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

A REPORT OF FINDINGS
DECEMBER 2003

By:
Kerry Lowden
Kim English
Nicole Hetz
Linda Harrison

Office of Research and Statistics

Division of Criminal Justice
700 Kipling Street, Suite 1000
Denver, CO 80215
303-239-4442
http://dcj.state.co.us/ors

Kerry Lowden, *Project Manager*
Kim English, *Research Director*
Raymond T. Slaughter, *Director, Division of Criminal Justice*
Pamela Sillars, *Acting Executive Director, Department of Public Safety*

This study was funded by the Byrne Memorial Fund grant number D22BD19502 from the Division of Criminal Justice Drug Control and System's Improvement Program (DCSIP).

ACKNOWLEDGEMENTS

The research was made possible by a grant funded by the Division of Criminal Justice's Drug Control and Systems Improvement Program, grant number D22BD19502. We would like to thank Lance Clem of the Drug Control and System's Improvement Program, and the DCSIP Advisory Board, for supporting this evaluation allowing DCJ to meet the legislative mandate to evaluate the effectiveness of the SOMB's *Standards and Guidelines.*

We would also like to thank all those who assisted us in this research effort. We are especially grateful for the assistance of SOMB program administrator, Nancy Feldman, and the SOMB chair, Jill McFadden. We are grateful to Chris Row of the Division of Probation Services and the 89 probation officers who participated in this study. We thank Ernie Fernandez, a parole supervisor at the Department of Corrections and the 21 parole officers who participated in this study. Equally important were the SOMB-approved treatment providers and polygraph examiners who spent many hours answering our interview questions and allowing us into their files.

Finally, we would like to thank Elisa Di Trolio, Diane Pasini-Hill, Diane Patrick, Julie Rodriguez, Germaine Miera, Kristen Godbey, Elizabeth Smith, and Suzanne Gonzales for their contributions to the design, management, and data collection efforts for this evaluation. Thanks to Linda Harrison and Nicole Hetz for their work with analyzing all the data. As always we would like to thank Pat Lounders, Carole Poole, and Raymond Slaughter from the Division of Criminal Justice for their continued support of our research efforts.

While these contributions were invaluable to the research process, any errors or omissions remain the responsibility of the Office of Research and Statistics.

TABLE OF CONTENTS

11 **Executive Summary**
14 **Section One: Introductions**
14 *Background*
14 *Purpose of the Report: A Process Evaluation*
15 *Organization of this Report*
15 *What are the Best Practices*
17 **Section Two: Research Design**
17 *Measuring Effectiveness*
17 *Were all the Standards and Guidelines studied?*
17 *Data Collection*
21 **Section Three: Colorado's Sex Offender Treatment, Monitoring and Containment System**
21 *Brief Overview*
23 *Limitations of this Research*
25 **Section Four: Findings from the Process Evaluation**
25 *1.000 Guidelines for Pre-Sentence Investigations*
28 *2.000 Standards for Mental Health Sex-Offense Specific Evaluations*
34 *3.000 Standards of Practice for Treatment Providers*
50 *5.000 Standards and Guidelines for Management of Sex Offenders on Probation, Parole, and Community Corrections*
80 *6.000 Standards for Polygraphy*
85 **Section Five: Barriers to Implementation**
88 **Section Six: Recommendations to Enhance the Implementation of the Colorado *Standards and Guidelines***
91 **Section Seven: Tracking Sex Offenders**
91 *Methods to Tracking*
92 *Monitoring Offender Recidivism*
95 **Appendices**
Appendix A: Detailed list of descriptions of the Standards and Guidelines
Appendix B: Interview Questionnaires
Appendix C: Data Collection Instruments
Appendix D: Types of Services Delivered
Appendix E: Safety Plans for Specific Events
Appendix F: Situations for which Consequences and Sanctions are Imposed
Appendix G: Geographic Maps of Registered Sex Offenders
Appendix H: Studies that have Tracked Sex Offenders
Tables
25 *Table 1: Pre-Sentence Investigation Reports (PSIR) Found in the Files*
26 *Table 2: Information Addressed in the Pre-Sentence Investigation Reports (PSIR)*
28 *Table 3: Mental Health Sex Offense-Specific Evaluation Found in the Files*
29 *Table 4: Most Commonly Used Instruments for the Mental Health Sex Offense-Specific Evaluation*
30 *Table 5: Areas Addressed and Considered to be Problem from the Mental Health Sex Offense-Specific Evaluation*
33 *Table 6: Recommendations in the Mental Health Sex Offense-Specific Evaluation*
37 *Table 7: Treatment Plans Found in Treatment Provider Files*
37 *Table 8: Language Contained in Treatment Plans*
37 *Table 9: Treatment Provider Telephone Responses to Areas Addressed in the Treatment Plans*
38 *Table 10: Treatment Plans Found in Treatment Provider Files Address the Following Areas*
39 *Table 11: Types of Services Documented in the Treatment Provider Files*
39 *Table 12: Relapse Prevention Plans Found in Treatment Provider Files*

40 *Table 13: Treatment Plan Documentation*
40 *Table 14: Progress in Treatment: Presence and Frequency of Documentation*
41 *Table 15: Signed Waivers of Confidentiality Found in Treatment Provider Files*
41 *Table 16: Treatment Contract Addresses Confidentiality Waivers*
42 *Table 17: Documentation from the Treatment Provider Files Regarding Content of the Treatment Contract*
43 *Table 18: Telephone Responses from Treatment Providers about Working with Offender Family Members*
43 *Table 19: Treatment Provider Telephone Responses About Which Family Members They Work With*
44 *Table 20: Details of Treatment Contract*
45 *Table 21: More About the Treatment Contract*
45 *Table 22: Level of Denial Assessed During The Mental Health Sex Offense-Specific Evaluation?*
46 *Table 23: Documenting Denial Process*
46 *Table 24: Documentation Regarding Treatment for Denial*
47 *Table 25: Denial Six Months Later: Documentation*
47 *Table 26: Use of Plethysmograph and Abel Screen*
48 *Table 27: Open-ended question to therapists: How do you use the polygraph results?*
48 *Table 28: Open-ended question to therapists: What sanctions or consequences are imposed for deceptive results?*
49 *Table 29: Open-ended question to therapists: What sanctions or consequences are imposed for inconclusive results?*
52 *Table 30: Multiple Responses from Open-Ended Questions: Who is Typically Part of the Interagency Community Supervision Team?*
52 *Table 31: Open-Ended, Multiple Responses about the Advantages to a Team Approach*
53 *Table 32: Open-Ended, Multiple Responses about the Disadvantages to a Team Approach*
53 *Table 33: Telephone Responses about Teams Experiencing Conflict*
54 *Table 34: Treatment Provider Contact with Probation Officers*
54 *Table 35: Treatment Provider Contact with Parole Officers*
55 *Table 36: Supervising Officer Contact with Treatment Providers*
56 *Table 37: Polygraph Examiner Contact with Supervising Officers*
56 *Table 38: Additional Contact Information*
57 *Table 39: Documentation in Officer Files that the Team Convened in Person, by Phone or Email*
58 *Table 40: Documentation from the Files that Officer Discussed the Offender with Therapist or Examiner, during a Six Month Time Period*
58 *Table 41: Circumstances for When Supervising Officers Talk to Polygraph Examiners About Offenders on Their Caseloads*
58 *Table 42: Circumstances for When Treatment Providers Talk to Polygraph Examiners About Offenders on Their Caseloads*
59 *Table 43: Telephone Survey Responses to Providing Input into the Question Content for the Polygraph Exam*
59 *Table 44: Supervising Officer Responses about Imposing Consequences for Polygraph Results*
59 *Table 45: Relapse Prevention Plans in Supervising Officer Files*
60 *Table 46: Supervising Officer Telephone Responses about Receiving Monthly Progress Reports*
60 *Table 47: Open-ended Telephone Responses about the Types of Information Received in Progress Reports*
60 *Table 48: Evidence of Monthly Progress Reports in Supervising Officer Files*
60 *Table 49: Number of Times Found in the Supervising Officer Files*
61 *Table 50: Telephone Responses from Team Members about Discussing Plans for Offender's Contact with Child Victim and Plans for Family Reunification*
61 *Table 51: Notification of Sex Offender Registration in Supervising Officer Files*
61 *Table 52: Multiples Responses from Supervising Officer Telephone Surveys about the Types of Trainings Officers Receive*
62 *Table 53: Supervising Officer Telephone Responses about when they Receive Training*
62 *Table 54: Supervising Officer Telephone Responses about Receiving Additional Training/Continuing Training*
62 *Table 55: Supervising Officer: Frequency of Additional Training/Continuing Education*

63 *Table 56: Additional Types of Training Mentioned*
63 *Table 57: Telephone Survey Responses from Treatment Providers about Working with Multiple Supervising Officers*
64 *Table 58: Multiple Responses from Supervising Officers about Reasons for Contact with Treatment Providers*
64 *Table 59: Polygraph Examiner Phone Survey Responses To Being Considered Part of Interagency Community Supervision Team*
65 *Table 60: Telephone Survey Reponses about Receiving Copies of Polygraph Reports from Polygraph Examiners*
65 *Table 61: Copies of Polygraph Reports Found in Files*
66 *Table 62: Evidence in the Files that the Offender can have No Contact with their Victims*
66 *Table 63: Evidence in the Files that the Offender is Prohibited Contact with Children Under Age 18*
66 *Table 64: Evidence in the Files that the Offender may not Date, Befriend, or Marry Anyone who has Children Under Age 18*
67 *Table 65: Evidence in the Files that the Offender is Prohibited in Places Primarily Used by Children*
67 *Table 66: Evidence in the Files of Employment or Volunteering Restrictions*
67 *Table 67: Evidence in the Files that the Offender is Prohibited from Possessing Pornographic or Sexually Stimulating Materials*
68 *Table 68: Evidence in the Files that the Offender has been Notified that they Shall Not Consume or Possess and Drugs or Alcohol*
68 *Table 69: Evidence in the Files that the Offender's Residence Must Be Approved in Advance*
68 *Table 70: Evidence in the Files that the Offender has been Notified that they will be Required to Undergo a Blood, Saliva, and DNA test*
69 *Table 71: Evidence in the Files that the offender is restricted from High-Risk Situations and Potential Victims*
69 *Table 72: Evidence in the Files that the Offender signed Releases of Information*
69 *Table 73: Evidence in the Files that the Offender May Not Hitchhike or Pick Up Hitchhikers*
70 *Table 74: Evidence in the Files that the Offender will Attend and Actively Participated in Evaluations and Treatment and Not Change Treatment Providers Without Prior Approval*
70 *Table 75: Number of times officer files document source of information regarding Non-Compliant behavior*
71 *Table 76: 204 Polygraph Exams Used to Monitor Offenders*
71 *Table 77: Type of Polygraph Exams used to Monitor Offenders in the Community*
71 *Table 78: Open-Ended, Multiple Responses from Supervising Officer Telephones Surveys about the Use of the Polygraph Exam Information in Monitoring Offender Behavior*
72 *Table 79: Telephone Responses from Supervising Officers about Sanctions for Deceptive or Inconclusive Polygraph Results*
72 *Table 80: Documentation of Offender Experiencing Stress or Crisis in Supervising Officer File*
72 *Table 81: Officer Files: Number of Times Documentation Reflected Offenders Experienced Stress/Crisis in the Past 12 Months*
73 *Table 82: Monitoring Responses to the Stress/Crisis Offenders Experienced*
74 *Table 83: Among Treatment Providers Who Have Offenders With Child Contact On Their Caseloads: How Many Offenders Have Contact?*
75 *Table 84: Telephone Responses to the Various Ways Offenders Have Contact With Children*
75 *Table 85: Telephone Responses About Victim Advocates or Therapists Involvement in Decisions Regarding Offender Contact with Children*
76 *Table 86: Supervising Officer Telephone Responses about how these Victim Advocates or Therapists are involved in Child Contact Decisions*
76 *Table 87: Treatment Provider Telephone Responses about how these Victim Advocates or Therapists are Involved*
76 *Table 88: Documentation in Supervising Officer Files About Collaboration with Others Regarding Possible Communication, Visits, And Family Reunification*
77 *Table 89: Multiple Responses from Supervising Officers about How the Child Contact Decision is Made*

77 *Table 90: Multiple Responses from Treatment Providers about How the Child Contact Decision is Made*
78 *Table 91: Multiple Responses from Supervising Officers Regarding Who Makes Child Contact Decisions*
78 *Table 92: Multiple Responses from Telephone Surveys about Additional Requirements Placed on Offenders Who Have Contact With Children*
79 *Table 93: Supervising Officers Telephone Responses about Where Documentation can be Found Allowing Offenders to have Contact with Children*
80 *Table 94: Polygraph Examiners Telephone Responses about Conducting Post-Conviction Exams Before the Standards and Guidelines were Published*
80 *Table 95: Telephone Responses from Polygraph Examiners About the Length of Time That They Have Worked with Sex Offenders*
81 *Table 96: Telephone Responses from Polygraph Examiners about the Offender's Readiness for the Polygraph Exam*
81 *Table 97: Open-Ended Question to Polygraph Examiners: What Are the Advantages of a Team Approach?*
81 *Table 98: Open-ended question to Polygraph Examiners: What Are the Disadvantages to a Team Approach?*
81 *Table 99: Evidence in Polygraph Reports that All Test Questions Allow for Yes or No Answers*
82 *Table 100: Types of Information that Should Be Included in the Polygraph Examination Written Report*
83 *Table 101: Evidence in Polygraph Reports that the Standards for Polygraph Test Questions Are Being Followed*
85 *Table 102: Telephone Survey Responses about Barriers to Implementing the Standards and Guidelines*
85 *Table 103: Telephone Survey Responses about the Types of Barriers Encountered*
86 *Table 104: Telephone Survey Responses: about if they have Found Ways to Overcome Barriers*
86 *Table 105: Telephone Surveys Responses about Ways of Overcoming Barriers*
87 *Table 106: Telephone Surveys Responses to Impediments to Overcoming Barriers*
94 *Table 107: Summary of Multiple Studies That Tracked Sex Offenders*

EXECUTIVE SUMMARY

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

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

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

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

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

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

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

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

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

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

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

***

SECTION ONE: INTRODUCTION

Background

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

Purpose of this Report: A Process Evaluation

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

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

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

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

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

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

Organization of this Report

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

What are Best Practices?

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

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

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

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

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

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

***

SECTION TWO: RESEARCH DESIGN

Measuring Effectiveness

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

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

Were all of the *Standards and Guidelines* studied?

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

Data Collection

Telephone Interviews

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

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

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

File Reviews

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

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

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

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

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

[1] A minimum of two researchers traveled to most sites so that anomalies in the file could be discussed and decisions about scoring procedures would be made by more than one person.
[2] The list of cases was obtained using the Colorado Integrated Criminal Justice Information System (CICJIS) that allowed access to Judicial's ICON database maintained in the RS 6000. Cases charged with a sex crime and meeting the time criteria were identified as the population from which the sample would be selected.

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

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

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

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

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

---

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

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

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

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

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

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

***

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

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

Brief Overview

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

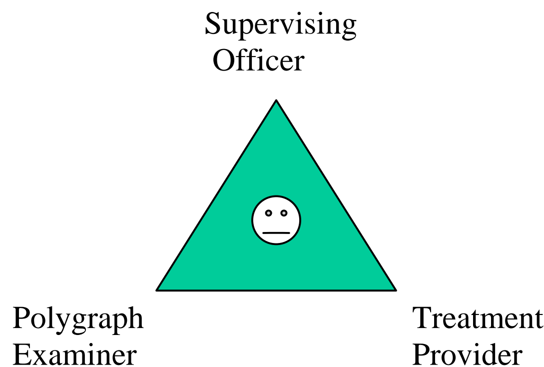
The *Standards and Guidelines* are described in a document that is over 100 pages in length, and issues are clarified and expanded in over 50 pages of appendices. The document reflects the careful thinking of a multi-disciplinary group and is founded on 13 guiding principles:

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

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

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

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



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

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

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

[8] Lowden et al., July 2003.

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

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

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

Limitations of this Research

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

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

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

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

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

SECTION FOUR: FINDINGS FROM THE PROCESS EVALUATION

1.000
GUIDELINES FOR PRE-SENTENCE INVESTIGATIONS

SUMMARY OF FINDINGS:

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

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

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

Data supporting these findings are presented below.

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

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

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

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

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

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

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

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

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

2.000
STANDARDS FOR MENTAL HEALTH SEX OFFENSE-SPECIFIC EVALUATIONS

SUMMARY OF FINDINGS:

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

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

Data supporting these findings are presented below.

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

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

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

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

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

AND

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

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

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

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

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

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

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

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

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

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

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

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

2.110 The evaluator shall recommend:

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

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

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

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

3.000
STANDARDS OF PRACTICE FOR TREATMENT PROVIDERS

SUMMARY OF FINDINGS:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

3.100 ♦ Sex Offense-Specific Treatment

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

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

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

The treatment plan shall:

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

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

Table 7: Treatment Plans Found in Treatment Provider Files

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

Table 8: Language Contained in Treatment Plans

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Table 12: Relapse Prevention Plans Found in Treatment Provider Files

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

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

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

AND

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

Table 13: Treatment Plan Documentation

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

*Treatment plans were found in 42 of 54 files.

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

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

3.200 ♦ Confidentiality

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

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

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

Table 16: Treatment Contract Addresses Confidentiality Waivers

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

*49 treatment contracts were found in 54 provider files.

3.300 ♦ Treatment Provider-Client Contract

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

*Not everyone responded.

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

<table>
<tr><th>n=64</th><th>Spouses</th><th>Children</th><th>Adult Relatives (parents, siblings, aunt/uncles, cousins, in-laws)</th></tr>
<tr><td>Male</td><td>48.3% (29)</td><td>31.7% (19)</td><td rowspan="2">53.3% (32)</td></tr>
<tr><td>Females</td><td>95.0% (57)</td><td>36.7% (22)</td></tr>
</table>

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

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

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

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

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

Table 20: Details of Treatment Contract

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

C The contact shall also, (as applicable):

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

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

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

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

5. Describe limitations or prohibitions on employment or recreation.

Table 21: More About the Treatment Contract

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

3.600 ♦Community Placements and Treatment of Sex Offenders in Denial

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

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

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

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

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

Table 23: Documenting Denial Process

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

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

If YES…

Table 24: Documentation Regarding Treatment for Denial

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

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

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

Table 25: Denial Six Months Later: Documentation

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

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

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

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

Table 26: Use of Plethysmograph and Abel Screen

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

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

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

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

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

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

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

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

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

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

SUMMARY OF FINDINGS:

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

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

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

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

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

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

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

Data supporting this summary is presented below.

5.100 ♦ Establishment of an Interagency Community Supervision Team

5.120 Each team at a minimum, should consist of:

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

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

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

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

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

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

*Response not offered by this group.

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

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

*Response not offered by this group.

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

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

*Response not offered by this group.

5.150 The team should demonstrate the following behavioral norms:

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

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

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

Table 33: Telephone Responses about Teams Experiencing Conflict

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

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

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

Table 34: Treatment Provider Contact with *Probation Officers*

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

Table 35: Treatment Provider Contact with *Parole Officers*

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

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

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

Table 36: Supervising Officer Contact with *Treatment Providers*

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

Table 37: Polygraph Examiner Contact with *Supervising Officers*

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

Table 38: Additional Contact Information

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

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

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

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

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

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

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

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

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

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

5.200 ♦ Responsibilities of the Supervising Officer for Team Management

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

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

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

*Not everyone responded to this question.

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

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

*Not everyone responded to this question.

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

Table 45: Relapse Prevention Plans in Supervising Officer Files

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

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

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

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

*Not everyone responded to this question.

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

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

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

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

IF SOME, BUT NOT MONTHLY…

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

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

* Response not given by this group.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

*Not everyone responded.

Table 56: Additional Types of Training Mentioned

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

5.300 ♦ Responsibilities of the Treatment Provider within the Team

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

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

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

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

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

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

5.400 ♦ Responsibilities of the Polygraph Examiner within the Team

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

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

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

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

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

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

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

Table 61: Copies of Polygraph Reports Found in Files

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

5.500 ♦ Conditions of Community Supervision

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

G Sex offenders shall not consume or possess alcohol.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

L Sex offenders shall not hitchhike or pick up hitchhikers.

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

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

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

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

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

5.600 ♦ Behavioral Monitoring of Sex Offenders in the Community

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

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

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

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

Table 76: 204 Polygraph Exams Used to Monitor Offenders

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

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

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

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

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

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

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

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

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

*Response not offered for this finding.

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

1. The offender is experiencing stress or crisis;

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

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

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

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

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

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

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

SUMMARY OF FINDINGS:

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

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

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

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

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

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

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

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

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

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

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

*The number of cases varies due to missing data.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

6.000
STANDARDS FOR POLYGRAPHY

SUMMARY OF FINDINGS:

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

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

6.100 ♦ Standards of Practice for Sex Offender Clinical Polygraph Examiners

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

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

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

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

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

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

*Data missing from one case.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

* * *

SECTION FIVE: BARRIERS TO IMPLEMENTATION

SUMMARY OF BARRIERS:

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

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

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

*Not everyone responded.

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

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

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

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

Table 105: Telephone Surveys Responses about Ways of Overcoming Barriers

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

Table 106: Telephone Surveys Responses to Impediments to Overcoming Barriers

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

*Not everyone responded.

***

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

***

SECTION SEVEN: TRACKING SEX OFFENDERS

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

Methods of Tracking

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

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

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

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

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

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

Monitoring Offender Recidivism

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

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

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

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

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

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

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

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

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

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

Table 107: Summary of Multiple Studies That Tracked Sex Offenders

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

* Includes treatment in the community.
**Prison treatment here is participation in the intense therapeutic community for sex offenders, a very intense program.
***Parole includes supervision and sex offender treatment in the community.

* * *