct any relevant child contact screens and make associated recommendations.
Determine any recommendations for non-sex offense treatment and supervision based on evaluation of nosexual offending risk-need.
YES
Consider referral for non-sex offense treatment. Include applicable sentence conditions.
Where the individual has a low risk of sexual recidivism but evidences risk of further generalist or non-sexual violent offending, consider recommending non-sex offense treatment with relevant supervision terms and conditions.

Guidelines for Evaluation of Adult or Juvenile Females Who Have Committed Sex Offenses and Have a New Non-Sex Crime

These guidelines are for sex offense-specific evaluations of adult or juvenile females who have a past sex offense and a new non-sex crime, who meet the statutory definition of a sex offender. These guidelines also apply to adult or juvenile females with a past sex offense who are convicted of Failure to Register.[176]

Per statute, all sex offenders in the state of Colorado "as part of the presentence or probation investigation (are) required pursuant to section 16-11-103, to submit to an evaluation for treatment, an evaluation for risk, procedures required for monitoring of behavior to protect the victims, and potential victims, and an identification developed pursuant to section 16-11.7-103 (4)." Further, all sex offenders in the state of Colorado are required, as part of any sentence to probation, commitment to the Department of Human Services, sentence to community corrections, incarceration with the Department of Corrections, placement on parole, or out-of-home placement to "undergo treatment to the extent appropriate to such offender based upon the recommendations of the evaluation and identified made pursuant to section 16-11.7-104…"[177] Finally, it is noted that sex offenders sentenced to community supervision (probation or parole) may be supervised by specialized sex offender supervision officers and subject to some or all of the specialized terms and conditions of supervision developed for sex offenders.[178]

INTRODUCTION

The ***Guidelines for Evaluation of Adult and Juvenile Females Who Have Committed Sex Offenses and Have a New Non-Sex Crime*** includes a series of protocols and a decision aid. The Guidelines are designed to be used with the applicable Colorado SOMB Standards and Guidelines for the Evaluation, Assessment, Treatment, and Behavioral Monitoring of Adult Sexual Offenders (hereafter referred to as the SOMB Adult Standards and Guidelines) and the Colorado SOMB Standards and Guidelines for the Evaluation, Assessment, Treatment, and Supervision of Juveniles Who Have Committed Sexual Offenses (hereafter referred to as the SOMB Juvenile Standards and Guidelines). The Guidelines are provided to assist Evaluators in meeting the SOMB Standards and Guidelines when these evaluations are requested but are not a required protocol.

GUIDELINE PROTOCOLS

Use of SOMB Approved Evaluators

An Adult Evaluator should be used when the current non-sex crime, including Failure to Register, and the most recent sex offense, occurred when 18 years or older.

An Adult Evaluator should be used if the current non-sex crime, including Failure to Register, occurred as an adult (i.e., when 18 years or older) and the most recent sexual offense was adjudicated as a juvenile. The SOMB Juvenile Standards and Guidelines apply, however, as the past sex offense was

[176] Failure to register is a new non-sex offense criminal conviction.

[177] 236 See 16-11.7-105 C.R.S.

[178] 237 See 18-1.3-1007 C.R.S.

adjudicated as a juvenile. Ideally, an Evaluator with both Juvenile and Adult listed provider status is used, but when unavailable, the Adult-listed Evaluator should consult with a Juvenile-listed provider. The consultation should be documented in the client record and evaluation. For young adults aged 18-25 years, Evaluators should also consult the SOMB Young Adult Modification Protocol.

A Juvenile Evaluator should be used if both the current non-sex crime, including Failure to Register, and the most recent sex offense are adjudicated as a juvenile.

For further discussion and clarification about the correct application of the juvenile and adult standards, see the SOMB Bulletin *Applicability of the Adult or Juvenile Standards for Individuals Meeting the Definition of a Sexual Offender (16-11.7-102)*, dated June 5, 2014.

Multidisciplinary Collaboration

The Evaluator should seek relevant background information, including the discharge summary, from the prior Community Supervision Team (CST) or Multi-Disciplinary Team (MDT), as well as any adjunct treatment providers, if available. Evaluators are encouraged to use judgment in the amount of effort given if the information is difficult to obtain. Evaluations should not be unnecessarily delayed when prior treatment information is unavailable.

The Evaluator should document the information obtained from other sources in the evaluation and document unsuccessful attempts to gain information in the client record.

The Evaluator should be available to consult with the PSI Officer to answer questions about the evaluation and to review the treatment recommendations as needed.

If the evaluation is before the individual enters a plea, the evaluation may need updating following conviction and sentencing. If the Evaluator who completed the pre-plea evaluation is no longer available, a new Evaluator can complete the update.

Evaluator Competency

Evaluators should be familiar with this Appendix, the applicable SOMB Adult and Juvenile Standards and Guidelines, and the SOMB Adult Appendix M: Female Sex Offender Risk Assessment.

DECISION AID

The decision aid is to assist Evaluators and for use in conjunction with the applicable Colorado SOMB Adult and Juvenile Standards and Guidelines. While available to use, it is not a required protocol. Evaluators should use clinical judgment when determining the most appropriate evaluation of the client and when making recommendations within the requirements of the SOMB Adult and Juvenile Standards and Guidelines Section 2.000 and the SOMB Adult Appendix M: Female Sex Offender Risk Assessment. The evaluation should give due consideration *within an overall assessment of risk* to the past sexual offending, the amount of time residing sex offense-free in the community, and the new non-sex crime.

When using the decision aid or other methods, Evaluators should take care to consider individual differences and the potential impact on the suitability of assessment instruments, recidivism risk, and desistance processes. Individual differences include race-ethnicity, immigration status, sexual

orientation, gender identity, mental health, developmental-cognitive disabilities, and physical disabilities. Evaluators should also take care to ensure any assessment instruments used are normed and validated for the appropriate age group and female gender.[179]

The decision aid incorporates research on female sexual recidivism risk alongside existing research and best practice. Although the research with females is less developed than with males, some consistent findings have emerged. The sexual and violent recidivism rate for females is much lower than for males. Studies show the sexual recidivism rate is typically 1-3% over 5 to 10-year follow-up periods, excluding prostitution-related offenses.[180] This rate is about 4-5 times lower than male adults convicted of sex offending and lower than male juveniles convicted of sex offending. Consequently, the prototypical female convicted or adjudicated of a sex offense falls within the low-risk classification.[181]

For the subgroup of females whose conviction involves prostitution of a child or minor, research finds a higher number within the relatively small group of female sexual recidivists.[182] The most likely explanation is these crimes involve a significant economic element, and the perpetrators have higher levels of general criminality.[183] Research also shows females convicted of a sex offense have relatively low violent recidivism rates, commonly in the range of 4-8% inclusive of sexual recidivism.[184] The rates of any re-offense range from 10%-50% but with a substantial proportion involving more minor offenses.[185]

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[179] For example, the Static-99R, VASOR-2, SOTIPS, and J-SOAP-II risk assessment instruments are all designed and normed for males and not suitable for use with females.

[180] Cortoni, F., Hanson, R. K., & Coache, M. E. (2010). The recidivism rates of female sexual offenders are low: A meta-analysis. *Sexual Abuse: A Journal of Research & Treatment, 22*(4), 387-401; Epperson, E., Fuller, N., & Phenix, A. (2018). *Female sexual offender recidivism: An empirical analysis of registered female sex offenders in California.* SARATSO; McGinnis, W. J. (2015). *The validity of the Iowa sex offender risk assessment for predicting recidivism in female sexual offenders.* [Doctoral Thesis, University of Iowa]. University of Iowa Research Repository; Miller, H. A., & Marshall, E. A. (2019). Comparing solo- and co-offending female sex offenders on variables of pathology, offense characteristics, and recidivism. *Sexual Abuse, 31*(8), 972-990; Sandler, J. C., & Freeman, N. J. (2009). Female sex offender recidivism: A large-scale empirical analysis. *Sexual Abuse: A Journal of Research & Treatment, 21(*4), 455-473.

[181] Although they may have a range of criminogenic and non-criminogenic needs.

[182] Cortoni, F., Hanson, R. K., & Coache, M.-E. (2010). The recidivism rates of female sexual offenders are low: A meta-analysis. *Sexual Abuse: A Journal of Research & Treatment, 22*(4), 387-401; Sandler, J. C., & Freeman, N. J. (2009). Female sex offender recidivism: A large-scale empirical analysis. *Sexual Abuse: A Journal of Research & Treatment, 21*(4), 455-473.

[183] Cortoni, Sandler, & Freeman, N. (2015). Women convicted of promoting prostitution of a minor are different from women convicted of traditional sexual offenses: A brief research report. *Sexual Abuse: A Journal of Research & Treatment, 27*(3), 324-334.

[184] Cortoni, F., Hanson, R. K., & Coache, M. E. (2010). The recidivism rates of female sexual offenders are low: A meta-analysis. *Sexual Abuse: A Journal of Research & Treatment, 22*(4), 387-401; Epperson, E., Fuller, N., & Phenix, A. (2018). *Female sexual offender recidivism: An empirical analysis of registered female sex offenders in California.* SARATSO; McGinnis, W. J. (2015). *The validity of the Iowa sex offender risk assessment for predicting recidivism in female sexual offenders.* [Doctoral Thesis, University of Iowa]. University of Iowa Research Repository; Miller, H., A. & Marshall, E. A. (2019). Comparing solo- and co-offending female sex offenders on variables of pathology, offense characteristics, and recidivism. *Sexual Abuse: A Journal of Research & Treatment, 31*(8), 972-990; Sandler, J. C., & Freeman, N. J. (2009). Female sex offender recidivism: A large-scale empirical analysis. *Sexual Abuse: A Journal of Research & Treatment, 21*(4), 455-473.

[185] Cortoni, F., Hanson, R. K., & Coache, M. E. (2010). The recidivism rates of female sexual offenders are low: A meta-analysis. *Sexual Abuse: A Journal of Research & Treatment, 22(*4), 387-401; Epperson, E., Fuller, N., & Phenix, A. (2018). *Female sexual offender recidivism: An empirical analysis of registered female sex offenders in California.* SARATSO; McGinnis, W. J. (2015). *The validity of the Iowa sex offender risk assessment for predicting recidivism in female sexual offenders.* [Doctoral Thesis, University of Iowa]. University of Iowa Research Repository; Miller, H., A. & Marshall, E. A. (2019). Comparing solo- and co-offending female sex offenders on variables of pathology, offense characteristics, and recidivism. *Sexual Abuse: A Journal of Research & Treatment, 31*(8), 972-990; Sandler, J. C., & Freeman, N. J. (2009). Female sex offender recidivism: A large-scale empirical analysis. *Sexual Abuse: A Journal of Research & Treatment, 21*(4), 455-473.

At present, research finds the only static risk factor consistently predictive of increased risk of female sexual recidivism is having more than one prior arrest or conviction for a sex offense.[186] In one large study, past child abuse convictions, more prior convictions, and older age of first sex offense were significantly associated with sexual recidivism,[187] but these factors have not been replicated in other studies. Several studies have highlighted possible dynamic risk factors (criminogenic needs) related to female *index* sex offending. However, index offending occurs before detection and sanction and does not reflect sexual recidivism per se.[188] Female-specific research on treatment outcomes, protective factors, and desistance processes for sexual recidivism is lacking.

In summary, the research consistently indicates that females with a conviction for a sex offense are typically at low risk for sexual recidivism. With higher rates of general re-offending, many may commit a new non-sex crime. Currently, there is no empirical evidence that a subsequent conviction for a non-sex crime increases the risk of future sexual recidivism.[189] Thus, research supports the position that females with a conviction for sex offending have a low risk of sexual recidivism unless there is compelling evidence of a higher risk. Such evidence may include a reported intention to re-offend sexually, disclosure of sexually deviant interests, being in a relationship with a partner who is at elevated risk of sex offending (i.e., a prior or potential co-offender), or having a history of sex offending that persisted despite detection (e.g., multiple arrests for sex crimes). Other risk-elevating factors may include having significantly compromised self-regulation skills that impair the ability to inhibit acting on inappropriate sexual urges, or the presence of significant criminogenic needs associated with past sex offending. The exception is the subgroup of females with a history of prostituting a child or minor. This subgroup should be considered as posing a higher base-rate risk of further prostitution-related sex offending, particularly if a general criminal or antisocial lifestyle is present.

Decision Aid Format

The decision aid is illustrated in a flowchart that outlines three main phases.

The first phase involves evaluating the individual's current sexual recidivism risk following the period in the community sex offense-free.

[186] Freeman, N. J., & Sandler, J. C. (2008). Female and male sexual offenders: A comparison of recidivism patterns and risk factors. *Journal of Interpersonal Violence, 23*(10), 1394–1413; Marshall, E. A., & Miller, H. (2020). Arbitrary decision making in the absence of evidence: An examination of factors related to treatment selection and recidivism for female sexual offenders. *Journal of Sexual Aggression, 26*(2), 178-192.

[187] Sandler, J. C., & Freeman, N. J. (2009). Female sex offender recidivism: A large-scale empirical analysis. *Sexual Abuse: A Journal of Research & Treatment, 21*(4), 455-473.

[188] Potential criminogenic needs associated with index sexual offending indicated in research are inappropriate sexual interests and sexual self-regulation, offense-supportive cognitions, intimacy and social functioning deficits including emotional congruence with a child and child-adult boundary distortions, self-regulation issues including substance abuse/dependence, previous victimization, and male coercion and dependency (co-offending). Distal vulnerability (risk) factors include victimization, mental illness, interpersonal problems, and ongoing life stressors. Research has clearly shown that females convicted of sexual offending are a heterogeneous group, with variety present in their offending, distal and proximal risk factors, offense pathways, and motivational influences. See Cortoni, F. & Gannon, T. (2017). The assessment of female sex offenders. In D. P. Boer et al. (Eds.), *The Wiley handbook on the theories, assessment, and treatment of sexual offending*, Vols. 1-3, (pp. 1017-1036). Chichester, UK: Wiley Blackwell.

[189] In contrast to research with adult male sex offenders that has demonstrated a small risk-increasing effect of conviction for a subsequent non-sex offense. See Hanson, R. K., Harris, A. J. R., Letourneau, E., Helmus, L. M., & Thornton, D. (2018). Reductions in risk based on time offense-free in the community: Once a sexual offender, not always a sexual offender. *Psychology, Public Policy, and Law, 24*(1), 48-63; Thornton, D., Hanson, R. K., Kelley, S. M., & Mundt, J. C. (2021). Estimating lifetime and residual risk for individuals who remain sexual offense free in the community: Practical applications. *Sexual Abuse: A Journal of Research and Treatment, 33*(1), 3-33.

The past evaluation for the most recent sex offense should be obtained, if available. The past evaluation should be updated to be current. Note that when the most recent sex offense was adjudicated as a juvenile, evaluations completed 6 months or more ago should be updated. If the past evaluation is unavailable or unsuitable, a new evaluation of the current sexual recidivism risk should be conducted. The new evaluation should be consistent with the applicable SOMB Adult and Juvenile Standards and Guidelines Section 2.000 and the SOMB Adult Appendix M: Female Sex Offender Risk Assessment. The evaluation should give due consideration *within an overall assessment of risk* to potential static and dynamic risk factors, protective factors, and strengths. The evaluation should include due consideration of the time sex offense-free in the community and the new nonsexual offending.

For females, the evaluation will be primarily a clinical assessment of relevant factors. The use of standardized risk assessment instruments developed and normed solely on males is prohibited.[190] Other instruments that assess non-sexual recidivism risk or psychological factors that are validated with females may be appropriate where relevant.

The evaluation of risk and treatment needs should attend to potentially static and dynamic risk factors, protective factors, and strengths. The evaluation should include due consideration of the time sex offense-free in the community and the new non-sex crime.

The second phase involves considering additional factors that influence the need for any current sex offense-specific treatment.

Research supports the position that females with a conviction for sex offending have a low risk of sexual recidivism unless there is compelling evidence of higher risk. The potential factors listed that favor desistance or having low sex offense-specific intervention needs are not exhaustive. Similarly, the potential factors listed that favor the presence of sex offense-specific intervention needs is not exhaustive. Other considerations may apply to specific females. Evaluators should use their clinical judgment. The considerations need not be "all present" or "all absent" to proceed through the pathways. Instead, they are factors to consider when determining the best combination of recommendations. Evaluators should apply clinical judgment in determining their significance.

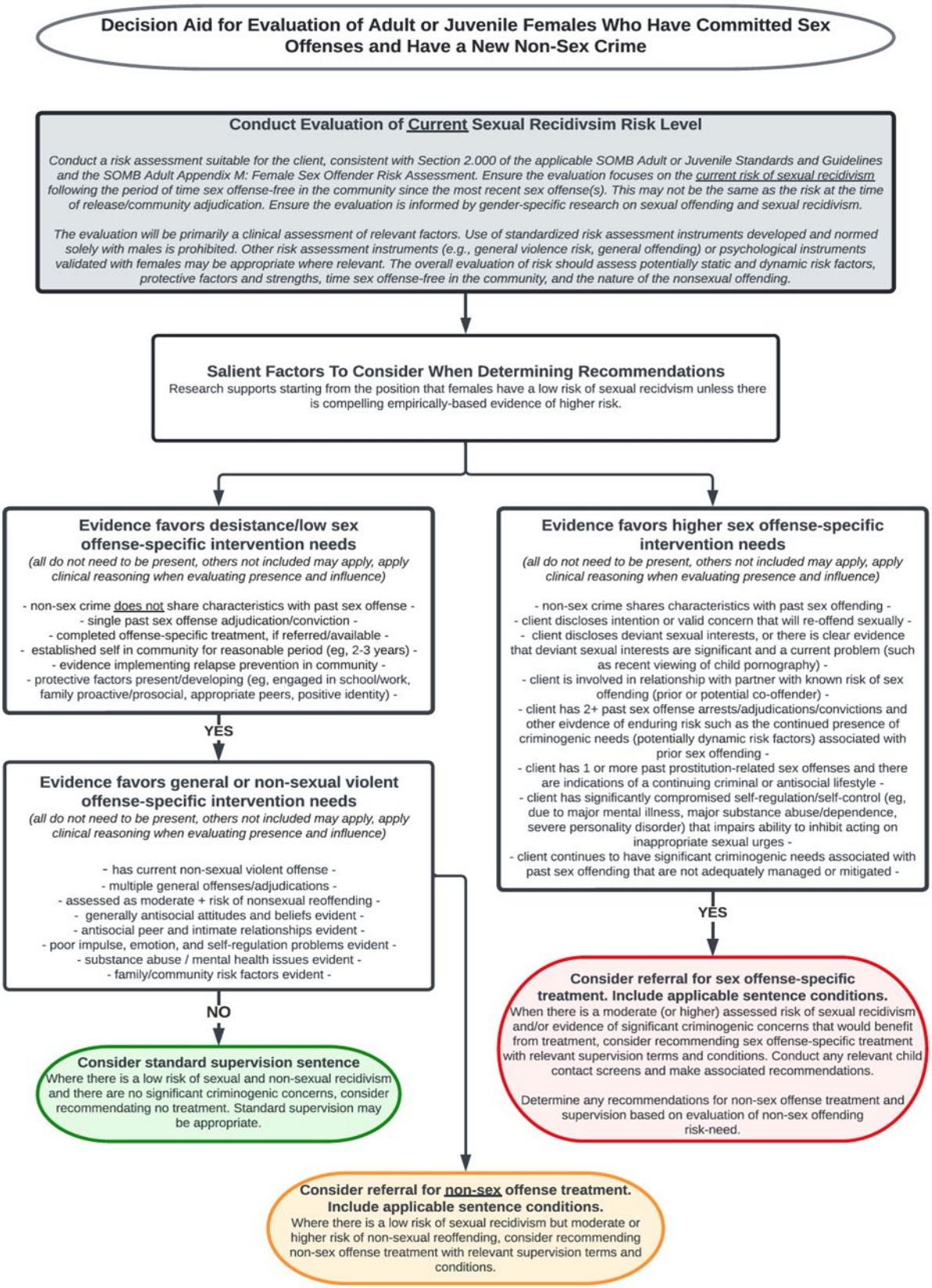
The third phase involves considering the appropriate treatment recommendations.

The intention is for final treatment and sentence recommendations to be matched to the risk-need level of the individual, taking into consideration treatment responsivity and non-sexual offending patterns. The options are recommendations for standard supervision only, non-sex offense treatment (e.g., substance abuse or mental health treatment), or sex offense-specific treatment. Any sex offense-specific treatment recommendations shall be consistent with the applicable SOMB Adult or Juvenile Standards and Guidelines Section 2.000.

Evaluators may assess other non-sex offending treatment needs. When doing so, Evaluators should use reliable and validated methods to screen or assess non-sex offending risk, criminogenic needs, and related psychosocial factors. The presence, type, and severity of criminogenic needs associated with non-sex offending may be distinct from, or overlap, those for sex offending. Where sex offense-specific

[190] See SOMB Adult Standards and Guidelines Appendix M: Female Sex Offender Risk Assessment.

and non-sex offending treatment needs coexist, Evaluators should consider the combination and sequencing of treatment recommendations.


Decision Aid for Evaluation of Adult or Juvenile Females Who Have Committed Sex Offenses and Have a New Non-Sex Crime
Conduct Evaluation of Current Sexual Recidivsim Risk Level
Conduct a risk assessment suitable for the client, consistent with Section 2.000 of the applicable SOMB Adult or Juvenile Standards and Guidelines and the SOMB Adult Appendix M: Female Sex Offender Risk Assessment. Ensure the evaluation focuses on the current risk of sexual recidivism following the period of time sex offense-free in the community since the most recent sex offense(s). This may not be the same as the risk at the time of release/community adjudication. Ensure the evaluation is informed by gender-specific research on sexual offending and sexual recidivism.
The evaluation will be primarily a clinical assessment of relevant factors. Use of standardized risk assessment instruments developed and normed solely with males is prohibited. Other risk assessment instruments (e.g., general violence risk, general offending) or psychological instruments validated with females may be appropriate where relevant. The overall evaluation of risk should assess potentially static and dynamic risk factors, protective factors and strengths, time sex offense-free in the community, and the nature of the nonsexual offending.
Salient Factors To Consider When Determining Recommendations
Research supports starting from the position that females have a low risk of sexual recidivism unless there is compelling empirically-based evidence of higher risk.
Evidence favors desistance/low sex offense-specific intervention needs
(all do not need to be present, others not included may apply, apply clinical reasoning when evaluating presence and influence)
- non-sex crime does not share characteristics with past sex offense -
- single past sex offense adjudication/conviction -
- completed offense-specific treatment, if referred/available -
- established self in community for reasonable period (eg, 2-3 years) -
- evidence implementing relapse prevention in community -
- protective factors present/developing (eg, engaged in school/work, family proactive/prosocial, appropriate peers, positive identity) -
YES
Evidence favors general or non-sexual violent offense-specific intervention needs
(all do not need to be present, others not included may apply, apply clinical reasoning when evaluating presence and influence)
- has current non-sexual violent offense -
- multiple general offenses/adjudications -
- assessed as moderate + risk of nonsexual reoffending -
- generally antisocial attitudes and beliefs evident -
- antisocial peer and intimate relationships evident -
- poor impulse, emotion, and self-regulation problems evident -
- substance abuse / mental health issues evident -
- family/community risk factors evident -
NO
Consider standard supervision sentence
Where there is a low risk of sexual and non-sexual recidivism and there are no significant criminogenic concerns, consider recommendating no treatment. Standard supervision may be appropriate.
Evidence favors higher sex offense-specific intervention needs
(all do not need to be present, others not included may apply, apply clinical reasoning when evaluating presence and influence)
- non-sex crime shares characteristics with past sex offending -
- client discloses intention or valid concern that will re-offend sexually -
- client discloses deviant sexual interests, or there is clear evidence that deviant sexual interests are significant and a current problem (such as recent viewing of child pornography) -
- client is involved in relationship with partner with known risk of sex offending (prior or potential co-offender) -
- client has 2+ past sex offense arrests/adjudications/convictions and other eivdence of enduring risk such as the continued presence of criminogenic needs (potentially dynamic risk factors) associated with prior sex offending -
- client has 1 or more past prostitution-related sex offenses and there are indications of a continuing criminal or antisocial lifestyle -
- client has significantly compromised self-regulation/self-control (eg, due to major mental illness, major substance abuse/dependence, severe personality disorder) that impairs ability to inhibit acting on inappropriate sexual urges -
- client continues to have significant criminogenic needs associated with past sex offending that are not adequately managed or mitigated -
YES
Consider referral for sex offense-specific treatment. Include applicable sentence conditions.
When there is a moderate (or higher) assessed risk of sexual recidivism and/or evidence of significant criminogenic concerns that would benefit from treatment, consider recommending sex offense-specific treatment with relevant supervision terms and conditions. Conduct any relevant child contact screens and make associated recommendations.
Determine any recommendations for non-sex offense treatment and supervision based on evaluation of non-sex offending risk-need.
Consider referral for non-sex offense treatment. Include applicable sentence conditions.
Where there is a low risk of sexual recidivism but moderate or higher risk of non-sexual reoffending, consider recommending non-sex offense treatment with relevant supervision terms and conditions.

Guidelines for Evaluation of Male Adults Who Have Committed Sex Offenses as an Adult and Have a New Non-Sex Crime.

These guidelines are for sex offense-specific evaluations of male adults who have a past sex offense as an adult and a new non-sex offense, who meet the following statutory definition of a sex offender. These guidelines also apply to male adults who have a past sex offense as an adult and who are convicted of Failure to Register.[191]

Per statute, all sex offenders in the state of Colorado "as part of the presentence or probation investigation (are) required pursuant to section 16-11-103, to submit to an evaluation for treatment, an evaluation for risk, procedures required for monitoring of behavior to protect the victims, and potential victims, and an identification developed pursuant to section 16-11.7-103 (4)." Further, all sex offenders in the state of Colorado are required, as part of any sentence to probation, commitment to the Department of Human Services, sentence to community corrections, incarceration with the Department of Corrections, placement on parole, or out-of-home placement to "undergo treatment to the extent appropriate to such offender based upon the recommendations of the evaluation and identified made pursuant to section 16-11.7-104…"[192] Finally, sex offenders sentenced to community supervision (probation or parole) may be supervised by specialized sex offender supervision officers and subject to some or all of the specialized terms and conditions of supervision developed for sex offenders.[193]

INTRODUCTION

The ***Guidelines for Evaluation of Male Adults Who Have Committed Sex Offenses as an Adult and Have a New Non-Sex Crime*** includes a series of protocols and a decision aid. The Guidelines are designed to be used with the applicable Colorado SOMB Standards and Guidelines for the Assessment, Evaluation, Treatment, and Behavioral Monitoring of Adult Sex Offenders (hereafter referred to as the SOMB Adult Standards and Guidelines). The Guidelines are provided to assist Evaluators in meeting the SOMB Adult Standards and Guidelines when these evaluations are requested but are not a required protocol.

GUIDELINE PROTOCOLS

Use of SOMB Approved Evaluators

An Adult Evaluator should be used when the current non-sex crime, including Failure to Register, and the most recent sex offense, occurred when 18 years or older.

For young adults aged 18-25 years, Evaluators should also consult the SOMB Young Adult Modification Protocol.

Multidisciplinary Collaboration

[191] Failure to register is a new non-sex offense criminal conviction.

[192] 236 See 16-11.7-105 C.R.S.

[193] 237 See 18-1.3-1007 C.R.S.

The Evaluator should seek relevant background information, including the discharge summary, from the prior Community Supervision Team (CST) and any adjunct treatment providers, if available. Evaluators are encouraged to use judgment in the amount of effort given if the information is difficult to obtain. Evaluations should not be unnecessarily delayed when prior treatment information is unavailable.

The Evaluator should document the information gained from other sources in the evaluation and document all unsuccessful attempts to gain information in the client record.

The Evaluator should be available to consult with the PSI Officer to answer questions about the evaluation and to review the treatment recommendations as needed.

If the evaluation is before the individual enters a plea, the evaluation may need updating following conviction and sentencing. If the Evaluator who completed the pre-plea evaluation is no longer available, a new Evaluator can complete the update.

Evaluator Competency

Evaluators should be familiar with this Appendix and the applicable SOMB Adult Standards and Guidelines. Evaluators new to the Time-Free actuarial tables or risk calculator who apply this method are encouraged to seek training, consultation, and clinical supervision as needed.

DECISION AID

The decision aid is to assist Evaluators and for use in conjunction with the applicable Colorado SOMB Adult Standards and Guidelines. While available to use, it is not a required protocol. Evaluators should use clinical judgment when determining the most appropriate evaluation of the client and when making recommendations within the requirements of the SOMB Adult Standards and Guidelines Section 2.000. The evaluation should give due consideration *within an overall assessment of risk* to the past sexual offending, the amount of time residing sex offense-free in the community, and the new non-sex crime.

When using the decision aid or other methods, Evaluators should take care to consider individual differences and the potential impact on the suitability of assessment instruments, recidivism risk, and desistance processes. Individual differences include race-ethnicity, immigration status, sexual orientation, gender identity, mental health, developmental-cognitive disabilities, and physical disabilities. Evaluators should also take care to ensure any assessment instruments used are appropriately normed and validated.

The decision aid incorporates research on projected lifetime sexual recidivism risk, desistance, and protective factors, alongside existing research and best practices. Of relevance, recent research demonstrated that the amount of time male adults with a sex offense history reside in the community sex offense-free has a risk-reducing effect on sexual recidivism rates. The research also found that a new conviction for non-sex offending has a risk-increasing effect.[194] From that research, an actuarial method to estimate 20-year sexual recidivism rates for adult males with a history of sex offending and

[194] Hanson, R. K., Harris, A. J. R., Letourneau, E., Helmus, L. M., & Thornton, D. (2018). Reductions in risk based on time offense-free in the community: Once a sexual offender, not always a sexual offender. *Psychology, Public Policy, and Law, 24*(1), 48-63. https://doi.org/10.1037/law0000135.

a new non-sex conviction is available.[195] The actuarial approach can be applied using either the published Time-Free Actuarial Risk Tables[196] or the Time-Free Risk Calculator.[197] An overview of how to apply these methods is provided below.

The concept of desistance is built into the decision aid and included in the Time-Free actuarial methods. Desistance refers to when the risk of new sex offending is very low and not different from the risk posed by others without convictions for sex offending.[198] To meet the desistance threshold, an individual with a history of sex offending and a new non-sex conviction has to reside in the community without any known sex offending for a sufficient number of years. The number of years needed varies by the risk level at the time of release or community sentencing. For example, someone at high risk must reside in the community sex offense-free for several years longer to meet the desistance threshold than someone at moderate risk at release. The desistance threshold in the actuarial tables and calculator is when the 20-year sexual recidivism rates are under 3%.[199] At the desistance level, further sex offense-specific treatment is usually not indicated.[200]

Research on potential *protective factors* that mitigate risk and are part of the desistance process has also progressed, supporting inclusion within an overall evaluation of risk and treatment recommendations.[201]

[195] Thornton, D., Hanson, R. K., Kelley, S. M., & Mundt, J. C. (2021). Estimating lifetime and residual risk for individuals who remain sexual offense free in the community: Practical applications. *Sexual Abuse, 33*(1), 3-33. https://doi.org/10.1177/1079063219871573. See also Helmus, L. M., Lee, S. C. Phenix, A., Hanson, R. K., Thornton, D. (2021). *Static-99R & Static-2002R Evaluator's Workbook*. SAARNA. https://saarna.org/static-99/

[196] Published in Thornton, D., Hanson, R. K., Kelley, S. M., & Mundt, J. C. (2021). Estimating lifetime and residual risk for individuals who remain sexual offense free in the community: Practical applications. *Sexual Abuse, 33*(1), 3-33. https://doi.org/10.1177/1079063219871573.

[197] The Lifetime Residual Risk Calculator is an Excel file and is free to download from: https://saarna.org/static-99/. A user manual is available free to download from: https://saarna.org/download/user-manual-lifetime-residual-risk-calculator-2/. See also Helmus, L. M., Lee, S. C. Phenix, A., Hanson, R. K., Thornton, D. (2021). *Static-99R & Static-2002R Evaluator's Workbook*. SAARNA. https://saarna.org/static-99/

[198] A statistical threshold for defining desistance is when a sexual offender's risk for a new sexual offense is no different than the risk presented by individuals who have no prior sexual offense history but who have a history of non-sexual crime. See Hanson, R. K., Harris, A. J. R., Letourneau, E., Helmus, L. M., & Thornton, D. (2018). Reductions in risk based on time offense-free in the community: Once a sexual offender, not always a sexual offender. *Psychology, Public Policy, and Law, 24*(1), 48-63. https://doi.org/10.1037/law0000135.

[199] Thornton, D., Hanson, R. K., Kelley, S. M., & Mundt, J. C. (2021). Estimating lifetime and residual risk for individuals who remain sexual offense free in the community: Practical applications. *Sexual Abuse, 33*(1), 3-33. https://doi.org/10.1177/1079063219871573.

[200] Hanson, R. K., Bourgon, G., McGrath, R. K., Kroner, D., D'Amora, D. A., Thomas, S. S., & Tavarez, L. P. (2017). *A five-level risk and needs system: Maximizing assessment results in corrections through the development of a common language*. New York, NY: The Council of State Governments Justice Center.

[201] Nolan, T., Willis, G. W., Thornton, D., Kelley, S. M., Beggs Christofferson, S. (2022). Attending to the positive: A retrospective validation of the Structured Assessment of Protective Factors-Sexual Offense Version. *Sexual Abuse, 35*(2), 1-20. https://doi.org/10.1177/10790632221098354; Willis, G. M., Kelley, S. M., & Thornton, D. (2020). Are protective factors valid constructs? Interrater reliability and construct validity of proposed protective factors against sexual reoffending. *Criminal Justice & Behavior, 47*(11), 1448-1467. https://doi.org/10.1177/0093854820941039.

Decision Aid Format

The decision aid is illustrated in a flowchart that outlines three phases.

The first phase involves determining the individual's current sexual recidivism risk following the period in the community sex offense-free.

Use either of the actuarial Time-Free methods (i.e., the published tables or the downloadable calculator) or an alternative best practice assessment suitable for the individual. The use of an actuarial method should occur within an *overall evaluation* of risk and consideration of treatment needs that attends to static and dynamic risk factors, protective factors, and strengths. The evaluation should include due consideration of the time sex offense-free in the community and the new non-sex crime. An advantage of the Time-Free actuarial method is that it statistically combines the effect of risk factors, time sex offense-free, and new non-sex conviction into a single risk estimate. Additional assessment can focus on other relevant factors not included or sufficiently covered in the Time-Free actuarial assessment. Such factors may include dynamic risk factors, if not part of the actuarial instrument used, or protective factors. If not using a Time-Free actuarial method, the evaluation should follow best practices according to the SOMB Standards and Guidelines Section 2.000 and sufficiently attend to each relevant area.

An overview is provided below on how to apply the actuarial Time-Free methods. Although these methods were developed using data on the first non-sex conviction, the approach is applicable when there are multiple non-sex convictions since the most recent sex offense. Guidance is included below on how to approach the evaluation of the additional non-sex convictions.[202]

The second phase involves considering additional factors that influence the need for current sex offense-specific treatment.

The considerations in the second phase align with the Five-Level Risk and Needs System[203] and the expertise of the Best Practices Committee. The considerations are not exhaustive. Other considerations may apply to specific individuals. Evaluators should use their clinical judgment. The considerations need not be "all present" or "all absent" to proceed through the pathways. Instead, they are factors to consider when determining the best combination of recommendations. Evaluators should apply clinical judgment in determining their significance.

The third phase involves considering the appropriate treatment recommendations.

The intention is for final treatment and sentence recommendations to be matched to the risk-need level of the individual, taking into consideration treatment responsivity and non-sex offending patterns. The options are: no recommendation for offense-specific treatment, targeted offense-specific treatment (e.g., a refresher program or treatment on a specific domain or criminogenic need), and comprehensive sex offense-specific treatment. In some instances, high-intensity comprehensive

[202] The frequency and density of the additional non-sex convictions are factors external to the actuarial assessment and considered within an overall evaluation of risk. See Thornton, D., Hanson, R. K., Kelley, S. M., & Mundt, J. C. (2021). Estimating lifetime and residual risk for individuals who remain sexual offense free in the community: Practical applications. *Sexual Abuse, 33*(1), 3-33. https://doi.org/10.1177/1079063219871573.

[203] Hanson, R. K., Bourgon, G., McGrath, R. K., Kroner, D., D'Amora, D. A., Thomas, S. S., & Tavarez, L. P. (2017). *A five-level risk and needs system: Maximizing assessment results in corrections through the development of a common language*. New York, NY: The Council of State Governments Justice Center.

offense-specific treatment may be appropriate, but the individual may not be suitable for a community-based setting.

Any sex offense-specific treatment recommendations shall be consistent with the SOMB Adult Standards and Guidelines Section 2.000. Evaluators may assess other non-sex offending treatment needs also. When doing so, Evaluators should use reliable and validated methods to screen or assess non-sex offending risk, criminogenic needs, and related psychosocial factors. The presence, type, and severity of criminogenic needs associated with non-sex offending may overlap or be distinct from those for sex offending. Where sex offense-specific and non-sexual offending treatment needs coexist, Evaluators should consider the combination and sequencing of treatment recommendations.

Applying the Time-Free Actuarial Methods

Thornton et al. (2021) published lifetime risk estimates for male adults with a history of sex offending who remain sex offense-free in the community but have a new non-sex conviction. The method allows evaluations to statistically account for the risk-reducing effect of time sex offense-free in the community and the risk-increasing effect of having a new non-sex conviction since the most recent sex offense. Evaluators can use either the Time-Free Actuarial Tables published by Thornton et al. (2021) or the Time-Free Risk Calculator available for free download at https://saarna.org. Provided below is the relevant Time-Free Actuarial Table (see Table 1). Provided also is a simplified version that highlights only the thresholds for desistance by initial risk level at the time of release or community sentencing (see Table 2).

To use the Time-Free Actuarial Table determine the following:

(1) *The male adult's sexual recidivism risk level at the time of release to the community for the current (most recent) sex offending.*

For male adults who served prison time for their sex offending, this is the sexual recidivism risk evaluation closest to their release date. For male adults sentenced to the community only, this is the sexual recidivism risk evaluation at the start of the community-based sentence. For male adults with multiple past sex offenses, use the sexual recidivism risk evaluation for the most recent sex offense.

In most cases, a validated, actuarial evaluation of sexual recidivism risk will have occurred before release or community supervision which can be accessed and used as part of the current evaluation. Where the appropriate past sexual recidivism risk evaluation is unavailable or unsuitable, the Evaluator will need to complete (essentially reconstruct) the actuarial assessment for the time of release. For Static-99R assessments, the total score and risk level are in Table 1.[204] For other instruments (e.g., VASOR, SOTIPS, or VASOR/SOTIPS combinations)[205], Evaluators can use either the risk level in Table 2 as a guide or the Time-Free Calculator.

[204] The Static-99R is designed for use with adult males already charged or convicted of a least one sexual offense against a child or non-consenting adult. It is not recommended for use with females or use with young male adults less than 18 years old at the time of release. In limited instances, the Static-99R may be applicable to male juveniles who committed a sexual offense when 17 years of age and who are released when 18 or older. The *Static-99R manual revised (2016)* discusses the limitations of use with adolescents who committed a sexual offense and who are released once 18 or older.

[205] The VASOR-2 and SOTIPS are designed for use with adult males who have been committed at least one qualifying sexual offense when 18 years or older.

(2) *The number of years sex offense-free in the community.*

Calculate the years at liberty in the community since the most recent sex offense by subtracting time served for either technical violations or new non-sex offending. Only count full years living in the community toward years sex offense-free. For example, a male adult in the community for 3 ½ years without sex offending counts as three years. Do not count periods where extensive monitoring precluded an opportunity to offend (e.g., stringent GPS monitoring or constant oversight). Under those circumstances, it is unlikely a time-free effect occurred.

(3) *The number of non-sex convictions since the most recent sex offense.*

Count only non-sex convictions after the most recent sexual offense and since release (or the start of the community sentence, where applicable). Non-sex convictions do not include technical violations, even where the violation resulted in a return to prison.[206] Only new non-sex convictions count here.[207] A conviction for failure to register is a new non-sex conviction.[208]

The research for the Time-Free Actuarial Tables and Time-Free Risk Calculator determined the effect for the first non-sex conviction only. Therefore, treat the additional non-sex convictions as factors external to the Time-Free actuarial assessment. Consider the frequency, density, and type of that additional non-sex offending within the overall risk evaluation.

When multiple instances of non-sex conviction are present since the most recent sex offense, use the total years at liberty in the community since the most recent sex offense as the follow-up year on the Time-Free Actuarial Tables.[209]

(4) *The appropriate reference group.*

The Routine/Complete Samples should be the default reference group unless there is a strong case-specific justification to use the High-Risk/High-Need Samples reference group.[210] The primary consideration is whether a significant density of risk factors external to the actuarial measure is present that indicates the male adult is a member of a higher-risk group than placed by the risk assessment. For example, there are significant dynamic risk factors not being factored into the initial actuarial risk level.[211]

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[206] If a technical violation results in a return to prison, then the time spent in prison is subtracted from the time sex offense-free in the community (see step 2).

[207] The non-sexual conviction must be a criminal offense that is sufficiently serious it could lead to jail time or community supervision. Citations that would not result in jail time or community supervision are not included here.

[208] For further discussion, see pages 5-6 of the *User Manual Lifetime Residual Risk Calculator* https://saarna.org/download/user-manual-lifetime-residual-risk-calculator-2/.

[209] In cases where it has been several years since the conviction for the first non-sexual offense (e.g., the individual has been several years on community supervision already), the follow-up year would be years at liberty in the community since the index sexual offense, subtracting time served from calendar time. This is included in the calculations used in the Time-Free Risk Calculator. As previously noted, where there are multiple non-sexual offense convictions, the frequency, density, and type of these additional convictions should be considered within the overall evaluation of risk.

[210] See Hanson, R. K., Thornton, D., Helmus, L., & Babchishin, K. M. (2016). What sexual recidivism rates are associated with Static-99R and Static-2002R scores? *Sexual Abuse, 28*, 218-252. https://doi.org/10.1177/1079063215574710.

[211] This is particularly relevant if the individual has a low-to-moderate score on an actuarial measure that only considers static factors when there is strong evidence for higher risk based on the evaluation of dynamic risk factors. See Hanson et al. (2016) for an explanation of the

The Time-Free Risk Calculator requires a similar process as the Time-Free Actuarial Tables. However, the calculator provides recidivism rates for any actuarial measure used, not specifically the Static-99R. The calculator also provides a tool to help determine time-free in the community using date data. Input into the Time-Free Calculator involves completing several clearly labeled data fields. An associated manual is freely downloadable that provides detailed instructions.[212]

Table 1 presents Thornton et al.'s (2021) Routine/Complete Samples sexual recidivism risk table for male adults with a past sex offense conviction and a subsequent non-sex conviction.[213] The numbers are the percent projected to re-offend sexually over 20 years follow-up in the community. For example, the projected rate for a male adult with a Static-99R score of 2 (Level III/Moderate Risk) at release with a new non-sex conviction after five years is 7.7%. This projected rate of sexual recidivism is comparable to that of someone with moderate risk at release (Static-99R, Level III, score 1-2).[214] If a male adult with the same risk score had a first non-sex conviction after 11 years sex offense-free in the community, the projected rate is 2.8% and below the threshold for desistance. In the latter scenario, the male adult has a very low risk of sexual recidivism over the next 20 years, even though a new non-sex offense was committed.

In Table 1, two sets of values are underlined. One set runs down across the right side of the table and marks the transition out of the highest Static-99R risk category (level IVb; above 35%) to the next lower risk category. The other set of underlined values runs down across the left side of the table and marks the transition into the lowest risk category (level I; below 3%). The transition into the lowest risk category is the transition to the desistance threshold.

Table 2 is a simplified version of Table 1 that shows the risk level and range of years living sex offense-free in the community needed to reach the desistance threshold. Column one is the risk level at the time of release or community sentence (without Static-99R scores). The risk level nomenclature was changed to be consistent with common instruments and the SOMB Adult Standards and Guidelines. Low through High risk was substituted for Level I through IVb. Column two shows the years sex offense-free in the community required for the desistance level for each initial risk level.

As shown in Table 2, when the risk level at release is higher, more years living sex offense-free in the community (up to 20) are required to lower risk to desistance levels. For example, someone at Low-Moderate risk at release who commits a non-sex offense requires seven years in the community sex offense-free to meet the desistance threshold. In contrast, someone at Moderate-High risk at release who commits a non-sex offense requires 15-16 years in the community sex offense-free to meet the desistance level.

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effect of using different reference samples and guidance on the selection of the reference group. Alternatively, the Routine/Complete Samples reference group could be used, and the additional dynamic risk could be factored clinically into the overall evaluation of risk.

[212] The Lifetime Residual Risk Calculator is an Excel file and is free to download from: https://saarna.org/download/time-free-in-the-community-calculator-excel/. A user manual is available free to download from: https://saarna.org/download/user-manual-lifetime-residual-risk-calculator-2/. See also Helmus, L. M., Lee, S. C. Phenix, A., Hanson, R. K., Thornton, D. (2021). *Static-99R & Static-2002R Evaluator's Workbook*. SAARNA. https://saarna.org/static-99/

[213] Thornton, D., Hanson, R. K., Kelley, S. M., & Mundt, J. C. (2021). Estimating lifetime and residual risk for individuals who remain sexual offense free in the community: Practical applications. *Sexual Abuse*, *33*(1), 3-33. https://doi.org/10.1177/1079063219871573.

[214] This interpretation was achieved by comparing the current expected 20-year rate of sexual recidivism (7.7%) against the projected rates in the Projected Residual Risk Table 7 from Thornton et al. (2021). The interpretation can also be achieved by comparing the current expected sexual recidivism rate against those in the revised Static-99R normative data for routine/complete samples (Table S4) published by Lee, S. C. & Hanson, R. K. (2021). Updated 5-year and new 10-year sexual recidivism rate norms for Static-99R with routine/complete samples. *Law & Human Behavior*, *45*(1), 24-38. https://saarna.org/download/new-lee-s-c-hanson-r-k-2021-updated-5-year-and-new-10-year-sexual-recidivism-rate-norms-for-static-99r-with-routine-complete-samples-law-and-human-behavior-451-24-38/

Table 2 shows the *range* of years required in the community sex offense-free for desistance in column 2 for each of the initial risk scores within a risk category. For example, an initial risk score at the low end of the moderate risk category requires nine years in the community sex offense-free to reach desistance. In comparison, an initial risk score at the high end of the moderate risk category requires 13 years. When applying the range of years to individual cases, a conservative approach is to take the upper number of years. However, Evaluators should consider the overall evaluation of risk and whether there are factors supporting desistance at the lower range of years.

Table 1. Projected Sexual Residual Risk for Adult Men with a History of Sexual Offending and a New Non-Sexual Conviction: Routine/Complete Samples.[215] [216]

Table 5. Projected Residual Risk (Sexual Recidivism Rates as Percentages) From Time of Release Up to 20 Years Sex Offense Free in the Community for Routine/Complete Samples by Time of First Nonsexual Recidivism.

	Initial risk (based on Static-99R scores)													
	Level I		Level II		Level III			Level IVa		Level IVb				
Follow-up year	−3	−2	−1	0	1	2	3	4	5	6	7	8	9	10
<1	2.6	3.8	5.5	8.0	11.0	15.5	21.4	28.9	38.2	48.8	60.4	71.6	81.3	88.9
1	2.3	3.3	4.7	6.9	9.6	13.6	18.8	25.5	34.1	44.1	55.3	66.6	76.8	85.3
2	2.0	2.8	4.1	6.0	8.3	11.8	16.5	22.5	30.3	39.5	50.2	61.3	71.9	81.2
3	1.7	2.4	3.5	5.2	7.2	10.3	14.4	19.7	26.8	35.2	45.2	56.1	66.7	76.5
4	1.5	2.1	3.1	4.5	6.2	8.9	12.5	17.2	23.5	31.2	40.5	50.8	61.3	71.4
5	1.2	1.8	2.6	3.9	5.4	7.7	10.8	15.0	20.6	27.5	36.0	45.7	55.9	66.0
6	1.1	1.5	2.2	3.3	4.6	6.6	9.3	13.0	17.9	24.0	31.7	40.7	50.4	60.4
7	0.9	1.3	1.9	2.8	3.9	5.7	8.0	11.1	15.4	20.9	27.8	36.0	45.1	54.8
8	0.8	1.1	1.6	2.4	3.3	4.8	6.8	9.5	13.3	18.0	24.1	31.5	39.9	49.1
9	0.6	0.9	1.4	2.0	2.8	4.1	5.8	8.1	11.3	15.4	20.8	27.4	35.0	43.5
10	0.5	0.8	1.2	1.7	2.4	3.4	4.9	6.8	9.6	13.1	17.7	23.5	30.3	38.0
11	0.5	0.7	1.0	1.4	2.0	2.8	4.1	5.7	8.0	11.0	15.0	20.0	25.9	32.8
12	0.4	0.5	0.8	1.2	1.6	2.3	3.3	4.7	6.6	9.1	12.5	16.7	21.9	27.9
13	0.3	0.4	0.6	0.9	1.3	1.9	2.7	3.8	5.4	7.4	10.2	13.8	18.1	23.3
14	0.2	0.3	0.5	0.7	1.0	1.5	2.2	3.0	4.3	6.0	8.2	11.1	14.7	19.0
15	0.2	0.3	0.4	0.6	0.8	1.2	1.7	2.4	3.3	4.6	6.4	8.7	11.6	15.1
16	0.1	0.2	0.3	0.4	0.6	0.9	1.2	1.8	2.5	3.5	4.8	6.5	8.7	11.4
17	0.1	0.1	0.2	0.3	0.4	0.6	0.9	1.2	1.7	2.4	3.4	4.6	6.2	8.1
18	0.1	0.1	0.1	0.2	0.3	0.4	0.5	0.8	1.1	1.5	2.1	2.9	3.9	5.1
19	<0.1	<0.1	0.1	0.1	0.1	0.2	0.3	0.4	0.5	0.7	1.0	1.4	1.8	2.4
20	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0

Note. Recidivism rate projections based on 5-year logistic regression estimates from Hanson, Thornton, Helmus, and Babchishin (2016). Underlined values mark the transition out of Level IVb (above 35%) and into Level I (less than 3%).

[215] Thornton, D., Hanson, R. K., Kelley, S. M., & Mundt, J. C. (2021). Estimating lifetime and residual risk for individuals who remain sexual offense free in the community: Practical applications. *Sexual Abuse, 33*(1), 3-33. https://doi.org/10.1177/1079063219871573.

[216] In cases where it has been several years since the conviction for the first non-sexual offense (e.g., the individual has been several years on community supervision already), the follow-up year would be years at liberty in the community since the index sexual offense, subtracting time served from calendar time (Thornton et al., 2021). As previously noted, where there are multiple non-sexual offense convictions, the frequency and density of these additional convictions should be considered within the overall evaluation of risk.

Table 2. Number of Years Required Sex Offense Free in the Community For Desistance By Risk Level At Release For Adult Men With a History of Sexual Offending and a First Non-Sexual Conviction (Routine/Complete Samples)[217]

Risk Level At Time of Release (Based on validated risk measure)	Range of Years Offense-Free in the Community Required for Desistance*
Low Risk	< 1 - 2 years
Low-Moderate Risk	5 - 7 years
Moderate Risk	9 - 13 years
Moderate-High Risk	15 - 16 years
High Risk	17 - 19 years

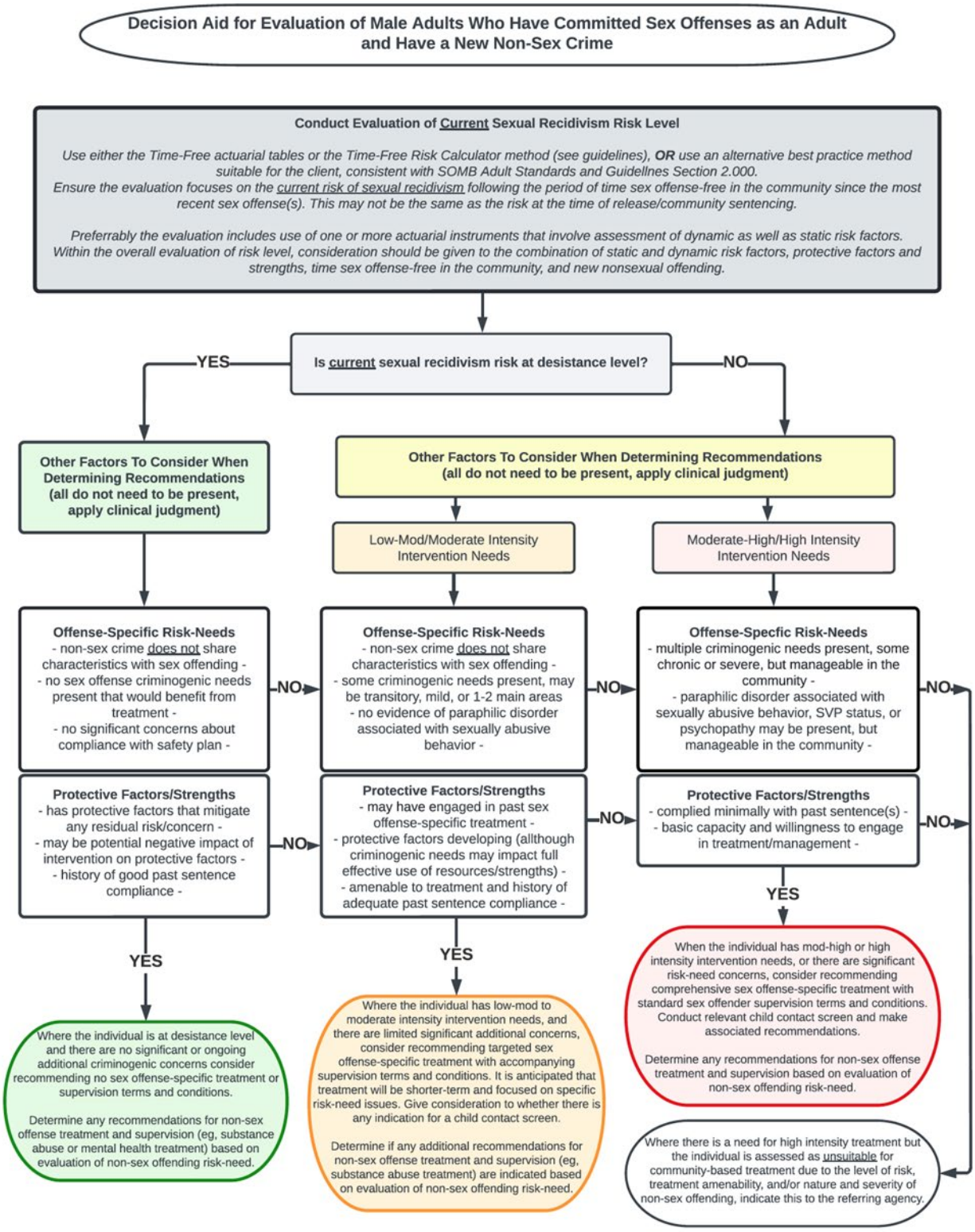
*The *range* of years is the number required for desistance at the lower and upper scores within that risk level.

When using this method, remember

- The tables only apply to male adults with a history of sex offending and a new non-sex conviction. The tables are not suitable for juveniles, adults whose conviction for sex offending was only as a juvenile, or females.[218]
- When there is more than one non-sex conviction following the most recent sex offense, the frequency, density, and type of additional convictions should be considered external to the actuarial estimates and considered as part of an overall risk evaluation.
- Non-sex convictions do not include technical violations. Failure to Register is considered a new non-sex conviction, not a technical violation.
- The routine/complete samples should be the default reference group unless there is a strong case justification for using the High-Risk/High-Need Samples reference group.
- The risk classifications, including desistance, are only specific to sexual recidivism risk and do not provide information about risk for non-sexual recidivism.
- Table 2 shows the *range* of years required in the community sex offense-free for desistance across the initial risk scores within that risk category. When determining whether there is sufficient evidence for desistance or not, Evaluators should consider the overall evaluation of risk.

[217] In cases where it has been several years since a conviction for the first non-sexual offense (e.g., the individual has been several years on community supervision already), the follow-up year would be years at liberty in the community since the index sexual offense, subtracting time served from calendar time (Thornton et al., 2021). As previously noted, where there are multiple non-sexual offense convictions, the frequency, density, and nature of these additional convictions should be considered within the overall evaluation of risk.

[218] In limited instances, the Static-99R can be used with male juveniles who committed a sexual offense when 17 years of age and who are released when 18 or older. The Static-99R manual revised (2016) discusses the limitations of use with adolescents. The VASOR-2 and SOTIPS are only intended for use with males who committed at least one qualifying sexual offense when 18 years or older.


Decision Aid for Evaluation of Male Adults Who Have Committed Sex Offenses as an Adult and Have a New Non-Sex Crime
Conduct Evaluation of Current Sexual Recidivism Risk Level
Use either the Time-Free actuarial tables or the Time-Free Risk Calculator method (see guidelines), OR use an alternative best practice method suitable for the client, consistent with SOMB Adult Standards and Guidellnes Section 2.000.
Ensure the evaluation focuses on the current risk of sexual recidivism following the period of time sex offense-free in the community since the most recent sex offense(s). This may not be the same as the risk at the time of release/community sentencing.
Preferrably the evaluation includes use of one or more actuarial instruments that involve assessment of dynamic as well as static risk factors. Within the overall evaluation of risk level, consideration should be given to the combination of static and dynamic risk factors, protective factors and strengths, time sex offense-free in the community, and new nonsexual offending.
Is current sexual recidivism risk at desistance level?
YES
NO
Other Factors To Consider When Determining Recommendations (all do not need to be present, apply clinical judgment)
Other Factors To Consider When Determining Recommendations (all do not need to be present, apply clinical judgment)
Low-Mod/Moderate Intensity Intervention Needs
Moderate-High/High Intensity Intervention Needs
Offense-Specific Risk-Needs
- non-sex crime does not share characteristics with sex offending -
- no sex offense criminogenic needs present that would benefit from treatment -
- no significant concerns about compliance with safety plan -
NO
Offense-Specific Risk-Needs
- non-sex crime does not share characteristics with sex offending -
- some criminogenic needs present, may be transitory, mild, or 1-2 main areas
- no evidence of paraphilic disorder associated with sexually abusive behavior -
NO
Offense-Specfic Risk-Needs
- multiple criminogenic needs present, some chronic or severe, but manageable in the community -
- paraphilic disorder associated with sexually abusive behavior, SVP status, or psychopathy may be present, but manageable in the community -
NO
Protective Factors/Strengths
- has protective factors that mitigate any residual risk/concern -
- may be potential negative impact of intervention on protective factors -
- history of good past sentence compliance -
NO
Protective Factors/Strengths
- may have engaged in past sex offense-specific treatment -
- protective factors developing (allthough criminogenic needs may impact full effective use of resources/strengths) -
- amenable to treatment and history of adequate past sentence compliance -
NO
Protective Factors/Strengths
- complied minimally with past sentence(s) -
- basic capacity and willingness to engage in treatment/management -
NO
YES
YES
YES
Where the individual is at desistance level and there are no significant or ongoing additional criminogenic concerns consider recommending no sex offense-specific treatment or supervision terms and conditions.
Determine any recommendations for non-sex offense treatment and supervision (eg, substance abuse or mental health treatment) based on evaluation of non-sex offending risk-need.
Where the individual has low-mod to moderate intensity intervention needs, and there are limited significant additional concerns, consider recommending targeted sex offense-specific treatment with accompanying supervision terms and conditions. It is anticipated that treatment will be shorter-term and focused on specific risk-need issues. Give consideration to whether there is any indication for a child contact screen.
Determine if any additional recommendations for non-sex offense treatment and supervision (eg, substance abuse treatment) are indicated based on evaluation of non-sex offending risk-need.
When the individual has mod-high or high intensity intervention needs, or there are significant risk-need concerns, consider recommending comprehensive sex offense-specific treatment with standard sex offender supervision terms and conditions. Conduct relevant child contact screen and make associated recommendations.
Determine any recommendations for non-sex offense treatment and supervision based on evaluation of non-sex offending risk-need.
Where there is a need for high intensity treatment but the individual is assessed as unsuitable for community-based treatment due to the level of risk, treatment amenability, and/or nature and severity of non-sex offending, indicate this to the referring agency.

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Appendix F: Sex Offense-Specific Intake Review for Clients Who Have Been in Prior Treatment

The Colorado Sex Offender Management Board (SOMB) supports SOMB Listed Treatment Providers providing comprehensive intake assessments for clients seeking entry into a treatment program with a prior history of sex offense specific (SOS) treatment. This document should be used as guidance in conjunction with the applicable SOMB Adult or Juvenile standards. The SOMB's purpose in developing this document is to ensure continuity of care via a thorough review of relevant prior treatment and supervision information to aid in the planning of treatment needs for the client. To this end, it is imperative that the Treatment Provider make every reasonable effort to identify and obtain past treatment records. In the absence of such records, it is the responsibility of the Treatment Provider to conduct a thorough and collaborative treatment review with the client to determine what treatment has been completed, what components of treatment need additional focus, and what components of treatment have not yet been completed. Through the completion of this review, a client's individual treatment needs can be determined. Clients should not be required to re-start treatment solely due to a change in Treatment Providers and the lack of available information from the prior Treatment Provider. On the other hand, mere completion of a treatment objective does not preclude the client from repeating such an objective if behavioral indicators suggest the need for additional treatment in this area.

The following information shall be reviewed collaboratively with the client to determine the starting point for the current treatment. It is recommended that this documented be **completed by the primary therapist** over the course of the first 2-3 sessions. This form may also be used for an on-going re-assessment of client treatment needs, as well as a final assessment at the time of discharge.

Client's Name: DOB:

Therapist completing intake: Date of intake:

Index Offense:

Past convictions / Adjudications:

Has the client previously received SOS treatment? ☐ Yes ☐ No
If yes, list previous providers:

Has the client signed releases to talk with previous treatment providers? ☐ Yes ☐ No

Length of time previously in treatment:

Does the client have any certificates of completion/documentation of treatment module completion?
☐ Yes ☐ No
If yes, list certificates/documentation:

Reason for discharge or transfer:

Have the following individuals been contacted for collateral information?
☐ Probation/Parole Officer ☐ Family ☐ Victim Therapist or DA's office
☐ Past Providers ☐ DHS Caseworker / DYC

What barriers or obstacles interfered with the client's successful engagement with the prior treatment, if any?

What factors aided the client in being successful in treatment? (What worked well?)

What are the client's strengths?

Have specialized assessments (Polygraph, PPG, ABEL/Affinity) been completed?
☐ Yes ☐ No
Identify and provide results:

What was the date of the last Sex Offense Specific Evaluation?
Risk assessment results:
Results in terms of critical treatment needs:
Recommendations for treatment planning:

Current Risk Level:

Are there any specific conditions that have been previously set by the CST/MDT?
Provide details:

Are there any activities or special accommodations that have been previously approved by the CST/MDT?
Provide details:

Are there any approved safety plans in place at this time?
Provide details:

What recommendations have been made by previous treatment providers?

Which standards are applicable for the client? ☐ Adult ☐ Juvenile

Sex Offense Specific Intake Review for Clients Who Have Been in Prior Treatment

For clients subject to Juvenile Standards:

Yes	No	Partial	Treatment
☐	☐	☐	Is the client able to discuss their offense without blaming, minimizing or justifying their behavior?
☐	☐	☐	Is the client able to properly assign responsibility for the offense and discuss the impact and harm done to their victim(s)?
☐	☐	☐	Is the client able to discuss the clarification process and what steps have been taken?
☐	☐	☐	Is the client able to define abusive behaviors (abuse to self, others, property, and/or physical, sexual and verbal abuse)?
☐	☐	☐	Is the client able to identify and discuss their patterns of thoughts, feelings and behaviors associated with their offending behavior?
☐	☐	☐	Is the client able to discuss how they consistently interrupt patterns of thoughts and behaviors associated with their abusive behaviors?
☐	☐	☐	Is the client able to identify and discuss negative thoughts they have supportive of antisocial or violence themed attitudes?
☐	☐	☐	Is the client able to discuss the role of sexual arousal in offending behavior and discuss abusive, illegal, and/or harmful sexual fantasies and their plan to manage their arousal and fantasies?
☐	☐	☐	Is the client able to discuss strategies for anger management, conflict resolution, problem solving, stress management, frustration tolerance, delayed gratification, cooperation, negotiation and compromise?
☐	☐	☐	Is the client able to identify and discuss their risk factors and a plan to manage these risk factors?
☐	☐	☐	Is the client able to discuss their safety plan and relapse prevention strategies?
☐	☐	☐	Is the client able to discuss and demonstrate emotional regulation and utilize self-protection skills?
☐	☐	☐	Is the client able to identify pro-social relationship skills and pro-social supports?

Yes	No	Partial	**Additional Information**
☐	☐	☐	Is there a Qualified Informed Supervisor (as defined in standard 9.100)?
☐	☐	☐	Are there additional adjunct treatment needs? (i.e. substance abuse, suicidal ideation, mental health needs, cognitive needs or challenges, etc) How have these needs been addressed in the past? How will these needs be addressed at this time?
☐	☐	☐	Has a relapse prevention plan been completed?
			Who has or is currently able to provide support to the client? (Include any training or classes the person completed)

Upon completion of the intake review provide a brief narrative regarding how the above information was gathered and verified beyond solely client self-report. Include information about how the client is able to demonstrate internalization of treatment concepts.

Based upon the information gathered during the intake review the following recommendations are made regarding the current focus of treatment.

_____ _____
SOMB Treatment Provider - signature SOMB Treatment Provider - printed name

_____ _____
Client – signature Client - printed name

_____ _____
Supervisor - signature (where applicable) Supervisor - printed name

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Appendix G: SOMB Position Paper Regarding a Sex Offender's Contact with His or Her Own Child

Colorado Sex Offender Management Board (SOMB)
Position Regarding A Sex Offender's Contact with His or Her Own Child
Approved March 18, 2016

Currently, in the State of Colorado, a person defined as a "sex offender" in C.R.S. §16-11.7-102 (2) and required to complete sex offense-specific treatment under the SOMB's *Adult Standards and Guidelines for the Assessment, Evaluation, Treatment and Behavioral Monitoring of Adult Sex Offenders* or under *the Standards and Guidelines for the Evaluation, Assessment, Treatment and Supervision of Juveniles Who Have Committed Sexual Offenses* (herein referred to as *Standards & Guidelines*) is not allowed contact with his or her own child,[219] unless one of three conditions are met:

1. The offender meets the criteria for a Child Contact Assessment (CCA), completes the evaluation process with favorable recommendations, and the Community Supervision Team adopts those recommendations; or

2. The offender engages in treatment and meets the criteria as outlined in 5.700 of the *Adult Standards and Guidelines for the Assessment, Evaluation, Treatment and Behavioral Monitoring of Adult Sex Offenders* (herein referred to as *Standards & Guidelines*).

3. If under the purview of the *Juvenile Standards and Guidelines,* the Multi-Disciplinary Team adopts those recommendations.

The recent Court ruling in the *United States vs. Burns*, 775 F.3d 1221 (10th Cir. 2014) impacts Colorado's current approach to parent-child contact and therefore necessitates Colorado re-evaluate its approach. In *Burns*, the Court ruled that a parent has a constitutional right to familial association. In part, "A father has a fundamental liberty interest in maintaining his familial relationship with his [child]." *Burns* at 1223, citing *United States v. Edgin*, 92 F.3d 1044, 1049 (10th Cir. 1996). The Court continued, stating that "When a court imposes a special condition that limits a fundamental right or liberty interest, the court must justify the condition with compelling circumstances." *Id*. At 1223. A

[219] Per Section 5.710 of the *Standards and Guidelines,* an own minor child is defined as "a minor child with whom the offender has a parental role, including but not limited to, biological, adoptive, and step-child(ren)." In addition, per the *United States vs. White*, 782 F.3d 1118 (10th Circuit 2015), an emphasis is given to those who have a "custodial" relationship with their own child.

conviction, alone, may not meet the criteria for compelling evidence for restraining a parent's constitutional right to parental association.

In light of this recent ruling, lawyers, probation officers, evaluators and therapists, among others, must determine how to best assist the Judge in making informed decisions. Courts must balance a parent's constitutional right to parental association with concerns of posing undue risk to the children of sexual offenders.

In order to assist the Courts in determining whether or not compelling circumstances to limit such contact exist, it is now recommended that evaluators add information to the sex offense specific evaluation discussing the risk factors that may impact the risk a client poses to his/her child(ren). The SOMB recognizes there are few empirically identified risk factors that predict a convicted sex offender's risk for sexually offending against his/her own child. The discussion should rely on the research supported evidence regarding risk of sexual re-offense and should include potential risk for the offender to victimize across gender and age categories.[220] This section should explain how these factors may or may not translate to risk of a new sexual offense against a child. Protective factors are important and should be considered. The suggested risk factors that are consistently identified in research, and that may be relevant to identify and discuss in the evaluation, include, but are not limited to:

A. Risk Level for sexual recidivism[221]
B. Number of convictions for sexual offenses[222]
C. Number of sexual offenses (does not have to be a conviction) involving minors[223]
D. The nature of the relationship of the offender to the victim(s)[224]

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E. Number of victims[225]
F. Age and gender[226]
G. Intellectual and developmental disabilities of the victim and the offender[227]
H. Age, gender and abuse history of the offender[228]
I. Sexual offense responsibility [229]
J. Results of a sexual interest/sexual arousal assessment[230]
K. Diagnosis of pedophilia[231]
L. Psychopathy or psychopathology (via PCL-R, Millon Clinical Inventory, etc.)[232]
M. Cognitive distortions related to child victims or children in general[233]

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N. Years sex offense free in the community[234]

Some of the above risk factors are also identified in other sections of the sex offense specific evaluation. However, it may be helpful to summarize those factors specifically related to an offender's contact with his or her own child.

In addition, it is recognized that the necessary information to discuss each listed factor may not be available at the time of the sex offense specific evaluation. In those circumstances, it is appropriate to note the limitations of the available information.

This information should be clearly identified in the sex offense specific evaluation. Please note, evaluators are not required to make a recommendation either for or against such contact, unless the evaluator chooses to include such a recommendation, but rather to provide information to assist a judge in decision formulation.

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Recidivism: A Meta-Analysis. *Trauma Violence Abuse, 14*(1), 34-53; Hempel, I., S., Buck, N., M., Goethals, K., R., & Marle, H., J., C. (2012). Unraveling sexual associations in contact and noncontact child sex offenders using the single category - implicit association test. *Sexual Abuse: A Journal of Research and Treatment, 25*(5) 444–460; Whitaker et al. (2008). Risk factors for the perpetration of child sexual abuse: a review and meta-analysis. *Child Abuse & Neglect, 32*(5), 529-548.

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Appendix H: Disaster Emergency Management Safety Plan

DISASTER EMERGENCY SAFETY PLAN (DESP)

___ Judicial District, Adult Probation Department, Parole Region, or Community Corrections Facility
And/or
_____ Law Enforcement Agency

Sex Offender Unit

Name: _____ Telephone Number: _____

Supervising Officer: _____ Telephone Number: _____

Treatment Provider: _____ Telephone Number: _____

Other Therapist: _____ Telephone Number: _____

In the event of a disaster (a natural or man-made event that negatively affects life, property, livelihood such as a fire, flood, weather event, etc.), I will implement the following Emergency Management Plan as developed with my supervising officer. I understand that all of the terms and conditions of registration and supervision, including no contact with children and victims, still remain in full force. I understand that my plan must include going to a safe location that does not violate my terms and conditions of supervision (e.g. no schools or other places where children, or my victim may be present), and that I am to remain accountable for all of my other safety plans and treatment requirements (e.g. treatment attendance, taking required psychotropic medication, checking in on schedule, etc.). Finally, I understand that a more comprehensive emergency risk management plan will be developed later with my treatment provider.

In the event of a disaster, I agree to keep in touch with my supervising officer and the other members of any community supervision team (CST) I may have. In addition, I agree to keep the following persons informed, on a daily basis, of my whereabouts, leaving good contact information with each of them.

In case of emergency, I will keep in daily contact with at least one of the following:

(1)
Name: _____

Address: _____
_____

Phone: (c) _____

(w) _____

(h) _____

(2)
Name: _____

Address: _____
_____

Phone: (c) _____

(w) _____

(h) _____

[This person should reside outside of the impacted area]

(3)

Name: _____ The following list will remain off limits.

Address: _____ _____

_____ _____

Phone: (c) _____ _____

(w) _____ _____

(h) _____ _____

The overriding purpose of this emergency plan is to keep me and the public safe. Compliance with this plan by keeping in touch with my supervising officer and community supervision team will help keep me in compliance with my legal obligations by following the directives of my supervisors.

In an emergency, were my home not available for me to reside in, I intend to stay temporarily at one of the following locations:

_____

_____

I understand that if I have no other place to go that is safe and legal, then I will report to the local shelter and disclose my registration status to the shelter staff and law enforcement at the time I enter. I will take responsibility for contacting law enforcement immediately upon arrival at any shelter. I agree to follow all law enforcement instructions regarding housing and notifying my supervisor of any instructions that I receive.

My supervisor's agency contact or on call supervisor's number is _____.

Signature _____ Supervising Officer_____

DATE: ____ /____/____. Date: ____ /____/____.

Keep a copy of this Disaster Emergency Safety Plan with your other important papers

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Appendix I: Guidance to Providers on the Use of Medical Marijuana, Prescription Medications and Over the Counter Medications by Sexual Offenders

Approved January 15, 2016

Recent legislation has impacted the use of medical marijuana by sexual offenders on probation. Probation officers are complying with this legislation.

House Bill (H.B.) - 15-1267

Pursuant to H.B. 15-1267, individuals on probation, including those convicted of a sex crime, are generally permitted to possess or use medical marijuana if they have a valid medical marijuana card. There are two exceptions to the individual being allowed to use medical marijuana:

1. If the crime for which the probationer was convicted is a violation of Article 43.3 of Title 12, C.R.S. (Colorado Medical Marijuana Code), the probationer cannot use/possess medical marijuana. This is not discretionary on the part of the judge.

2. The law provides that the court, on a discretionary basis, may prohibit use/possession if the "court determines, based on the assessment as required by section 18-1.3-209, a prohibition against the possession or use of medical marijuana is necessary and appropriate to accomplish the goals of sentencing as stated in 18-1-102.5." Probation officers are to provide the court with pertinent information regarding the assessment, and the court reaches a decision after considering the results of the assessment as well as the goals of sentencing.

Providers who have concerns about abuse/dependence may share those concerns with the probation officer; however, those concerns will not change the fact that a court's discretion relative to the use/possession of medical marijuana is extremely limited.

Guidance to SOMB Listed Providers On the Use of Medical Marijuana, Prescription Medications, and Over the Counter Medications by Sexual Offenders

In light of H.B. – 15-1267, the SOMB is offering the following guidance to SOMB Listed Providers. It is not uncommon for a client of therapeutic services to be under the care of a physician and be prescribed medication. This medication can be in the form of prescription narcotics for pain management, prescription psychotropic medication for mental health symptoms, or even medical marijuana. It is

important for mental health professionals to consult with the client's medical provider to determine the effects of the medication, possible side effects, and potential impacts to the therapeutic process.

The Colorado Mental Health Practice Act (12-43-208 and 12-43-209) specifically prohibit a mental health professional from "engaging in the practice of medicine" or to "advise a client with reference to medical problems." The mental health professional should, however, assess during treatment sessions if a client's decision-making and judgement are affected by medication use. A client cannot be impaired during treatment and needs to be able to focus, be present, participate, and track content of treatment sessions. The prescription of a medication or medical marijuana by a physician does not prohibit a SOMB Listed Provider from also determining as necessary whether the medication or medical marijuana use is being abused by the client. The various ethical codes of conduct, including the American Counseling Association, discuss the "inability of incapacitated adults to give consent." In these cases the mental health professional should discuss the concerns with the client and other members of the treatment team to determine the best course of action.

Specific Guidance Regarding Medical Marijuana and Clients in Treatment for a Sexual Offense

Obtain Information from the Probation Officer

SOMB listed providers, in conjunction with the Community Supervision Team (CST), or Multidisciplinary Team (MDT, should obtain information from the probation officer regarding the allowance or prohibition of medical marijuana use while under court supervision.

SOMB Listed Providers Agency Policies

Ethical standards allow mental health professions, including SOMB Listed Providers, to determine which clients they accept, or do not accept, into treatment, and whether their program has policies or protocols in place to address client impairment due to substance or medication use, including medical marijuana.

Confidentiality of the Marijuana Registry

It is important to keep in mind that per the State Court Administrator's Office, a sex offender's "status on the medical marijuana registry is not public information. It is a class 1 misdemeanor to release or make public confidential information from the marijuana registry. Therefore, if the information regarding a person's status is to be released, it is important to secure a signed release of information from the client before doing so, or place with communication with the court under confidential cover[235]."

Testing and Assessment Considerations

Medical marijuana usage by clients in sex offense specific treatment may affect their polygraph results. Therefore, the use of medical marijuana by clients subject to polygraph assessment should be discussed with the polygraph examiner and prescribing physician. The CST/MDT should make a determination about the suitability of a client for assessment utilizing polygraph, plethysmograph, VRT, and alternative monitoring and accountability measures.

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[235] Memorandum from the State Court Administrator's Office (DPS 09-01, March 5, 2009).

Appendix J: Notice of Recommendation Concerning Removal from Sex Offender Registry

( ) COUNTY ( ) DENVER JUVENILE ( ) DISTRICT COURT, *_____ COUNTY, COLORADO* *_____ County Courthouse* *Courthouse Address:* *_____* *People of the State of Colorado* *In the Interest of:* *_____, Juvenile* *and concerning Respondent:* *_____* *(Name of Parent / Guardian)*	♦COURT USE ONLY♦
	Case Number: _____JD_____ (please indicate the case in which the juvenile was ordered to register as a sex offender) Division: Courtroom:

MOTION TO FILE THIS NOTICE AND ANY ATTACHMENTS UNDER SEAL &
NOTICE OF RECOMMENDATION OF
SEX OFFENSE-SPECIFIC TREATMENT PROVIDER
CONCERNING REMOVAL FROM SEX OFFENDER REGISTRY

Motion to File Under Seal: The undersigned requests the Court accept this notice and any attachments under seal. This filing contains confidential mental health treatment information that should be kept private, subject to any release, in whole or in part, that may occur with the knowledge, approval, and supervision of this Court.

Notice: This notice is being provided to advise the Court that (name of client) _____ entered into sex offense-specific treatment on _____ (date) and was discharged on _____ (date) from:

Name of Program: _____

Address: _____

Phone Number: _____ **Fax Number:** _____

Email Address: _____

Based upon my consideration of (name of client) _____'s participation in treatment, as of this date, I do/do not recommend that this Court relieve him/her of the duty to register as a sexual offender in the state of Colorado. I have/have not attached additional information concerning my recommendation.

This recommendation is provided because (except in the case of a deferred adjudication), among other factors, the Court shall consider the recommendations of a person's sex offense-specific treatment provider in determining whether to remove the person from the sex offender registry. Colo. Rev. Stat. § 16-22-113(1)(e). Consequently, this recommendation does not reflect consideration of events transpiring between the date of its filing and the date upon which this Court ultimately may entertain a petition to discontinue registration.

_____

Signature of SOMB-Approved Provider _____ **Printed name of SOMB-Approved Provider** **License # / credential (if applicable):** _____ Dated: _____	

NOTE: PLEASE DETACH THIS PAGE BEFORE FILING THE FORM

INSTRUCTIONS TO THERAPISTS FOR JUVENILE DEREGISTRATION RECOMMENDATION FORM:

At the time of discharge from treatment, ***print or type*** the information required by the form and sign the signature block. Where text is underlined, please **circle one** option, *e.g.*, **do/do not**.

The form is to be filed in the court and under the juvenile ("JD") case number where the client was ordered to register as a sex offender. If venue was subsequently changed to a different county, the form should be filed under the *last* case number and in the *last* county having jurisdiction over the client for the offense requiring registration. The address for each County and District Court in Colorado is to be entered in the caption and is available under "Find a Court" at: http://www.courts.state.co.us/

This form may be filed with the court in person at the courthouse or submitted via U.S. Mail to the Clerk's Office at the court's mailing address. A Probation Officer may also assist you in properly filing this form with the court.

PURPOSE OF THIS DOCUMENT:

In Colorado, some clients will not become eligible or file a petition to be taken off the sex offender registry until many years or decades after their sentences have terminated. Nevertheless, where a juvenile adjudication has entered, judges entertaining such petitions are required to consider the recommendations of treatment providers in assessing whether or not to relieve a person of the duty to register. For many clients, ***including adjudicated clients who have become adults by the time they petition to deregister***, obtaining documentation from their treatment provider may be difficult or impossible. This form has been developed as a tool to assist therapists in providing feedback to the court that is contemporaneous with the therapy process. It allows the therapist to share information with the court about their opinions concerning a juvenile's termination from treatment close in time to the treatment and while authorizations remain in effect allowing the therapist to divulge this otherwise confidential information to the court.

Similarly, Standard 3.420(C) of the *Standards and Guidelines for the Evaluation, Assessment, Treatment and Supervision of Juveniles Who Have Committed Sexual Offenses* requires treatment providers to prepare a written summary that includes "A current recommendation regarding whether registration should/should not continue based on information available at the date of the report."

Unlike most other records, court files are maintained forever. Consequently, by logging this information in the court record, it will remain available to clients and other parties to the case in the court's discretion.

Although State law advises that the court shall consider the recommendation of the therapist in evaluating a petition to discontinue registration, it provides limited guidance as to the nature of the information that is to be conveyed. This form allows the therapist to document his/her ultimate recommendation concerning the registry. If the therapist would like to further expand on the recommendation, s/he may attach a letter or report explaining his/her position more fully. Any documents received by the court under seal cannot be viewed by anyone else without subsequent court orders authorizing release.

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Appendix L: Safety Planning

Safety plans should be individualized to each youth based on their risks, needs and treatment progress. The list below is meant to help brainstorm ideas on how to make an effective safety plan for your particular client. Ideally, safety plans should be written by the youth with support from their caregivers and treatment providers.

1. Where is the client going or what is the activity?
   A. Is this an ongoing activity or a one-time event?
   B. If it's ongoing when will be it be reevaluated?
   C. What time/date will it take place?
   D. For overnight events
      a. Sleeping arrangements
      b. Door alarms?
      c. Supervision during sleeping hours

2. What are the risks of the actual event?
   A. Are there crowds? Can you get lost or wander off? What is the layout of the house/event?
   B. Will peers/friends be present?

3. What will the supervision plan be?
   A. Will there be informed supervisors present and who are they?
   B. Will a non-informed supervisor adult be there?
   C. Restroom use – any specifics to plan around (e.g.: should an adult go with you or check the bathroom first?)
   D. Possible requirements/needs of parents
      a. Room searches
      b. Check door alarm
      c. Making connections with other adults at planned activities (verify activity plan/potential contact with vulnerable persons/communicate expectations of youth to other adults)

4. Will there be children present?
   A. How old are they?
   B. Who is responsible for the supervision of the other children?

5. What is the plan for transportation?

6. Any potential contact with victim?
   A. How will unplanned contact be handled?

7. Internet use
   A. Will it be allowed?
   B. What about cell phones?

8. Triggers
   A. Environmental triggers
   B. Emotional triggers
   C. Physical triggers
   D. Cognitive Triggers

9. Plans/tools/coping skills of how to manage triggers and risks

10. Rewards and consequences
    A. Expectations for different levels of infractions

11. Check-in plan
    A. What if something doesn't go according to plan
    B. If you are unsupervised, do you need to check in?

12. Who needs to sign and agree?
    A. Probation/family/caseworker/treatment provider

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Appendix M: Polygraph Examination

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:

A. Sexual history polygraph examination

Minimal preparation requirements by the juvenile:

1. 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)

2. Identification of victims of past abusive sexual behaviors and specific types of unlawful sexual contact are clear

3. Identification of other non-abusive sexual history, including the juvenile's own sexual victimization history, consensual sexual experiences, non-coercive sexual contact with same-age family members, etc.

4. Demonstrates an adequate conceptual vocabulary regarding the test issues

5. Written preparation materials completed by the juvenile should be provided to the examiner prior to or at the time of the examination regarding sexual history disclosure, if required by the MDT

Examination areas may include:

1. Sexual offenses
2. Sexual behavior patterns
3. Consensual sexual contacts
4. Masturbation issues
5. Pornography issues
6. Grooming, silencing, and maintenance behaviors
7. 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.

B. Maintenance/monitoring polygraph examination

Minimal preparation requirements by the juvenile:

1. 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)

2. Demonstrates an adequate conceptual vocabulary regarding the test issues

3. Written preparation materials completed by the juvenile should be provided to the examiner prior to or at the time of the examination regarding current maintenance/monitoring issues, if required by the MDT

Examination areas may include:

1. Re-offense/lapse/relapse behaviors
2. Sexual contacts
3. Contacts with minors and/or vulnerable persons
4. Masturbation issues
5. Pornography issues
6. Grooming, silencing, and maintenance behaviors
7. Recent criminal behaviors
8. Compliance issues
9. Household boundaries
10. School boundaries

C. Specific issue polygraph examination

Minimal preparation requirements by the juvenile

1. 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)

2. Demonstrates an adequate conceptual vocabulary regarding the test issues

3. Conceptual understanding of the nature and time-frame of the issue, allegation, or inconsistency under investigation

4. Written preparation materials completed by the juvenile should be provided to the examiner prior to or at the time of the examination regarding specific issue to be investigated, if required by the MDT

5. 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:

1. Any history of involvement in the issue under investigation (absent of any allegation or reason to suspect involvement)
2. Specific issues regarding the allegation and/or discrepancies under investigation

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 abusive, illegal, and/or harmful 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:

1. To gain information relevant to the determination of risk level and/or progress in treatment
2. To deter problem behavior and encourage complianace and healthy/safe behavioral adjustment
3. 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:

A. The juvenile's history of involvement in sexual offense behaviors andsexual behaviors (sexual history polygraph examination);

B. 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);**

C. 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:

A. The nature and purpose of the polygraph test;

B. The information and results obtained from the polygraph test; and

C. 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:

A. Nature and purpose of the polygraph examination

1. Detection of information relevant to risk assessment and treatment planning
2. Verification of compliance with supervision and/or treatment requirements
3. Deterence of problem behaviors

Discussion: Polygraph examination outcomes may lead to increased or decreased activity restrictions and/or changes in supervision or treatment requirements.

B. Polygraph outcomes

1. Admissions/disclosures
2. Timeliness of admissions and disclosures (i.e., preparation, pre-test, post-test)
3. Scored test results
4. 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.

C. Case management context (to be considered when responding to polygraph examination outcomes)

1. Individual's diagnostic/developmental profile
2. Length of court supervision (remaining supervision period)
3. Progress in sex offense specific treatment
4. History of behavioral compliance
5. Quality and level of supervision in the individual's environment
6. 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. Failure to assist the juvenile with adequate preparation can impact the results of the exam.

   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 abusive, illegal, and/or harmful 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 are not allowed per the Standards and Guidelines.

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:

A. Erotica - swimsuit calendars, lingerie or underwear advertisements, non-pornographic magazines
B. Pornography - nudity in pornographic magazines, movies or websites
C. Sexually aggressive pornography - sexual materials depicting violence or force
D. 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.

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Appendix N: SOMB Sexual History Disclosure Packet for Juveniles Who Commit Sexual Offenses

Treatment Provider Guidelines for Sexual History Disclosure Packet
The therapist should work with the juvenile on this sexual history disclosure packet. The process should be therapist guided and directed.

A. The first step should be to orient the juvenile to the sexual history process including the disclosure packet. The therapist should explain all of the concepts to the juvenile to ensure understanding of the sexual history packet. All terms should be defined and explained.

B. The therapist should guard against the potential harmful impact of being exposed to terms beyond the juvenile's sexual experiences and ability to understand.

C. It is recommended that the therapist use a timeline to assess the juvenile's sexual functioning and experience as part of the process of deciding how to handle the sexual history disclosure packet process. The therapist may wish to base significant events based on significant life events (e.g. grade in school, etc.).

D. The therapist should then decide if the juvenile should complete the sexual history disclosure packet in the office during a therapeutic session, which is recommended and/or on his/her own.

E. The therapist should continue to support continued disclosure throughout the process by the juvenile. It is understood that additional disclosures may occur throughout the process.

F. It is important that the therapist communicate with the Polygraph Examiner:

1. The juvenile's developmental level.
2. The juvenile's extent of sexual experiences including his/her own victimization.
3. The areas that should be addressed and the polygraph examiner will be responsible for
4. constructing the questions.
5. The items or questions being modified after further discussion from the MDT.

The therapist should complete the Sexual History Interview Form (following page) with the juvenile. The therapist should use clinical judgment in determining which specific questions to ask the

juvenile. The Sexual history interview form should not be given to the juvenile to complete due to the need to limit exposure of items the juvenile may not be aware of.

Name:_____DOB:_____

Sexual History Interview Form

The therapist should answer each item as developmentally appropriate during the interview with the juvenile. It is recommended the therapist provide this form to the polygraph examiner rather than give it directly to the juvenile to take to the exam.

#	Item	Yes/No	Frequency (or total #)	Last Time
1.	Experienced sexually abusive, illegal, and/or harmful fantasies	Yes / No		
2.	Masturbated to abusive, illegal, and/or harmful fantasies	Yes / No		
3.	Cruising behaviors	Yes / No		
4.	Made photos/videos of self or others for sexual purposes	Yes / No		
5.	Abused animals	Yes / No		
6.	Sexually abused animals	Yes / No		
7.	Necrophilia (sexual contact with dead animals or people)	Yes / No		
8.	Arousal to offending memories	Yes / No		
9.	Verbal or physical abuse of a partner	Yes / No		
10.	Participation in cults or hate groups	Yes / No		
11.	Alcohol usage	Yes / No		
12.	Illicit drug usage	Yes / No		
13.	Provided alcohol/drugs to peers	Yes / No		
14.	Contact with victim/s after restriction	Yes / No		
15.	Self-mutilation (cutting or other self-abuse behavior)	Yes / No		
16.	Use of feces for sexual purposes	Yes / No		
17.	Use of urine for sexual purposes	Yes / No		
18.	Use of inanimate (non-human) objects for sexual arousal or masturbation	Yes / No		
19.	Nudity in public places	Yes / No		
20.	Sexual contact in public places	Yes / No		
21.	Consensual sexual contacts (non-abusive, not unlawful, non-coercive)	Yes / No		
22.	Sexual infidelity	Yes / No		
23.	Anonymous or casual sexual contacts (persons known less than 24 hours)	Yes / No		
24.	Sexual contact with same-sex partners (as a juvenile and adult)	Yes / No		
25.	Group sex activities	Yes / No		
26.	Consensual bondage activities	Yes / No		
27.	Sexual sadism (arousal to another's pain or humiliation)	Yes / No		
28.	Sexual masochism (arousal to your own pain or humiliation)	Yes / No		
29.	Anal sex activities	Yes / No		
30.	Sexual victimization	Yes / No		
31.	Computer sex behaviors (cybersex / sex-chat via computer or electronic device)	Yes / No		
32.	Telephone sex behaviors (phone sex lines, obscene phone calls)	Yes / No		
33.	Used a personal or dating service (telephone, computer or electronic device)	Yes / No		
34.	Visited or frequented topless bars / strip clubs	Yes / No		
35.	Visited or frequented adult bookstores or novelty shops	Yes / No		
36.	Visited or frequented erotic massage parlors (used erotic massage services)	Yes / No		
37.	Transexualism (wanting to be a member of the opposite sex)	Yes / No		
38.	Transvestitism (dressing as a member of the opposite sex)	Yes / No		
39.	Have you ever worn the undergarments/clothing/property of another person in a sexual manner?	Yes / No		
40.	Have you ever engaged in arson or sexually motivated fire-setting behaviors?	Yes / No		
41.	Have you ever verbally or physically abused a family member?	Yes / No		

Interview conducted by:_____

Instructions for the Juvenile to complete the Sexual History Disclosure Packet

A. Complete the following pages in the Sexual History Disclosure Packet.

    1. Sex Education
    2. Masturbation History
    3. Pornography History

B. Complete Consensual Sexual Behavior Summary form (Attachment)

C. Complete **one** Sexual Behavior Form (Attachment) for each identified victim (please include victims, charged or not charged).

    1. Make additional copies of individual pages or the Sexual Behavior Form (Attachment) as necessary.
    2. Do not leave any item blank. Answer YES or NO to every item

D. Complete the Sexual History summary form.

    1. Do not leave any item blank. Answer YES or NO to every item

Provide your treatment provider and supervising officer with copies of your completed sexual history disclosure packet as requested and keep a copy for your own records.

Bring a copy of your sexual history disclosure packet to your polygraph examination - your examiner may not need to read it but you may want to refer to it (it is better to have it and not need it than to need it and not have it.)

E. Direct all technical questions about the polygraph test to the polygraph examiner. Soliciting information about the polygraph from friends, books or other media is unlikely to improve your test results and tends to be correlated with cynicism, resistance, unresolved test results and failure to progress in treatment.

Any attempt to falsify or alter your polygraph examination results may be regarded as a non-compliant and deliberate attempt to interfere with a process intended to assure and promote safety in the community and your progress in treatment. Such behavior may become the basis for sanctions in treatment and supervision.

Definitions

Arson or Fire-setting Behaviors: Include all behaviors involving fire-setting for destructive purposes, thrill/excitement, or sexual arousal.

Images of Child Sexual Abuse (often referred to as Child Pornography): Include all activities related to viewing, possessing, using, producing, or distributing of nude or sexualized images of minors (persons under age 18), including computer, phone, tablet, or other devices. This would include sexting by juveniles (see definition of sexting).

Coercion – Includes sexual contact (including attempts) with any person (including boyfriends/girlfriends) whose compliance you obtained through any non-violent form of coercion (i.e., bribery, manipulation, gifts, trickery, money, drugs, alcohol, friendship), despite the person's stated or unstated unwillingness to participate, including after the individual says "no" or "stop."

Consent: The willing and voluntary permission or agreement a person gives to do something or for something to happen. Discuss all elements of consent (size, age, intellect, strength, power, authority, popularity).

Cruising: Search, by any means, a place for a casual sexual partner.

Deviancy: Actions or behaviors that violate social norms, including formally-enacted rules as well as informal violations of social norms.

Domestic Violence*: Include all behaviors you have engaged in involving hitting, striking, slapping, pushing, throwing things, or breaking things out of anger or frustration toward intimate relationship (e.g. boyfriend, girlfriend, husband, wife). Also include threats of harm or intimidation through the use of words, weapons, or gestures.

*Therapist note: Witnessing domestic violence can also be a significant treatment issue, and should be explored if it arises during discussion of this issue. It should not be recorded on the form but should be addressed via the treatment plan.

Exhibitionism or Indecent Exposure*: Include all incidents in which you accidentally or intentionally exposed (including attempts) your bare private parts (including in a vehicle) to unsuspecting persons in public places or in private. Include incidents when you wore loose or baggy clothing that allowed your sexual organs to become exposed to others. Also include mooning, streaking or flashing behavior, having sex in a public place and public urination while in view of others.

***Therapist note: The above definition is not based on Statute.**

Family violence*: Include all behaviors you have engaged in involving hitting, striking, slapping, pushing, throwing things, or breaking things out of anger or frustration toward a family member (e.g. sibling, parent, etc.). Also include threats of harm or intimidation through the use of words, weapons, or gestures.

*Therapist note: Although not sexually abusive behavior, this is a significant treatment issue, and should be explored if it arises. It should be addressed via the treatment plan.

Frottage: Opportunistic sexual rubbing, bumping or touching against strangers or unsuspecting (non-incapacitated) persons inside or outside the home. This includes sexual touching (including attempts) of others' private parts during any play, sexual hugging, horseplay, bathing, diaper changing, lap sitting, wrestling or athletic activities of unsuspecting persons in private or public places (e.g., babysitting, school, work, stores, gym, crowds.) To be considered if done for the purpose of sexual gratification.

Incapacitated: Temporarily or permanently impaired by a mental and/or physical deficiency or disability. Include all sexual contacts (including attempts) involving persons who are mentally or physically incapacitated. To include but not limited to incapacitation by being under the influence of drugs or alcohol or developmental disability.

Institutional Sexual Contact: Include all sexual contact (including attempts) with persons while in placement including jail, detention facilities, group or foster homes, treatment centers, medical or psychiatric hospitals, boarding schools, or any out of home placement.

Intimate relationship: A relationship between spouses, former spouses, past or present unmarried couples, or persons who are both the parents of the same child regardless of whether the persons have been married or have lived together at any time.

Masturbation: Manual stimulation of the genital organs of yourself or another for sexual pleasure.

Physical Force: Includes sexual contact (including attempts) with any person (including boyfriends/girlfriends) whom you physically hit or struck, physically restrained using your body strength or any object, or use of weapons, including implied or improvised weapons, posing a threat, continues after stating “no” or “stop” in order to prevent the person from resisting or escaping.

Physical sexual contact: Include all persons with whom you engaged in any form of rubbing or touching (including attempts) of a person's sexual organs (i.e., breasts/chest area, buttocks, vaginal area, penis), either over or under clothing, if it was for the purpose of sexual arousal, sexual gratification or stimulation, or “sexual curiosity,” along with all persons whom you caused or allowed to rub or touch your private parts, either over or under clothing, for the purpose of sexual arousal, sexual gratification or stimulation or sexual curiosity. Also include persons with whom you engaged in any sexual petting (i.e. sexual hugging and kissing) behaviors.

Pornography: Include all activities related to viewing, possessing, using, producing, or distributing of nude or sexualized images of minors (persons under age 18), including computer,

phone, tablet, or other devices. This would include sexting by juveniles (see definition of sexting).

Position of Trust: Any person who you have or have had authority over (e.g. babysitter, coach, younger relative, volunteer, tutor, mentor, etc.).

Relative/Family Member: Include all persons related by blood, marriage (excluding spouse or someone in a spousal role) or adoption (e.g., mother, father, sister, brother, aunt, uncle, grandparents, grandchildren, cousins, nieces, nephews, step-children, in-laws).

Sex Play Games: Includes any sex play games (e.g., mommy-daddy, house, doctor, show-me, spin-the-bottle, truth-or-dare, wrestling, horseplay, etc.) where sexual touching (including attempts) occurred.

Sexting: Sending nude or sexually suggestive pictures by electronic means (i.e. cell phone or other electronic devices) to another person.

Sexual Assault on a Child: Colorado Revised Statute 18-3-405. Any actor who knowingly subjects another not his or her spouse to any sexual contact commits sexual assault on a child if the victim is less than fifteen years of age and the actor is at least four years older than the victim.

Sexual Contact with Animals: Include all sexual behaviors (including attempts) involving domesticated, farm/ranch, or wild animals. Include all sexual contact with pets, whether your own or belonging to others for purposes of sexual gratification.

Sexually Explicit Images: Images of unsimulated, real sexual acts, sexual intercourse and uncovered genitalia.

Sexually explicit talk/calls: Include all sexual contacts/interactions and attempted sexual contacts/interactions via computer or electronic devices, including e-mails, chat rooms, Facebook, text, computer, skype, on-ling gaming, cyber-sex, live web-cams, electronic bulletin board systems, Internet Relay Chat, DCC chat channels, private bulletin boards, other user groups. Includes consensual sexual talk and unwanted obscene telephone calls.

Sleeping: Include all sexual contacts (including attempts) involving persons when they were (or appeared) asleep, or unconscious.

Solicitation: Includes all attempts to meet, or actually having made arrangements to meet, a stranger via computer or electronic devices, including cell phones, text messages, e-mails, chat rooms, cyber-sex, live web-cams, electronic bulletin board systems, Internet Relay Chat, DCC chat channels, private bulletin boards, other user groups.

Stalking Behaviors: Include all behaviors involving following someone without his/her awareness or permission. Include all incidents of following someone to his/her home, workplace or vehicle, or following others around a store, aisle, parking lot, campus, or community. Include all other efforts to monitor or observe another person's behavior without their knowledge (e.g. texting, Facebook, etc.).

Stranger: A person whom one does not know or is unfamiliar with.

Threat: Include all behaviors involving threats to harm, threatening gestures, or verbal threats of harm, including threats of harm towards the person's relatives or family members (including pets), in order to prevent the person from resisting or escaping.

Voyeurism or Sexual Peeping: Include all sexual behaviors (including attempts) involving peeping or voyeurism, including all attempts to look into someone's home, bedroom or bathroom or any other place where undressing may be expected to take place without the person's knowledge or permission, in attempt to view someone naked, undressing/dressing, or engaging in sexual acts. Include all voyeurism attempts involving using or creating a hole opening to view others for sexual arousal, including all attempts to use any optical devices (i.e., cameras, videotaping, cell phones, mirrors, binoculars, or telescope) to view others for sexual purposes. Also includes sexual peeping or voyeuring against persons who were (or appeared to be) asleep or incapacitated.

Sex Education

Describe when you learned about sexuality.

Describe where you learned about sexuality.

Describe from whom you learned about sexuality.

Masturbation History

List history of masturbation including age of onset, frequency, types of fantasy, and places (i.e., bedroom, bathroom, or outside of your residence). Please specifically note masturbation where you could view others or could possibly be observed by others while masturbating, including public restrooms, workplace/school settings, vehicles, and others' homes.

Include use, theft, or purchase of underwear, undergarments, or personal property for masturbation or sexual arousal. Include taking or keeping undergarments from sexual partners, relatives, friends, or strangers for masturbation or sexual arousal. Also include all incidents in which you returned someone's underwear or undergarments after using them for masturbation or sexual arousal.

Lastly, include masturbation to non-pornographic sexually stimulating images.

Pornography History

Include all activities related to use of pornography, including age of those depicted in pornography (e.g. images of child sexual abuse), types of pornography used (e.g. violent) and associated masturbation. Also include masturbation to non-pornographic sexually stimulating images. Include any sharing of nude or semi-nude images of yourself or others with another person (e.g. Sexting).

Consensual Sexual Behavior Summary

Your Name:_____DOB:_____

First Name	Their Age	Their Gender	Your Age	Kissing	Touching	Oral Sex	Anal Sex	Vaginal Sex	Mutual Masturbation	Sexting	Other

Sexual Behavior Form
Complete one form for each victim

Person's Name/Identifier:_____Relationship: _____
Gender: Female / Male Person's Age(s) at Time of Contact:_____Your Age(s) at Time of Contact: _____

TYPE OF CONTACT / BEVAVIOR: **(Circle words that apply)**	Circle	MOST POSSIBLE TIMES
1. Rubbed / touched person's breasts/chest area over clothing	YES NO	
2. Rubbed / touched person's bare breasts/chest area	YES NO	
3. Rubbed / touched person's vagina / penis area over clothing	YES NO	
4. Rubbed / touched person's bare vagina / penis	YES NO	
5. Rubbed penis / vagina against person's clothed vagina / penis / breasts / buttocks	YES NO	
6. Rubbed penis / vagina against person's bare vagina / penis / breasts / buttocks	YES NO	
7. Put tongue in person's mouth (i.e., French kissing)	YES NO	
8. Placed mouth / tongue on person's clothed vagina / penis	YES NO	
9. Placed mouth / tongue on person's bare vagina / penis area	YES NO	
10. Put mouth / tongue on person's anus, even slightly	YES NO	
11. Put finger inside person's vagina, even slightly	YES NO	
12. Put finger inside person's anus, even slightly	YES NO	
13. Put penis inside person's vagina, even slightly	YES NO	
14. Put penis against / inside persons' anus, even slightly	YES NO	
15. Put object inside person's vagina / anus (ointment, vibrator, stick, other)	YES NO	
16. Masturbated in presence of person	YES NO	
17. Ejaculated in presence of person	YES NO	
18. Masturbated using person's clothing / photos / property	YES NO	
19. Ejaculated in or on person's anus / vagina / body / mouth	YES NO	
20. Made / possessed/ distributed nude or partially nude photos / videos of person	YES NO	
21. Provided drugs / alcohol to person	YES NO	
22. Person rubbed my penis / vagina over clothing	YES NO	
23. Person touched / rubbed my bare penis / vagina	YES NO	
24. Person placed mouth / tongue on my bare penis / vagina	YES NO	
25. Person placed penis against / in my anus / vagina	YES NO	
26. Person put finger in my anus / vagina, even slightly	YES NO	

List other sexual behavior(s) with this person (not included above):_____

First contact?_____ Last contact?_____ Total sexual contacts?_____ Frequency?_____

Where did these contacts occur?_____

Did you cause this person to be sexual with others? If so, whom?_____

Who else was present at the time of these contacts?_____

Item	Description	Yes/No
A.	Was this person a relative or family member?	Yes / No

B.	Did you ever force or engage in violent sexual contact (prevent escape or resistance) with this person?	Yes / No
C.	Was this person ever asleep or unconscious during the sexual contact?	Yes / No
D.	Was this person ever under the influence of drugs or alcohol during the sexual contact?	Yes / No
E.	Was this person mentally or physically incapacitated?	Yes / No
F.	Was this person 4 or more years younger than you?	Yes / No
G.	Was this person 2-3 years younger than you?	Yes / No
H.	Were you in a position of trust over this person?	Yes / No
I.	Did you ever coerce (non-violent) sexual contact with this person?	Yes / No
J.	Did you ever engage in frottage (sexual rubbing against unsuspecting persons) with this person?	Yes / No
K.	Did you ever engage in sexually explicit talk with this person?	Yes / No
L.	Did you ever solicit this person in order to meet for sexual contact?	Yes / No
M.	Did you ever show a nude image of yourself to this person or see a nude image of the person?	Yes / No
N.	Did you ever engage in voyeurism (peeping) with this person?	Yes / No
O.	Did you ever engage in exhibitionism (public nudity) with this person?	Yes / No
P.	Did you ever engage in stalking with this person?	Yes / No
Q.	Did you ever engage in institutional sexual contact (out of home placement) with this person?	Yes / No
R.	Did you ever engage in any sex play games with this person?	Yes / No

Sexual History Summary

Item	*Yes No*	*# Persons*	*# Times*	*Last Time*	*Page*
A. Have you ever had sexual contact with a relative or family member?	*Yes No*				
B. Have you ever forced or engaged in violent sexual contact (prevent escape or resistance) with this person?	*Yes No*				
C. Have you ever had sexual contact with a person that was asleep or unconscious?	*Yes No*				
D. Have you ever had sexual contact with a person under the influence of drugs or alcohol?	*Yes No*				
E. Was this person mentally or physically incapacitated?	*Yes No*				
F. Was this person 4 or more years younger than you?	*Yes No*				
G. Was this person 2-3 years younger than you?	*Yes No*				
H. Were you in a position of trust over this person?	*Yes No*				
I. Have you ever coerced (non-violent) sexual contact with this person?	*Yes No*				
J. Have you ever engaged in frottage (sexual rubbing against unsuspecting persons) with this person?	*Yes No*				
K. Have you ever engaged in sexually explicit talk with this person?	*Yes No*				
L. Have you ever solicited this person in order to meet for sexual contact?	*Yes No*				
M. Have you ever shown a nude image of yourself to this person or see a nude image of the person?	*Yes No*				
N. Have you ever engaged in voyeurism (peeping) with this person?	*Yes No*				
O. Have you ever engaged in exhibitionism (public nudity) with this person?	*Yes No*				
P. Have you ever engaged in stalking with this person?	*Yes No*				
Q. Have you ever engaged in institutional sexual contact (out of home placement) with this person?	*Yes No*				
R. Have you ever engaged in any sex play games with this person?	*Yes No*				
S. List the number of consensual sexual partners.	*Yes No*				
T. Please list all YES answers from the Sexual History Interview form:	*Yes No*				
Signature/Date:_____ **Therapist Signature/Date:_____**					

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Appendix O: Informed Supervision

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 11.000) 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.

The Informed Supervision Agreement 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 11.000 of these Standards. The following eight (8) items constitute the basis for the initial Caregiver--Juvenile Supervision Plan.

A. 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.

B. 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.

C. The parent/guardian or caregiver must make arrangements for another informed supervisor to be present when the parent/guardian or caregiver is not available.

D. 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.

E. 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.

F. The parent/guardian or caregiver must make arrangements for and participate in sex offense specific evaluations, assessments and treatment with the juvenile.

G. The parent/guardian or caregiver must be involved with the multidisciplinary team to ensure safety and to enhance treatment progress.

H. 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.

The supervising officer/agent and/or DHS caseworker must document their action(s) in the following areas:

A. Review Informed Supervision Protocol with the informed supervisor, parent/guardian or caregiver and the juvenile who has committed a sexual offense.

B. 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.

C. Set an appointment to complete informed supervision requirements within the required time frames.

D. Set regular appointments between named parties including time and place.

Informed Supervision Agreement

Juvenile: _____

Respondent: _____

Relationship of Respondent: _____

Identified Informed Supervisor:_____

Relationship of Informed Supervisor to Juvenile:_____

The Informed Supervision Protocol requirements 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 _____
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 is attached:

Notes_____
_____

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

Appendix P: Criteria for the Use of Teletherapy

1. Prior to using teletherapy as a modality, the provider shall have training (formal training or informal training through supervision) specific to this modality.
2. Providers using teletherapy shall ensure the platform utilized complies with all HIPAA and confidentiality requirements.
3. Providers using teletherapy shall have procedures in place to complete and transmit treatment assignments, safety plans, and other necessary documents.
4. Except in extenuating circumstances, if conducting teletherapy both the client and the provider must be residing in the state of Colorado. If the client is residing in a state other than Colorado, the provider must follow any licensing requirements of the state the client is residing in as well as licensing requirements of Colorado.
5. The provider shall provide opportunities for both in-person and teletherapy sessions.
6. The provider shall have an established therapeutic relationship with the client, or clients for group therapy, prior to considering the use of teletherapy. If considering the use of teletherapy the provider shall:
    A. Check with the client(s) to determine if this is a modality they are comfortable with and want to pursue.
    B. Collaborate and consult with the CST/MDT regarding the clinician's recommendation/decision for teletherapy.
    C. Determine if there are any concerns that would impact the client's level of engagement or ability to attend teletherapy sessions (e.g. DD/ID concerns, specific responsivity needs, substance use concerns, concerns about inability to determine sexual arousal to specific topics, etc).
    D. Determine that the client(s) has a safe and confidential space to participate in teletherapy.
    E. Determine if body language can appropriately be assessed via teletherapy.

7. When conducting teletherapy the provider shall have a dedicated workspace that is free from distractions and ensures confidentiality.
    A. Providers shall not engage in non-session related tasks or activities while conducting teletherapy sessions (e.g. driving, recreation activities, tending to others, tending to non-session related work, etc.).
    B. Providers shall not have other individuals present during teletherapy sessions, with the exception of co-therapists, additional clients within group therapy, or approved MDT/CST members.

8. When conducting teletherapy the provider shall ensure they know the current location of the client(s) in the event an emergency occurs that would necessitate calling emergency personnel (e.g. suicidal ideation)
9. When initiating teletherapy the provider shall inform the client(s) of the parameters of teletherapy and have a signed agreement by the client(s) of their agreement to participate in teletherapy as well as the client's agreement to abide by the established parameters. Parameters shall, at a minimum, include:
    A. The reason teletherapy is being utilized (distance of client to services, medical conditions, lack of resources to support in person therapy, community risk, etc.)
    B. Agreement by the client(s) not to engage in non-therapy related activities during the session (e.g. driving, working, tending to others, recreational activities, use of substances, etc.).
    C. Agreement by the client(s) not to have anyone else in the session unless approved by the CST/MDT. This does not apply to other clients who are part of group therapy.
    D. Agreement by the client(s) to remain active and engaged during the session.
10. During the course of teletherapy the provider shall check in with the client(s) once per quarter to determine if teletherapy is meeting the client's needs, if adjustments are needed, and if the client(s) wishes to continue or discontinue teletherapy.
11. When conducting teletherapy the provider shall ensure the service matches the client's needs in relation to length and frequency in the same manner as would be provided with in-person sessions. The focus of teletherapy sessions shall follow the established goals and objectives for the client.
12. When conducting teletherapy the provider shall follow all SOMB standards and guidelines and ethical codes of conduct in the same manner as is expected during in-person therapy sessions.
13. When conducting teletherapy the provider shall provide regular updates to CST/MDT regarding participation, limitations, and how the rationale for teletherapy services may impact other activities of the client(s) (e.g. if teletherapy is being provided due to a community safety risk such as a pandemic, other community access/activities should be reviewed by the team).
14. When conducting teletherapy, in person sessions must be provided on the following schedule;
    A. Once per quarter for sessions provided on a monthly basis
    B. Once per quarter for sessions provided on a bi-weekly basis
    C. Once per month for sessions provided on a weekly basis
15. In rare cases the CST/MDT, in collaboration with the client(s), is authorized to modify any of the above criteria based on extenuating factors of the client that prevent the criteria from being met as written. If modifying the above criteria, the treatment provider shall document in the client's file the extenuating circumstances that warrant the modification, which criteria are being modified, and how client and community

safety are addressed through the modification. Such situations include, but are not limited to,

A. Medical conditions of the client,
B. Geographical/transportation barriers (distance, travel time, road conditions, transportation resources, etc.) of the client relative to the service provider,
C. Lack of reliable transportation that cannot be accommodated and would result in a barrier to treatment if criteria are not modified,
D. Safety concerns that prevent the criteria from being followed and would result in a barrier to treatment if criteria are not modified

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