COLORADO SEX OFFENDER MANAGEMENT BOARD

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

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

700 Kipling Street, Suite 3000
Denver, CO 80215
(303) 239-4442 or (800) 201-1325 (in Colorado)
website: http://dcj.state.co.us/odvsom/
email: somb@cdps.state.co.us

Revised March 2008

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INTRODUCTION

In 1992, the Colorado General Assembly passed legislation (Section 16-11.7-101 through Section 16-11.7-107, C. R. S.) that created a Sex Offender Treatment Board to develop standards and guidelines for the assessment, evaluation, treatment and behavioral monitoring of sex offenders. The General Assembly changed the name to the Sex Offender Management Board (SOMB) in 1998 to more accurately reflect the duties assigned to the SOMB. The *Standards and Guidelines* (*Standards*) were originally drafted by the SOMB over a period of two years and were first published in January 1996. The *Standards* were revised in 1998, 1999, 2004, and 2008 for two reasons: To address omissions in the original *Standards*, that were identified during implementation, and to keep the *Standards* current with the developing literature in the field of sex offender management. The *Standards* apply to adult sexual offenders under the jurisdiction of the criminal justice system. The *Standards* are designed to establish a basis for systematic management and treatment of adult sex offenders. The legislative mandate of the SOMB and the primary goals of the *Standards* are to improve community safety and protect victims.

While the legislation acknowledges, and even emphasizes, that sex offenders cannot be "cured," it also recognizes that the criminal sexual behaviors of many offenders can be managed. The combination of comprehensive sex offender treatment and carefully structured and monitored behavioral supervision conditions can assist many sex offenders to develop internal controls for their behaviors.

A coordinated system for the management and treatment of sex offenders "contains" the offender and enhances the safety of the community and the protection of victims. To be effective, a containment approach to managing sex offenders must include interagency and interdisciplinary teamwork.

These *Standards* are based on the best practices known today for managing and treating sex offenders. To the extent possible, the SOMB has based the *Standards* on current research in the field. Materials from knowledgeable professional organizations also have been used to direct the *Standards*. In the body of the document, standards are denoted by the use of the term "shall"; guidelines are distinguished by the use of the term "should".

It is not the intention of the legislation, or the SOMB, that these *Standards* be applied to the treatment of sexually abusive children or adolescents. Despite many similarities in the behavior and treatment of sexually abusive youth and adults, important differences exist in their developmental stages, the process of their offending behaviors, and the context for juveniles which must be addressed differently in their diagnosis and treatment. Please see the July 2003 publication of the *Standards and Guidelines for the Evaluation, Assessment, Treatment and Supervision of Juveniles Who Have Committed Sexual Offenses.*

In 1998, the Colorado General Assembly passed legislation directing the SOMB, in collaboration with the Department of Corrections, the Judicial Branch and the Parole Board, to also develop *Standards* for community entities that provide supervision and treatment specifically designed for sex offenders who have developmental disabilities. At a minimum, the Legislature mandates that these *Standards* shall determine whether an entity would provide adequate support and supervision to minimize any threat that the sex offender may pose to the community (Section 18-1.3-1009 (1)(c), C.R.S.).

The *Standards* that are designated with the letters "DD" after the Standard number are not intended to stand alone, but must be used in conjunction with the other *Standards and Guidelines for the Assessment,*

Evaluation, Treatment and Behavioral Monitoring of Adult Sex Offenders. The guiding principles of the *Standards* serve as the philosophical foundation for this document.

The *DD Standards* intend to better address the specific needs and risk of sex offenders with developmental disabilities. They are based in best practices known today for managing and treating sex offenders with developmental disabilities. To the extent possible, the SOMB has based these *Standards* on current research in the field. Materials from knowledgeable professional organizations have also been used to direct the *Standards*.

The management and treatment of sex offenders with developmental disabilities is a highly specialized field. Many decisions regarding the *Standards* must be made in the absence of clear research findings. Such decisions will be directed by the governing philosophy of public safety and a common sense interpretation of the Guiding Principles contained in this document.

Sex offender management and treatment is a developing specialized field. The SOMB will remain current on the emerging literature and research and will modify the *Standards* periodically on the basis of new findings. The current revisions of the *Standards* are evidence of this commitment. It is certain, however, that many decisions will have to be made in the absence of clear research findings. Such decisions will therefore be directed by the governing philosophy of public safety and on a common-sense interpretation of the following Guiding Principles which form the foundation of the *Standards*.

GUIDING PRINCIPLES

1. Sexual offending is a behavioral disorder which cannot be "cured."

Sexual offenses are defined by law and may or may not be associated with or accompanied by the characteristics of sexual deviance which are described as paraphilias. Some sex offenders also have co-existing conditions such as mental disorders, organic disorders, or substance abuse problems.

Many offenders can learn through treatment to manage their sexual offending behaviors and decrease their risk of re-offense. Such behavioral management should not, however, be considered a "cure," and successful treatment cannot permanently eliminate the risk that sex offenders may repeat their offenses.

2. Sex offenders are dangerous.

When a sexual assault occurs there is always a victim. Both the literature and clinical experience suggest that sexual assault can have devastating effects on the lives of victims and their families.

There are many forms of sexual offending. Offenders may have more than one pattern of sexual offending behavior and often have multiple victims. The propensity for such behavior is often present long before it is detected. It is the nature of the disorder that sex offenders' behaviors are inherently covert, deceptive, and secretive. Untreated sex offenders also commonly exhibit varying degrees of denial about the facts, severity and/or frequency of their offenses.

Prediction of the risk of re-offense for sex offenders is in the early stages of development. Therefore, it is difficult to predict the likelihood of re-offense or future victim selection.

Some offenders may be too dangerous to be placed in the community and other offenders may pose enough risk to the community to require lifetime monitoring to minimize the risk.

3. Community safety is paramount.

The highest priority of these Standards and Guidelines is community safety.

4. Assessment and evaluation of sex offenders is an ongoing process. Progress in treatment and level of risk are not constant over time.

The effective assessment and evaluation of sexual offenders is best seen as a process. In Colorado, criminal sexual offenders are first assessed and referred for a sex offense-specific evaluation during the pre-sentence investigation conducted by the Probation Department. Assessment of sex offenders' risk and amenability to treatment should not, however, end at this point. Subsequent assessments must occur at both the entry and exit points of all sentencing options, i.e. probation, parole, community corrections and prison. In addition, assessment and evaluation should be an ongoing practice in any program providing treatment for sex offenders.

In the management and treatment of sex offenders there will be measurable degrees of progress or lack of progress. Because of the cyclical nature of offense patterns and fluctuating life stresses, sex offenders' levels of risk are constantly in flux. Success in the management and treatment of sex offenders cannot be assumed to be permanent. For these reasons, monitoring of risk must be a continuing process as long as sex offenders are under criminal justice supervision. Moreover, the end of the period of court supervision should not necessarily be seen as the end of dangerousness.

5. **Assignment to community supervision is a privilege, and sex offenders must be completely accountable for their behaviors.**

   Sex offenders on community supervision must agree to intensive and sometimes intrusive accountability measures which enable them to remain in the community rather than in prison. Offenders carry the responsibility to learn and demonstrate the importance of accountability, and to earn the right to remain under community supervision.

6. **Sex offenders must waive confidentiality for evaluation, treatment, supervision and case management purposes**.

   All members of the team managing and treating each offender must have access to the same relevant information. Sex offenses are committed in secret, and all forms of secrecy potentially undermine the rehabilitation of sex offenders and threaten public safety.

7. **Victims have a right to safety and self-determination.**

   Victims have the right to determine the extent to which they will be informed of an offender's status in the criminal justice system and the extent to which they will provide input through appropriate channels to the offender management and treatment process. In the case of adolescent or child victims, custodial adults and/or guardians ad litem act on behalf of the child to exercise this right, in the best interest of the victim.

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.**

   All aspects of the community response and intervention system to child sexual abuse should be designed to promote the best interests of children rather than focusing primarily on the interests of adults. This includes the child's right not to live with a sex offender, even if that offender is a parent. In most cases, the offender should be moved or inconvenienced to achieve the lack of contact, rather than further disrupting the life of the child victim.

9. **A continuum of sex offender management and treatment options should be available in each community in the state.**

   Many sex offenders can be managed in the community on probation, community corrections, and parole. It is in the best interest of public safety for each community to have a continuum of sex offender management and treatment options. Such a continuum should provide for an increase or decrease in the intensity of treatment and monitoring based on offenders' changing risk factors, treatment needs and compliance with supervision conditions.

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.

It is the philosophy of the Sex Offender Management Board that setting standards for sex offender treatment providers alone will not significantly improve public safety. In addition, the *process* by which sex offenders are assessed, treated, and managed by the criminal justice and social services systems should be coordinated and improved.

11. The management of sex offenders requires a coordinated team response.

All relevant agencies must cooperate in planning treatment and containment strategies of sex offenders for the following reasons:

- Sex offenders should not be in the community without comprehensive treatment, supervision, and behavioral monitoring;
- Each discipline brings to the team specialized knowledge and expertise;
- Open professional communication confronts sex offenders' tendencies to exhibit secretive, manipulative and denying behaviors;
- Information provided by each member of an offender case management team contributes to a more thorough understanding of the offender's risk factors and needs, and to the development of a comprehensive approach to treating and managing the sex offender.

12. Sex offender assessment, evaluation, treatment and behavioral monitoring should be non-discriminatory and humane, and bound by the rules of ethics and law.

Individuals and agencies carrying out the assessment, evaluation, treatment and behavioral monitoring of sex offenders should not discriminate based on race, religion, gender, sexual orientation, disability or socioeconomic status. Sex offenders must be treated with dignity and respect by all members of the team who are managing and treating the offender regardless of the nature of the offender's crimes or conduct.

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 sex offenders' lives.

Sexual issues are often not talked about freely in families, communities and other settings. In fact, there is often a tendency to avoid and deny that sex offenses have occurred. Successful management and treatment of sex offenders involves an open dialogue about this subject and a willingness to hold sex offenders accountable for their behavior.

THE ROLE OF VICTIMS / SURVIVORS IN SEX OFFENDER TREATMENT

The Sex Offender Management Board recognizes that the behavior of sex offenders can be extremely damaging to victims and that their crimes can have a long-term impact on victims' lives. Moreover, the level of violence and coercion involved in the offense does not necessarily determine the degree of trauma experienced by the victim.

- Victims' involvement in the criminal justice process can be either empowering or re-victimizing. These *Standards* are based on the premise that victims should have the option to decide their level of involvement in the process, especially after the offender has been convicted and sentenced.

- Under the provisions of Colorado's Constitutional Amendment for Crime Victims, victims may state whether they wish to be notified about any changes in the offender's status in the criminal justice system. These *Standards* and Guidelines also suggest that, upon request, a victim should be informed about the offender's compliance with treatment and any changes in the offender's treatment status that might pose a risk to the victim (e.g. if the offender has discontinued treatment.) In certain situations, the interagency team described in Guideline 5.100 may communicate with a victim's therapist or a designated victim advocate. Further, if a victim is willing, s/he may be contacted for information during the pre-sentence investigation, in order to include additional victim impact information in the investigation report.

- Professionals in the criminal justice, evaluation, and treatment systems should contact victims through appropriate channels to solicit their input, since victims may possess valuable information that is not available elsewhere. In particular, a victim's information about an offender's offense patterns can assist evaluators, treatment providers and supervisors to develop treatment plans and supervision conditions that may prevent or detect future offenses.

The following *Standards* specifically address the opportunity for victim input: 1.040 (Pre-sentence Investigations); 2.060 (Sex Offense-Specific Evaluations); 3.120 (*Standards* for Treatment Providers); 3.210 (Confidentiality); 3.310 (Provider-Offender Contract); 5700 (Sex Offenders' Contact with Victims and Potential Victims).

DEFINITIONS

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

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

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

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

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

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

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

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

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

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

Denial: In psychological terms denial means a defense mechanism used to protect the ego from anxiety-producing information. (See also Defense Mechanisms and Levels and Types of Denial in section 3.500.)

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

Department: Department means the Colorado Department of Public Safety.

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

Developmental Disability:

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

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

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

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

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

Discussion Point: Some sexual offenders have intellectual and/or functional deficits that indicate a need for revised assessment, evaluation, treatment or behavioral monitoring even though they do not meet the federal definition for developmental disabilities.

Evaluators, treatment providers, polygraph examiners, and supervising officers shall provide services appropriate to each sex offender's developmental level.

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

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

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

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

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

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

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

Incapacitated Person: A person who lacks the ability to manage property and business affairs effectively by reason of mental illness, mental deficiency,

physical illness or disability, chronic use of drugs, chronic intoxication, confinement, detention by a foreign power, disappearance, minority, or other disabling cause (refer to Section 15-1.5-102 (5) C.R.S.).

Incidental Contact: Any verbal or physical contact.

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

Informed Assent:[1] Assent means compliance; a declaration of willingness to do something in compliance with a request; acquiescence; agreement. The use of the term "assent" rather than "consent" in this document recognizes that sex offenders are not voluntary clients, and that their choices are therefore more limited.

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

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

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

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

Non-deceptive Polygraph Examination Result: A non-deceptive polygraph examination result must include a deceptive response to control questions and only non-deceptive responses to all relevant questions. Any inconclusive or deceptive response to any relevant question disallows a non-deceptive examination result.

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

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

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

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

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

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

Secondary Victim: Secondary victim means a relative or other person closely involved with the primary victim who is severely impacted emotionally or physically by the trauma suffered by the primary victim.

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

(1) Any (adult) person convicted of a sex offense (defined below) in Colorado on or after January 1, 1994, or;

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

(3) Any person who is adjudicated as a juvenile or who receives a deferred adjudication on or after July 1, 2002, for an offense that would constitute a sex offense if committed by an adult or for any offense, the underlying factual basis of which involves a sex offense, or;

(4) Any person who receives a deferred judgment or deferred sentence for the offenses specified in below is deemed convicted, or;

(5) Any (adult) person convicted of any criminal offense in Colorado on or after January 1, 1994, and;

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

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

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

Sex Offense:

The following definition is based on statute.[2] For the purposes of this document, a sex offense is:

(1) Sexual Assault;

(2) Sexual Assault in the first, second and third degree as it existed prior to July 1, 2000;

(3) Unlawful Sexual Contact;

(4) Sexual Assault on a child;

(5) Sexual Assault on a child by one in a position of trust;

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

(6) Sexual Assault on a client by a psychotherapist;

(7) Enticement of a child;

(8) Incest;

(9) Aggravated Incest;

(10) Trafficking in children;

(11) Sexual Exploitation of children;

(12) Procurement of a child for sexual exploitation;

(13) Indecent Exposure;

(14) Soliciting for child prostitution;

(15) Pandering of a child;

(16) Procurement of a child;

(17) Keeping a place of child prostitution;

(18) Pimping of a child;

(19) Inducement of child prostitution;

(20) Patronizing a prostituted child, or;

(21) Internet luring of a child;

(22) Internet sexual exploitation of a child;

(23) Criminal attempt, Conspiracy, or Solicitation to commit any of the above offenses.

Sex Offender Polygraph: Sex offender polygraph means a criminal specific-issue polygraph examination of a suspected or convicted sex offender.

Sex Offense-Specific Treatment: Consistent with current professional practices, sex offense-specific treatment means a long term comprehensive set of planned therapeutic experiences and interventions to change sexually abusive thoughts and behaviors. Such treatment specifically addresses the occurrence and dynamics of sexually deviant behavior and utilizes specific strategies to promote change. Sex offense-specific programming focuses on the concrete details of the actual sexual behavior, the fantasies, the arousal, the planning, the denial and the rationalizations. Due to

the difficulties inherent in treating sex offenders and the potential threat to community safety, sex offense-specific treatment should continue for several years, followed by a lengthy period of aftercare and monitoring. Much more importance is given to the meeting of all treatment goals than the passage of a specific amount of time, since offenders make progress in treatment at different rates. The primary treatment modality for sex offense specific treatment is group therapy for the offenders. Adjunct modalities may include partner or couples therapy, psycho-education, and/or individual therapy. However, such adjunct therapies by themselves do not constitute sex offense-specific treatment.

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

SOMB: SOMB means the Colorado Sex Offender Management Board.

Special Populations: Persons subject to federally mandated protections and accommodations under the *Americans with Disabilities Act (1990*), *Section 504 of the Rehabilitation Act (1973),* or who were subject to the *Education of All Handicapped Act (1975)* and the subsequent *Individuals with Disabilities Education Act (1990)* and *Individuals with Disabilities Education Improvement Act (2004),* are clearly identified as special populations according to those legislative guidelines.

Standard: Standard means criteria set for usage or practices; a rule or basis of comparison in measuring or judging.

Standards and Guidelines: "*Standards*" means the S*tandards and Guidelines for the Assessment, Evaluation, Treatment and Behavioral Monitoring of Adult Sex Offenders.*

Supervising Officer: Supervising officer means the probation, parole, or community corrections officer or case manager to whom the offender's case is assigned.

Treatment: According to Section 16-11.7-102(4), C.R.S. treatment means therapy, monitoring and supervision of any sex offender which conforms to the *Standards* created by the SOMB. (See also Sex offense-specific treatment.)

Treatment Provider: A treatment provider means a person who provides sex offense-specific treatment to sex offenders according to the *Standards and Guidelines* contained in this document.

Victim Clarification Process: A process designed for the primary benefit of the victim, by which the offender clarifies that the responsibility for the assault/abuse resides with the offender. The process will clarify that the victim has no responsibility for the offender's behavior. It also addresses the damage done to the victim and the family. This is a lengthy process that occurs over time, including both verbal and written work on the part of the offender. Although victim participation is never required and is sometimes contraindicated, should the process proceed to an actual clarification meeting with the victim, all contact is victim centered and based on victim need.

1.000
GUIDELINES FOR PRE-SENTENCE INVESTIGATIONS

1.010 A pre-sentence report shall be prepared for each person convicted as a sex offender as defined in 16-11.7-102(2), and the court may not dispense with the pre-sentence evaluation, risk assessment, and report unless such a report has been completed within the last six months and there has been no material change that would affect the report in the past six months.

Discussion: The purpose of the pre-sentence investigation is to provide the court with verified and relevant information upon which to base sentencing decisions. Sex offenders pose a high risk to community safety and have special needs. Therefore, pre-sentence investigations on these cases differ from those in other types of cases, primarily by the inclusion of a sex offense-specific evaluation. The evaluation establishes a baseline of information about the offender's risk, type of deviancy, amenability to treatment and treatment needs.

The pre-sentence investigation report, including the results of the sex offense-specific evaluation, should follow the sex offender throughout the time the offender is under criminal justice system jurisdiction, whether on probation, parole, community corrections, or in prison.

1.020 In cases in which a defendant is found by the court on the record to be a sex offender as defined by C.R.S. 16-11.7-102(2), the pre-sentence investigation report should be completed by a pre-sentence investigator specially trained in sex offender management.

1.030 Probation officers assessing sex offenders during the pre-sentence investigation should have successfully completed required training. (See 5.222 for required training.)

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

- Criminal history
- Education/employment
- Financial status
- 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
- Sex offense-specific evaluation report
- Risk factors, risk level, and amenability to treatment
- The potential impact of the sentencing recommendation on the victim
- Sexually Violent Predator (SVP) assessment

Based on the information gathered, the pre-sentence investigation report should make recommendations about an offender's suitability for community supervision. If community supervision is recommended for an offender, special conditions and a supervision period sufficiently lengthy to allow for an extended period of treatment *and* a period of aftercare and behavioral monitoring should be requested.

1.050 When referring an offender for a sex offense-specific evaluation, pre-sentence investigators should send to the evaluator, as part of the referral packet:

- Police reports
- The victim impact statement
- Child protection reports
- A criminal history
- Any available risk assessment materials
- Prior evaluations and treatment reports
- Prior supervision records, if available
- Any other information requested by the evaluator

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

1.060 At the time of the intake interview, the pre-sentence investigation writer should provide the sex offender with a copy of the required disclosure/advisement form and should have the offender sign for receipt of the form.

Discussion: This disclosure/advisement form notifies an offender and other concerned parties of the requirements the offender will have to meet should probation be granted.

2.000 STANDARDS FOR SEX OFFENSE-SPECIFIC EVALUATIONS

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

Evaluators who provide evaluations to sex offenders with developmental disabilities shall be SOMB approved with a specialty in the evaluation of sex offenders with developmental disabilities in accordance with the qualifications required pursuant to *Standards*, section 4.000 DD.

2.010 Assessment and evaluation are ongoing processes and should continue through each transition of supervision and treatment. Re-evaluation by community supervision team members should occur on a regular basis to ensure recognition of changing levels of risk.

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

2.030 The evaluator shall obtain the informed assent of the offender for the evaluation, by advising the offender of the assessment and evaluation methods to be used, the purpose of the evaluation, and to whom the information will be provided. The evaluator shall explain to the offender about the role the evaluator fills with regard to the offender and the court. Results of the evaluation should be shared with the offender and any questions addressed. The evaluation shall explain the limits of confidentiality and the obligations regarding mandatory reporting of child abuse.

2.030 DD

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

Discussion: When the evaluator is working with a sex offender with developmental disabilities and obtaining informed assent, the evaluator (see Section 4.000 related to evaluator qualifications and Appendix E related to special populations) should be familiar with characteristics of persons with developmental disabilities such as cognitive functioning, communication style, mental health issues, vocabulary and language skills, or other significant limitations. If the evaluator feels that informed assent could not be acquired at the time of the evaluation, the evaluator shall

obtain assistance from a third party who is not a practitioner from within the same agency. A third party may be an individual or group of individuals who understands the definition of informed assent and who has had significant knowledge of the person's unique characteristics.

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

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

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

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

2.050 To ensure the most accurate prediction of risk for sex offenders, the following evaluation modalities are all required in performing a sex offense-specific evaluation:

- Use of instruments that have specific relevance to evaluating sex offenders
- Use of instruments with demonstrated reliability and validity
- Examination and integration of criminal justice information and other collateral information, including:
  - The details of the current offense
  - Documents that describe victim trauma, when available
  - Scope of offender's sexual behavior other than the current offense that may be of concern
- Structured clinical and sexual history interview
- Offense-specific psychological testing and standardized assessments/instruments
- Testing of deviant arousal or interest (i.e. Plethysmograph, Abel Screening or other Viewing Response Time (VRT) instruments)
- Use of at least one validated risk assessment instrument that was normed on a population most similar to the offender being evaluated.

Discussion: Evaluation instruments and processes will be subject to change as more is learned in this area. Because measures of risk are imperfect at this time, evaluation and assessment must be done by collecting information through a variety of methods. Evaluation and assessment therefore currently involve the integration of physiological, psychological, historical, and demographic information to adequately assess a sex

offender's level of risk and amenability to treatment. When the evaluator is in doubt, s/he should err on the side of protecting community safety in drawing conclusions and making recommendations.

2.050 DD

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

1. When possible, instruments should be used that have relevance and demonstrated reliability and validity which are supported by research in the mental health and sex offender treatment fields as they relate to persons with developmental disabilities.
2. If a required procedure is not appropriate for a specific client, the evaluator shall document in the evaluation why the required procedure was not done.

(B) Evaluators shall carefully consider the appropriateness and utility of using a plethysmograph assessment, or VRT assessment with sex offenders who have developmental disabilities. For these assessments to be effective with this population, evaluators shall assess whether the offender has a sufficient level of cognitive functioning to be able to adequately discriminate between stimulus cues. In addition, consideration shall be given to use of specialized protocols that have been developed for sex offenders who have developmental disabilities, such as the Behavioral Technologies, Inc. stimulus cue package for the plethysmograph and the Abel-Blasingame Assessment System *for Individuals with Intellectual Disabilities*™ (ABID). In administering the Abel Screening it is critical to use the questionnaire in addition to the VRT procedure. Further, the use of the relapse prediction scores from the Abel Screening are not recommended due to not having been adapted for use with sex offenders who have developmental disabilities and therefore, shall not be used by evaluators. Finally, the evaluator shall interpret the results of plethysmograph and VRT assessments with caution given the limited research and minimal validation of these tools with sex offenders who have developmental disabilities, and the evaluator shall seek other evaluative information to confirm diagnostic considerations generated by the plethysmograph and VRT assessment data.

2.060 A sex offense-specific evaluation of a sex offender shall evaluate the following required areas:

- Cognitive Functioning
- Mental Health
- Medical/Psychiatric Health
- Drug/Alcohol Use
- Stability of Functioning
- Developmental History
- Sexual Evaluation
- Risk
- Motivation and Amenability to Treatment
- Impact on Victim

2.060 DD

Evaluators shall also address the level of functioning and neuropsychological concerns for sex offenders with developmental disabilities and make appropriate recommendations regarding treatment modality and any need for additional behavioral interventions or containment and supervision requirements. To address an offender's level of functioning and appropriate treatment interventions, the evaluation areas on page 40 shall also be addressed.

Evaluators

SEX OFFENSE-SPECIFIC EVALUATION

Outlined in the following chart are the <u>required</u> areas of a sex offense-specific evaluation. The left hand column identifies the required areas to be evaluated. The right hand column identifies the required and optional evaluation procedures that may be used. All major categories identified in Standard 2.060 shall be addressed.

Evaluation Areas – Required	***Required and Optional Evaluation Procedures*** • *Closed bullet indicates a required method* ○ *Open bullet indicates an optional method*
COGNITIVE FUNCTIONING	
Intellectual Functioning (Mental Retardation, Learning Disability, and Literacy)	• *Clinical Interview (D)* • *History of Functioning and/or standardized tests:* • *Clinical Mental Status Exam (D)* • *Observational Assessment (E)* • *Case File/Document Review (F)* • *Collateral Information/Contact/Interview (F)* ○ *WAIS III (C)* ○ *TONI (Test of Non-Verbal Intelligence) (B)* ○ *Shipley Institute of Living Scale Revised (B)* ○ *Kaufman IQ Test for Adults (C)* ○ *Stanford Binet (C)* ○ *Slosson Intelligence Test – Revised (B)* ○ *Slosson Full-Range Intelligence Test (B)* ○ *Kaufman Brief Intelligence Test (B)* ○ *Universal Nonverbal Intelligence Test (C)*
Neuropsychological Functioning (fluid intelligence)	• *Clinical Interview (D)* • *Clinical Mental Status Exam (D)* ○ *Observational Assessment (E)* ○ *Case File/Document Review (F)* ○ *Collateral Information/Contact/Interview (F)* ○ *Test of Memory and Learning (C)* ○ *K-SNAP (B)* ○ *Cognistat – Neurbehavioral Cognitive Status Exam (B)* ○ *Boston Naming Test (B)* ○ *Boston Diagnostic Aphasia Test (C)* ○ *Luria-Nebraska Screening Test (B)* ○ *Weschler Memory Scale Revised (C)* ○ *Jacobs Cognitive Screening Test (B)* ○ *Quick Neurological Screening Test (B)* ○ *Bilingual Verbal Abilities Test (B)* ○ *Referral to Neuropsychologist if necessary (S)* ○ *WAIS III (C)* ○ *Bender – Gestalt (C)*

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Academic Achievement	• *Clinical Interview (D)* • *Clinical Mental Status Exam (D)* ○ *Observational Assessment (E)* ○ *Case File/Document Review (F)* ○ *Collateral Information/Contact/Interview (F)* ○ *Woodcock-Johnson Psychoeducational Battery, Revised (C)* ○ *Wide Range Achievement Test 3 (B)* ○ *Referral to Educational Diagnostic if necessary (S)* ○ *Referral to Vocational Specialist if necessary (S)*

MENTAL HEALTH	
Character/Personality Pathology	• *Clinical Interview (D)* • *Collateral Information/Contact/Interview (F)* • *Clinical Mental Status Exam (D)* • *Observational Assessment (E)* • *Case File/Document Review (F)* ○ *Hare Psychopathy Checklist Revised (C)* ○ *Psychopathy Checklist – Screening Version (B)* ○ *MCMI-III (C)* ○ *MMPI 2 (C)* ○ *Jessnes Inventory (C)* ○ *Rorschach Test (C)* ○ *Sentence Completion Series (B)* ○ *State-Trait Anger Inventory (B)* ○ *State-Trait Anxiety Inventory (B)* ○ *Social/Developmental History (D)*
Mental Illness	• *Clinical Interview (D)* • *Collateral Information/Contact/Interview(F)* • *Clinical Mental Status Exam (D)* • *Observational Assessment (E)* • *Case File/Document Review (F)* ○ *MCMI-III (C)* ○ *MMPI 2 (C)* ○ *Jessnes Inventory (C)* ○ *Rorschach Test (C)* ○ *Sentence Completion Series (B)* ○ *Symptom Checklist 90 (B)* ○ *Brief Symptom Inventory / Symptom Assessment 45 (B)* ○ *Trauma Symptom Checklist (C)* ○ *Beck Depression Inventory (A)* ○ *Positive and Negative Syndrome Scale (B)* ○ *Brief Psychiatric Rating Scale (B)*

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Self Concept/Self Esteem	• *Clinical Interview (D)* • *Clinical Mental Status Exam (D)* • *Observational Assessment (E)* • *Case File/Document Review (F)* • *Collateral Information/Contact/Interview (F)* ○ *MPD (Measures of Psychological Development) (B)* ○ *CAQ (Clinical Analysis Questionnaire) (D)* ○ *CPI (California Personality Inventory) (C)* ○ *MCMI-III (C)* ○ *MMPI 2 (C)* ○ *Jessnes Inventory (C)*

MEDICAL/PSYCHIATRIC HEALTH	
▭ *Pharmacological Needs* ▭ *Medical Condition Impacting Offending Behavior* ▭ *History of Medication Use/Abuse*	• *Clinical Interview (D)* • *Clinical Mental Status Exam (D)* • *Observational Assessment (E)* • *Case File/Document Review (F)* • *Collateral Information/Contact/Interview (F)* ○ *Referral to Physician, if indicated (S)* ○ *Referral to Psychiatrist, if indicated (S)* ○ *Referral for Medical Tests (S)*

DRUG/ALCOHOL USE*	
Use/Abuse	• *Clinical Interview (D)* • *Collateral Information/Contact/Interview (F)* • *Clinical Mental Status Exam (D)* • *Observational Assessment (E)* • *Case File/Document Review (F)* ○ *MCMI-III (C)* ○ *MMPI 2 (C)* ○ *Clinical Analysis Questionnaire (D)* ○ *Personal History Questionnaire (B)* ○ *SASSI – III (B)* ○ *Adult Substance Use Survey (B)* ○ *Substance Use History Matrix (B)*
Number of Relapses	• *Clinical Interview (D)* • *Collateral Information/Contact/Interview (F)* • *Treatment History (F)* • *Clinical Mental Status Exam (D)* ○ *Observational Assessment (E)* ○ *Case File/Document Review (F)*

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STABILITY OF FUNCTIONING	
Marital/Family Stability ▭ *Past* ▭ *Current* ▭ *Familial Violence* ▭ *Familial Sexual* ▭ *Financial* ▭ *Housing* ▭ *Social Support Systems*	• *Clinical Interview (D)* • *Interview Attitudes* • *Collateral Information/Contact/Interview (F)* • *Clinical Mental Status Exam (D)* • *Observational Assessment (E)* • *Case File/Document Review (F)* • *History of Functioning (F)* ○ *Personal History Questionnaire (B)* ○ *Family Environment Scale (B)* ○ *Dyadic Adjustment Scale (B)* ○ *Marital Satisfaction Inventory (B)*
Access to Children ▭ *Legal Relationship to Child*	• *Clinical Interview* • *Collateral Information* ○ *PRA (Parental Risk Assessment)*
Employment/Education ▭ *Completion of Major Life Tasks*	• *Clinical Interview (D)* • *Collateral Information/Contact/Interview (F)* • *History of Functioning (F)* • *Case File/Document Review (F)* ○ *Clinical Mental Status Exam (D)* ○ *Observational Assessment (E)* ○ *Personal History Questionnaire (B)*
Social Skills ▭ *Ability to Form Relationships* ▭ *Ability to Maintain Relationships* ▭ *Courtship/Dating Skills* ▭ *Ability to Demonstrate Assertive Behavior*	• *Clinical Interview (D)* • *Collateral Information/Contact/Interview (F)* • *Clinical Mental Status Exam (D)* • *Observational Assessment (E)* • *Case File/Document Review (F)* ○ *Interpersonal Behavior Survey (B)* ○ *Social Avoidance and Distress Scale (B)* ○ *Miller's Social Intimacy Scale (A)*

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*	• *Clinical Interview (D)* • *History of Functioning (F)* • *Collateral Information/Contact/Interview (F)* • *Clinical Mental Status Exam (D)* • *Observational Assessment (E)* • *Case File/Document Review (F)*

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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 Deviant Behaviors* ▭ *Witnessed or Experienced Victimization (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*	• *Clinical Interview (D)* • *History of Functioning (F)* • *Collateral Information/Contact/Interview (F)* • *Clinical Mental Status Exam (D)* • *Observational Assessment (E)* • *Case File/Document Review (F)* ○ *Personal Sentence Completion Inventory – Miccio-Fonseca (B)* ○ *Sex Offender Incomplete Sentence Blank (B)* ○ *Wilson Sexual Fantasy Questionnaire (B)* ○ *SONE Sexual History Background Form (D)* ○ *Colorado Sex Offender Risk Scale (Actuarial scale normed on Colorado offenders from probation, parole and prison)*
Reinforcement Structure for Deviant Behavior ▭ *Culture* ▭ *Environment* ▭ *Cults*	• *Clinical Interview (D)*
Arousal/Interest Pattern ▭ *Sexual Arousal or Sexual Interest*	• *Clinical Interview (D)* • *Plethysmograph (S) or Abel Assessment for sexual interest (S)*
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*	• *Clinical Interview (D)* • *History of Crimes (F)* • *Collateral Information (F)* • *Review of Criminal Records (F)* • *Review of Victim Impact Statement, if available (F)* ○ *Contact with Victim Therapist (F)* ○ *Polygraph (S)*
Sexual Deviance	• *Clinical Interview (D)* ○ *SONE Sexual History Background Form (R)* ○ *Multiphasic Sex Inventory I or II (C)* ○ *Hanson Sexual Attitudes Questionnaire (B)* ○ *Wilson Sex Fantasy Questionnaire (B)* ○ *Abel and Becker Card Sort (B)* ○ *Sexual Projective Card Sort (B)* ○ *Sexual Autobiography (R)* ○ *Attitudes Toward Women Scale (B)* ○ *Burt Rape Myth Acceptance Scale (B)* ○ *Abel and Becker Cognition Scale (B)*
Dysfunction (Impotence, Priapism, Injuries, Medications Affecting Sexual Functioning, Etc.)	• *Clinical Interview (D)* ○ *Multiphasic Sex Inventory I or II (C)* ○ *SONE Sexual History Background Form (R)* ○ *Medical tests (S)*

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Offender's Perception of Sexual Functioning	• *Clinical Interview (D)* • *History* ○ *Bentler Heterosexual Inventory (B)* ○ *Abel and Becker Card Sort (B)* ○ *Plethysmograph (S) or Abel Assessment for sexual interest (S)* ○ *Bentler Sexual Behavior Inventory (R)*
Preferences (Male/Female; Age; Masturbation; Use of Tools, Utensils, Food, Clothing; Current Sexual Practices; Deviant as well as Normal Behaviors)	• *Clinical Interview (D)* • *Plethysmograph (S) or Abel Assessment for sexual interest (S)*
Attitudes/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 vs. Ego-dystonic Sense of Deviant Behavior*	• *Clinical Interview (D)* ○ *Burt Rape Myth Acceptance Scale (B)* ○ *Multiphasic Sex Inventory I or II (C)* ○ *Buss/Durkee Hostility Inventory (R)* ○ *Abel and Becker Cognitions Scale (B)* ○ *Attitudes Towards Women Scale (B)* ○ *Socio-Sexual Knowledge and Attitudes Test (For use with sex offenders who have developmental disabilities) (B)*

RISK	
Risk of Re-offense	• *Criminal History* • *SOMB Checklist (7 Dynamic Indicators, normed on Colorado offenders from probation, parole and community corrections)* ○ *Colorado Sex Offender Risk Scale (Actuarial scale normed on Colorado offenders from probation, parole and prison)* ○ *Violence Risk Assessment Guide (Normed on a psychiatric hospital sample)* ○ *Sex Offense Risk Assessment Guide* ○ *Rapid Risk Assessment for Sex Offender Re-arrest (Sample excludes incest offenders)* ○ *MnSOST-R (Normed on Minnesota offenders in the Department of Corrections, excludes incest offenders)* ○ *CARAT* ○ *Static 99 or 2002* ○ *SONAR*
Risk of Failure in Treatment and Supervision	• *Clinical Interview* • *Criminal History* • *Colorado Sex Offender Risk Scale (Actuarial scale normed on Colorado offenders from probation, parole and prison)* ○ *PCLR* ○ *SONAR*

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MOTIVATION AND AMENABILITY TO TREATMENT	
	• *Clinical Interview (D)* • *Clinical Mental Status Exam (D)* • *Observational Assessment (E)* • *Case File/Document Review (F)* • *History of Functioning (F)* • *Review of Criminal Records* • *History of Compliance with Treatment and Supervision* o *DCJ Checklist*

IMPACT ON VICTIM	
Evaluate impact on victim and the offender's perception of impact on victim	• *Clinical Interview of Offender (D)* • *Case File/Document Review (F)* • *Review of Police Reports* • *Review Victim Impact Statement* o *Contact Victim Therapist/Advocates, when available* o *Interview Family Members*

Discussion: No single test should be seen as absolute or predictive; rather, results should be seen as contributing to the overall evaluation of the sex offender and his or her risk to the community. Offender's self-report is an unreliable source of information during the evaluation, and the evaluator shall take steps not to rely solely on self-report information.

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ADDITIONAL EVALUATION AREAS FOR SEX OFFENDERS WITH DEVELOPMENTAL DISABILITIES

Evaluation Areas - Required	***Required and Optional Evaluation Procedures*** • *Closed bullet indicates a required method* ○ *Open bullet indicates an optional method*
Level of planning in crime of conviction and other sexual offending behavior	• *History of functioning (D)* • *Structured interview (D)* • *Collateral information (F)*
"Street smarts"	• *History of functioning (D)* • *Structured interview (D)* • *Collateral information (F)*
Expressive and receptive language skills	• *Clinical evaluation (D)* ○ *Peabody Picture and Vocabulary Test Revised (PPVT-R) (B)* • *Collateral information (F)* ○ *Expressive tests, e.g. CELF, TOLD (B)*
Social judgment/ability to participate in group settings	• *History of functioning (D)* • *Structured interview (D)* • *Collateral information (F)* ○ *Young Adult Institute Tools (YAI Tools) (B)*
Adaptive behavior	• *Clinical evaluation (D)* ○ *Vineland Adaptive Behavioral Scale (B)* ○ *Adaptive Behavioral Scale of the American Association for Mental Retardation (B)*
Support systems	• *History of functioning (D)* ○ *Current DD system involvement (F)* ○ *Current family involvement (F)* ○ *Current social involvement (F,R)*
Executive functioning	• *History of functioning (D)* • *Structured interview (D)* • *Collateral information (F)* ○ *Wisconsin Card Sort Test (B)* ○ *Boston Naming Test (B)* ○ *Trail Making Test (B)* ○ *Bender-Gestalt (B)* ○ *Cognistat – Neurbehavioral Cognitive Status Exam (B)*

DD Discussion: Many widely used risk assessment tools have not been created specifically for adult sex offenders with developmental disabilities. Therefore, the evaluator shall use caution when choosing to use such instruments and when interpreting the resulting data.

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2.070 The evaluator shall make recommendations or findings regarding:

- Level of risk
- Amenability for treatment
- Appropriateness for community placement.
  - The evaluator shall assess the sex offender's level of denial (see Standard 3.510). The evaluator shall not recommend community based treatment and supervision for a sex offender who is in Level 3: Severe Denial (see Standard 3.520).
- Type of placement (e.g. outpatient, residential)
- Intensity of offense-specific treatment (i.e. frequency of treatment contact)
- Multi axial diagnoses
- Treatment of co-existing conditions and further assessments needed to address areas of concern
- The need for medical/pharmacological treatment, if indicated
- Expectations for involvement in treatment of the offender's family
- Specific risk factors that require management and potential interventions
- Access to, contact with and/or restrictions against contact with children and victims

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.

2.070 DD

If the sex offender with developmental disabilities meets the statutory requirements for completion of the Sexually Violent Predator Risk Assessment, the instrument shall be completed using the existing instruments as required pursuant to Section 18-3-414.5, C.R.S. The evaluator shall document any concerns regarding this instrument's validity for the client.

2.080 In the evaluation process, physiological testing through the use of polygraph examinations can be useful in understanding an offender's level of deception and denial and is recommended in the evaluation process. The polygraph should not be used to determine guilt or innocence or as the primary finder of facts for legal purposes. (See Sections 6.000 for standards on the use of the polygraph.)

2.090 Evaluators have an ethical responsibility to conduct evaluation procedures in a manner that ensures the integrity of testing data, the humane and ethical treatment of the offender, and compliance with the mental health statutes. Evaluators should use testing instruments in accordance with their qualifications and experience. Un-interpreted raw data from any type of testing should never be released to those not qualified to interpret.

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

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

3.000 STANDARDS OF PRACTICE FOR TREATMENT PROVIDERS

3.100 Sex Offense Specific Treatment

3.110 Sex offense specific treatment must be provided by a treatment provider listed at the full operating level or the associate level under these *Standards*.

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

The supervision agreement shall include:

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

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

Discussion: *Upon written request to the SOMB, reasonable accommodations to the face-to-face requirement of this Standard may be approved in order to allow for extraordinary circumstances.*

- The length of the supervision agreement.
- The type of supervision (i.e. individual or group supervision, or both).
- The nature of the supervision (focus on treatment, evaluation, or both).

The Full Operating Level Supervisor shall conduct one hundred (100) hours of co-facilitated treatment in the same room with the applicant, or shall ensure that another Full Operating or Associate Operating Level treatment provider is conducting co-facilitated treatment in the same room. It is incumbent upon the supervisor to determine the appropriate time to move the applicant from exclusively co-facilitated clinical contact to non-co-facilitated clinical contact based upon that individual's progress in attaining competency to perform such treatment.

The Full Operating Level supervisor shall review and co-sign all treatment plans, evaluations and reports by the applicants. The Full Operating Level supervisor is responsible for all clinical work performed by the applicant.

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

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

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

The treatment plan shall:

- Provide for the protection of victims and potential victims and not cause the victim(s) to have unsafe and unwanted contact with the offender;
- Address the issue of ongoing victim input (will the victim be involved, in what manner, at what stage of treatment, etc.);
- Be individualized to meet the unique needs and risks of the offender;
- Identify the issues to be addressed, the planned intervention strategies, and the goals of treatment;
- Define expectations of the offender, his/her family (when possible), and support systems.

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

- Document the goals of treatment, the methods used, and the client's observed progress, or lack thereof, toward reaching the goals in the treatment plans;
- Record specific achievements, failed assignments, rule violations and consequences;
- Accurately reflect the client's treatment progress, sessions attended, and changes in treatment.

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

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

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

B. Group therapy (with the group comprised only of sex offenders) is the preferred method of sex offense-specific treatment. At a minimum, any method of psychological treatment used must conform to the *Standards* for content of treatment (see F below) and must contribute to the management of sex offenders. The sole use

of individual therapy is not recommended with sex offenders, and should be avoided except when geographical—specifically rural—or disability limitations dictate its use;

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

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

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

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

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

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

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

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

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

F. The provider shall employ treatment methods that are based on recognition of the need for long-term, comprehensive, offense-specific treatment for sex offenders. The

provider shall use an evidence-based approach. Self-help or time-limited treatment shall be used only as adjuncts to long-term, comprehensive treatment[3];

G. The provider, in consultation with the Community Supervision Team (CST), shall determine treatment intensity including frequency and duration of contact based on offender's needs and risk. The treatment provider shall consult with the CST regarding the need for referral to a program of different intensity if not offered in his/her program;

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

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

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

I. Offense-specific treatment for sex offenders shall:

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

2. Require offenders to complete a full sex history disclosure and to disclose all current sex offending behaviors;

3. Reduce offenders' denial and defensiveness;

[3] Yates, P.M. (2002) in "What Works: Effective Intervention with Sex Offenders" In H.E.Allen (Ed), Risk Reduction:Interventions for Special needs Offenders (pp.115-163), Lanham, MD: American Correctional Association
Yates, P.M., Goguen, B.C., Nicholaichuk, T.P., Williams, S.M., and Long, C.A. (2000) National Sex Offender Programs. Ottawa, Ontario: Correctional Service of Canada.
Andrews and Bonta (1998) - Andrews, D.A., and Bonta, J. (1998) The Psychology of Criminal Conduct. Cincinnati, OH: Anderson.
Fernandez et al (1998) - Fernandez, Y.M., Marshall, W.L., Serran, G., Anderson, D., and Marshall, L. (2002) Group Process in Sex Offender Treatment. Ottawa, Ontario: Correctional Services of Canada.
The Sex Offender: Issues in Assessment, Treatment, and Supervison of Adult and Juvenile Populations (2005) Ed. by Barbara K. Schwartz. Kingston, N.J.: Civic Research Institute

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

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

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

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

8. Identify and treat offenders' cognitive distortions;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

21. Identify and address issues of gender role socialization;

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

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

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

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

L. Recognizing the importance that the continuum of treatment intensity is dependant on offender progress, providers shall offer phases of reduced treatment intensity following an offender successfully addressing all applicable issues and concepts contained in *Standards* 3.160 (I) 1–22. This phase of treatment shall include regular polygraph examinations. The main focus of this reduced intensity "maintenance treatment" shall be to:
   - Enhance application of those concepts learned in *Standards* 3.160 (I) 1–22 in the client's current lifestyle, including internalizing, integrating and consolidating these concepts;
   - Refine re-offense prevention skills. As offenders apply concepts it is possible that they will have lapses, which shall be addressed during the maintenance treatment;
   - Return offenders to a more intensive phase of treatment if clinically indicated.

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

- Satisfactorily addressed all applicable issues listed in *Standards* 3.160 (I) 1 – 22;
- Completed the non-deceptive sexual history disclosure polygraph process;
- Yielded non-deceptive results on the two most recent and consecutive maintenance polygraphs and they are absent any information not previously disclosed to the containment team;
- Produced an objective sexual arousal or interest measure demonstrating management of deviance;
- Demonstrated consistent compliance with treatment and supervision conditions;
- Modified his/her lifestyle to actively manage his/her risk and consistently applies the concepts learned in treatment. In addition, he/she discloses and addresses ongoing risk factors in treatment;
- Accepted s/he needs ongoing treatment and external support irrespective of required supervision conditions.

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

3.200 Successful Completion of Legally Mandated Treatment

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

The decision to end treatment shall be based on:

- A determination by the team that the offender would not pose an undue risk to victim and community safety without treatment;
- A reexamination of the offender's progress over an extended period of time in the maintenance phase of treatment;
- A determination that the offender is low risk on criminogenic factors as defined by all information gained over the course of treatment and supervision.

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

3.300 Confidentiality

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

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

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

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

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

3.400 Treatment Provider-Client Contract

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

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

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

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

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

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

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

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

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

2. Comply with all requirements to pay for the cost of assessment and treatment for the victim(s) and their family(ies), including all medical and psychological tests, and consultation;

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

4. Actively involve relevant family and support system;

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

6. Participate in polygraph testing and sexual arousal/interest testing as prescribed in the *Standards*;

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

8. Maintain physical safety in the living environment and community.

C. Failure to comply with the terms of the contract may result in termination from treatment. The contract shall also, (as applicable):
   - Provide instructions and describe limitations regarding the client's contact with victims, secondary victims, and children;
   - Describe limitations or prohibitions on the use or viewing of sexually stimulating, violent material and material related to deviant sexual interest;
   - Describe the responsibility of the client to protect community safety by avoiding risky, aggressive, or re-offending behavior, avoiding high risk situations, and reporting any such forbidden behavior to the provider and the supervising officer as soon as possible;
   - Describe limitations or prohibitions on the use of alcohol or drugs not specifically prescribed by medical staff;
   - Describe limitations or prohibitions on employment and recreation.

3.500 Managing Sex Offenders in Denial

3.510 Levels of Denial

The following is a description of different levels of denial as it relates to the conviction. This classification is similar to those proposed by Salter (1988)[4], Leflen and Sturn

[1] Salter, A. (1988). *Treating Child Sex Offenders & Victims*, Newbury Park, CA: Sage Publications. Laflen, B. & Sturm

(1993)[5], Winn (1993)[6], and Brake and Shannon (1995)[7]. These levels should be used in conjunction with the rest of 3.500.

Level 1: Low Denial
This level consists of attitudes that reflect low or occasional avoidance of responsibility. Most offenders present with Level 1 denial at one time or another. Offenders presenting with Level 1 denial are considered to be "admitters of fact."

Level 2: Moderate to High Denial
This level consists of offenders who a) admit to some of the behavior involved in the offense, but justify its occurrence or minimize its importance, b) offenders who admit the facts of the offense, but deny the sexually abusive aspect of the offense, and/or c) offenders who do not admit committing the current sexual offense, but admit to engaging in less harmful sexual behaviors.

Level 3: Severe Denial
This level consists of offenders who deny committing the current offense and refuse to acknowledge responsibility for even remotely similar behaviors. Offenders may also appear excessively hostile or defensive. These types of denial are most resistant to change.

3. 520 Sex offenders who are in Level 3 Denial shall not be recommended for community based treatment and supervision.

Discussion: Secrecy, denial, and defensiveness are part of sex offenders' pathology. Almost all offenders fluctuate in their level of accountability or minimization of the offenses. Although most are able to admit responsibility for the sexual offense relatively soon after conviction, some offenders do not. As denial impedes treatment engagement and progress[8], an offender's continued denial of the sexual offense after conviction threatens community safety. Offender denial is highly distressing and emotionally damaging to victims.

3. 530 When a sex offender in severe denial is placed in the community, despite the requirements of 3.520, (e.g. on mandatory parole), a Denier Intervention shall specifically address the sex offender's denial and defensiveness as it relates to preventing the sex offender from successfully participating in sex offender treatment. Denier Intervention

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[2] Laflen, B. & Sturm, W.R. (1994) UNDERSTANDING and WORKING with DENIEL in SEXUAL OFFENDERS. Journal of Child Sexual Abuse, 3, pp.19-36 Discussion article conceptualizing denial in adult sexual offenders as stages through which the offender will cyclically progree during treatment.

[6] Winn, M.E. (1996) THE STRATEGIC AND SYSTEMIC MANAGEMENT OF DENIAL IN THE COGNITIVE/BEHAVIORAL TREATMENT OF SEXUAL OFFENDERS. Sexual Abuse: A Journal of Research and Treatment, 8, pp.25-36. Presents a rationale for working with denial as a component of pre-treatment, identifies types of denial and offers several interventions to address the function and maintenance of denial in the offender and his family.

[7] Brake, S. C. & Shannon, D. (1997). USING PRE-TREATMENT TO INCREASE ADMISSION IN SEX OFFENDERS in THE SEX OFFENDER: NEW INSIGHTS, TREATMENT INNOVATIONS AND LEGAL DEVELOPMENTS, Civic Research Press, pp. 5-1-5-16. Describes a program for deniers, which resulted in a "significant reduction of denial in 58%" of offender participants.

[8] Denial was found to be inversely associated with treatment engagement and progress (Levenson & MacGowan, 2004). Further, the Division of Criminal Justice, Office of Research and Statistics, found that denial measured early in treatment using the SOMB Checklist significantly correlated with treatment failure/revocation (see English, Kleinsasser and Retzlaff, 2002, "The Colorado Sex Offender Risk Scale" in the *Journal of Child Sexual Abuse*, *Vol. 11*, No. 2).

shall not exceed three months and shall be regarded as preparatory for offense-specific treatment.

Discussion: Although all offense-specific treatment programs usually begin by addressing minimization and defensiveness, Denier Intervention for those in Level 3 Denial, typically occurs separately from regular group therapy that is provided for offenders who have, at a minimum, admitted the crime of conviction. Level 3 deniers are not considered amenable to offense specific treatment. They do not admit sex offenses and therefore do not acknowledge a need to work on issues that contribute to their offending behavior or re-offense plans. Since severe denial prevents therapists from obtaining critical information from the offender, they are unable to develop effective interventions to address the offending behavior. Further, including deniers in regular groups may disrupt the group's focus on treatment tasks and encourage other offenders to deny their crimes and can increase their level of denial. Denier Intervention for Level 3 Denial may include a variety of modalities specifically designed to reduce denial and resistance to treatment and supervision.

During the time an offender is attending Denier Intervention, the CST should work closely together to ensure maximum containment, supervision and accountability measures are enforced for the offender. Intermediate sanctions should also be used during the course of Denier Intervention to reduce denial and encourage disclosure. In addition to requiring the offender to undergo an instant offense polygraph regarding the offense of conviction, the CST shall also require the offender to undergo Maintenance polygraph testing to monitor current behavior and enable the CST to respond to concerns quickly.

3.540 Use of the polygraph is important in reducing an offender's denial. Deniers shall be referred for an instant offense polygraph examination. Documentation is imperative for future revocation proceedings, in the event that an offender fails to make sufficient progress and is therefore terminated from Denier Intervention.

3.550 Offenders who are still in Level 3 Denial and are strongly resistant after this three (3) month phase of Denier Intervention shall be terminated from treatment and revocation proceedings should be initiated. Other sanctions and increased levels and types of supervision, such as home detention, electronic monitoring, etc., should be pursued if a revocation does not occur. In no case should a sex offender in continuing denial of the sexual offense remain indefinitely in Denier Intervention.

Discussion: It is important to support victim recovery and community safety by proceeding with revocations for those sex offenders whose continued denial or resistance make treatment ineffective.

3.560 Denier Intervention shall only be provided by treatment providers who also meet the requirements to provide sex offense-specific treatment, as defined in this document.

3.570 Progress in Denier Intervention is reflected by the offender's decreased resistance to treatment, decreased defensiveness and denial, and increased accountability for offense behavior.

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

3.600 Treatment of Sex Offenders Within the Department of Corrections

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

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

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

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

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

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

3.650 Treatment providers shall:

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

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

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

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

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

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

The supervision agreement shall include:

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

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

Discussion: *Upon written request to the SOMB, reasonable accommodations to the face-to-face requirement of this Standard may be approved in order to allow for extraordinary circumstances.*

- The length of the supervision agreement.
- The type of supervision (i.e. individual or group supervision, or both).
- The nature of the supervision (focus on treatment, evaluation, or both).

The Full Operating Level Supervisor shall conduct one hundred (100) hours of co-facilitated treatment in the same room with the applicant, or shall ensure that another Full Operating or Associate Operating Level treatment provider is conducting co-facilitated treatment in the same room. It is incumbent upon the supervisor to determine the appropriate time to move the applicant from exclusively co-facilitated clinical contact to non-co-facilitated clinical contact based upon that individual's progress in attaining competency to perform such treatment.

The Full Operating Level supervisor shall review and co-sign all treatment plans, evaluations and reports by the applicants. The Full Operating Level supervisor is responsible for all clinical work performed by the applicant.

4.200 All Applicants Begin at the Associate Level: With the possible exception of some out-of-state applicants, all applicants shall apply for, and be approved at the Associate Level treatment provider, evaluator, or polygraph examiner status prior to applying for Full Operating Level.

4.210 Professional Supervision of Associate Level Treatment Providers and Evaluators:

- Supervision of Associate Level treatment providers shall be done by Full Operating Level treatment providers in good standing.
- Supervision of Associate Level evaluators shall be done by Full Operating Level evaluators in good standing.
- The supervisor shall provide clinical supervision as stated in the Intent to Apply Section (4.100). Supervision hours for treatment and evaluation clinical work may be combined.
- The supervisor shall review and co-sign all treatment plans, evaluations, and reports generated by Associate Level treatment provider or an Associate Level evaluator.
- Full Operating Level adult treatment providers and evaluators shall supervise applicants applying to the Adult Provider List.

4.210 DD

Associate Level and Full Operating Level treatment providers and evaluators who want to provide evaluation and/or treatment services to adult sex offenders with developmental disabilities shall demonstrate compliance with and submit an application attesting to having met all requirements identified as Developmentally Disabled (DD) Standards in this section.

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

4.230 Movement between Adult and Juvenile Listing Status: Providers who are Full Operating or Associate Level treatment providers, evaluators, or polygraph examiners for juveniles who have committed sexual offenses may apply to be listed as an Associate Level treatment provider, evaluator, or polygraph examiner for adult sex offenders.

- The Full Operating Level or Associate Level treatment provider, evaluator, or polygraph examiner for juveniles who have committed sexual offenses shall submit an application outlining the level of compliance with the application

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

4.300 TREATMENT PROVIDER: Adult Associate Level: An Associate Level treatment provider may treat adult sex offenders under the supervision of a Full Operating Level treatment provider under these *Standards*. To qualify to provide sex offender treatment at the Associate Level under Section 16-11.7-106 C.R.S. an applicant shall meet all the following criteria:

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

B. The applicant shall hold a professional mental health license or be listed with the Department of Regulatory Agencies as an unlicensed psychotherapist, and not be under current disciplinary action;

C. The applicant shall have completed, within the past five (5) years, and in not less than one (1) year, a minimum of one hundred (100) direct face-to-face clinical contact co-therapy hours with adult sex offenders, in the same room, with a Full Operating or Associate Level treatment provider;

(C) DD

Of the one hundred (100) hours of direct face-to-face clinical co-therapy with adult sex offenders, the provider shall have completed twenty-five (25) hours with adult sex offenders with developmental disabilities while a Full Operating or Associate Level treatment provider with developmental disability specialty listing status is in the same room.

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

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

Discussion: *Upon written request to the SOMB, reasonable accommodations to the* face-to-face *requirement of this Standard may be approved in order to allow for extraordinary circumstances.*

(D) DD

The provider shall have completed 25% of their required supervision hours with a Full Operating Level treatment provider with developmentally disability specialty listing status.

E. Within the past five (5) years, the applicant shall have a total of fifty (50) hours of training with a minimum of the following hours in each category:

- Thirty-two (32) hours of sex offense specific training,
- Eight (8) hours victim issues training, and
- Ten (10) hours of training specific to the treatment of adult sex offenders.

These fifty (50) training hours may be utilized to meet the qualifications for both adult and juvenile treatment providers. The applicant must demonstrate a balanced training history. Please see the list of training categories in section 4.900;

(E) DD

Of the fifty (50) training hours, the provider shall have completed ten (10) training hours specific to the treatment of adult sex offenders with developmental disabilities.

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

G. The applicant shall provide satisfactory references as requested by the SOMB. The SOMB may also solicit such additional references as necessary to determine compliance with the *Standards*. The references shall relate to the work the applicant is currently providing;

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

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

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

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

4.310 Continued Placement of Associate Level Adult Providers on the Provider List: Using a current re-application form**,** Associate Level treatment providers shall apply for continued placement on the list every three (3) years by the date provided by the SOMB. Requirements are as follows:

A. The provider shall accumulate a minimum of six hundred (600) hours of clinical experience every three (3) years, three hundred (300) hours of which shall be direct face-to-face clinical contact with adult sex offenders;

(A) DD

Of the six hundred (600) hours of clinical experience, the provider shall accumulate one hundred fifty (150) hours with adult sex offenders with developmental disabilities, and of the one hundred (150) hours, seventy five (75) hours shall be direct face-to-face clinical contact with adult sex offenders with developmental disabilities.

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

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

Discussion: *Upon written request to the SOMB, reasonable accommodations to the face-to-face requirement of this Standard may be approved in order to allow for extraordinary circumstances.*

(B) DD

The provider shall have completed 25% of the required supervision hours with a Full Operating Level treatment provider with developmentally disability listing status.

C. The provider shall complete a minimum of forty (40) hours of continuing education every three (3) years in order to maintain proficiency in the field of sex offender treatment and to remain current on any developments in the assessment, treatment, and monitoring of sexual offenders. Eight (8) of the hours shall come from the area of victimology, and ten (10) of the hours shall be specific to the treatment of adult sex offenders.

These training hours may be utilized to meet the qualifications for both adult and juvenile treatment providers. The provider shall demonstrate a balanced training history. Please see the list of training categories in section 4.900;

(C) DD

Of the forty (40) training hours the providers shall have completed ten (10) training hours specific to the treatment of adult sex offenders with developmental disabilities.

D. The provider shall submit satisfactory references as requested by the SOMB. The SOMB may also solicit such additional references as necessary to determine compliance with the *Standards*. The references shall relate to the work the applicant is currently providing;

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

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

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

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

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

4.320 Movement to Full Operating Level: Associate Level treatment providers wanting to move to Full Operating Level status shall complete and submit documentation of all of the requirements listed in Standard 4.400 as well as a letter from the provider's supervisor indicating the provider's readiness to move to Full Operating Level status.

4.400 TREATMENT PROVIDER: Adult - Full Operating Level: A Full Operating Level treatment provider may treat adult sex offenders without supervision and may supervise Associate Level treatment providers. To qualify to provide sex offender treatment at the Full Operating Level under Section 16-11.7-106 C.R.S., a provider shall meet all the following criteria:

A. The provider shall have been approved on the provider list in good standing at the Associate Level or shall have met the requirements at the Associate Level as outlined in 4.300;

B. The provider shall have attained the underlying credential of licensure or certification and not be under current disciplinary action as a Psychiatrist, Psychologist, Clinical Social Worker, Professional Counselor, Marriage and Family Therapist, Clinical Psychiatric Nurse Specialist or Licensed Addiction Counselor;

C. The provider shall have completed within the past five (5) years, and in no less than one (1) year, one thousand (1000) hours of clinical experience specifically in the areas of sex offense specific evaluation and treatment, at least half (500) of

which shall have been direct face-to-face clinical contact with adult sex offenders;

Discussion: Clinical experience and direct face-to-face clinical contact hours may include hours previously utilized to achieve Associate Level treatment provider status.

(C) DD

Of the one thousand (1000) hours of clinical experience, the provider shall have completed two hundred fifty (250) hours with adult sex offenders with developmental disabilities, at least half, one hundred twenty-five (125) of which have been in direct face-to-face clinical contact with adult sex offenders with developmental disabilities.

D. The provider shall have received an additional sixty (60) direct face-to-face clinical contact co-therapy hours with convicted adult sex offenders, in the same room, with a Full Operating Level treatment provider;

Discussion: These sixty (60) hours of direct face-to-face clinical contact co-therapy hours are in addition to the one hundred (100 hours) that have previously been completed to achieve Associate Level treatment provider status.

(D) DD

Of the additional sixty (60) hours of direct face-to-face clinical contact co-therapy hours with adult sex offenders, in the same room, the provider shall have completed fifteen (15) hours with a Full Operating Level treatment provider with developmentally disability specialty listing status.

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

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

Discussion: *Upon written request to the SOMB, reasonable accommodations to the* face-to-face *requirement of this standard may be approved in order to allow for extraordinary circumstances.*

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

(E) DD

The provider shall have completed 25% of the supervision hours with a Full Operating Level treatment provider with developmentally disability specialty listing status.

F. Within the past five (5) years, the provider shall have a total of one hundred (100) hours of training with a minimum of the following hours in each category:

- sixty-five (65) hours of sex offense specific training,
- fifteen (15) hours victim issues training, and
- twenty (20) hours of training specific to the treatment of adult sex offenders

These training hours may be utilized to meet the qualifications for both adult and juvenile treatment providers. The provider shall demonstrate a balanced training history. Please see the list of training categories with examples in section 4.900;

Discussion: Training hours may include hours previously utilized to achieve Associate Level treatment provider status.

(F) DD

Of the one hundred (100) training hours, the provider shall have completed twenty (20) training hours specific to the treatment of adult sex offenders with developmental disabilities.

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

H. The provider shall submit satisfactory references as requested by the SOMB. The SOMB may also solicit such additional references as necessary to determine compliance with the *Standards*. The references shall include other members of the community supervision team;

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

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

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

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

4.410 FIRST RE-APPLICATION. Continued Placement of Full Operating Level Adult on the Provider List: Using a current re-application form, treatment providers shall re-apply for continued placement on the list every three (3) years by the date provided by the SOMB. Requirements are as follows:

A. The provider shall have the underlying credential of licensure or certification and not be under current disciplinary action as a Psychiatrist, Psychologist, Clinical Social Worker, Professional Counselor, Marriage and Family Therapist, Clinical Psychiatric Nurse Specialist or Licensed Addiction Counselor;

B. The provider shall accumulate a minimum of six hundred (600) hours of clinical experience every three (3) years, three hundred (300) hours of which shall be direct face-to-face clinical contact with convicted adult sex offenders;

(B) DD

Of the six hundred (600) hours of clinical experience, the provider shall accumulate one hundred fifty (150) hours with adult sex offenders with developmental disabilities, and of the one hundred fifty (150) hours, seventy-five (75) hours shall be direct face-to-face clinical contact with adult sex offenders with developmental disabilities.

C. The provider shall complete a minimum of forty (40) hours of continuing education every three (3) years in order to maintain proficiency in the field of sex offender treatment and to remain current on any developments in the assessment, treatment, and monitoring of sexual offenders. Eight (8) of the hours shall come from the area of victimology, and ten (10) of the hours shall be related to the treatment of adult sex offenders.

These training hours may be utilized to meet the qualifications for both adult and juvenile treatment providers. Please see the list of training categories in section 4.900;

(C) DD

Of the forty (40) training hours, the provider shall have completed ten (10) training hours specific to the treatment of adult sex offenders with developmental disabilities.

D. The provider shall submit satisfactory references as requested by the SOMB. The SOMB may also solicit such additional references as necessary to determine compliance with the *Standards*. The references shall relate to the work the applicant is currently providing;

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

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

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

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

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

4.420 SECOND AND SUBSEQUENT RE-APPLICATIONS. Continued Placement of Full Operating Level Adult Treatment Providers on the Provider List: Using a current re-application form, the treatment provider shall re-apply for continued placement on the List every three (3) years by the date provided by the SOMB. Requirements are as follows:

A. The provider shall have the underlying credential of licensure or certification and not be under current disciplinary action as a Psychiatrist, Psychologist, Clinical Social Worker, Professional Counselor, Marriage and Family Therapist, Clinical Psychiatric Nurse Specialist or Licensed Addiction Counselor;

B. The provider shall stay active in the field through clinical experience, supervision, administration, research, training, teaching, consultation and/or policy development;

C. The provider shall complete a minimum of forty (40) hours of continuing education every three (3) years in order to maintain proficiency in the field of sex offender treatment and to remain current on any developments in the assessment, treatment, and monitoring of sexual offenders. Eight (8) of the hours shall come from the area of victimology, and ten (10) of the hours shall be related to the treatment of adult sex offenders.

These training hours may be utilized to meet the qualifications for both adult and juvenile treatment providers. Please see the list of training categories in section 4.900. Treatment providers may substitute a combination of consulting, research, teaching, training or other equivalent activities that further their proficiency in the field of sex offender treatment;

(C) DD

Of the forty (40) hours of continuing education, the provider shall have completed ten (10) continuing education hours specific to the treatment of adult sex offenders with developmental disabilities.

D. The provider shall submit satisfactory references as requested by the SOMB. The SOMB may also solicit such additional references as necessary to determine compliance with the *Standards*. The references shall relate to the work the applicant is currently providing;

E. The applicant shall not have a conviction of, or a deferred judgment for, a municipal ordinance violation, misdemeanor, felony, or have accepted by a court a plea of guilty or nolo contender to a municipal ordinance violation, misdemeanor, or felony if the municipal ordinance violation, misdemeanor, or

felony is related to the ability of the approved applicant to practice under these *Standards* as reviewed and determined by the Application Review Committee. A certified copy of the judgment from a court of competent jurisdiction of such conviction or plea shall be conclusive evidence of such conviction or plea;

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

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

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

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

4.500 EVALUATOR: Associate Level: An Associate Level evaluator may evaluate adult sex offenders under the supervision of an evaluator approved at the Full Operating Level. To qualify to provide sex offender evaluation at the Associate Level under Section 16-11.7-106 C.R.S. an applicant shall meet all the following criteria:

A. The applicant shall have completed ten (10) adult sex-offense specific evaluations in the last five (5) years;

(A) DD

Of the ten (10) required adult sex offense specific evaluations, two (2) sex offense specific evaluations shall be completed on adult sex offenders with developmental disabilities.

B. The applicant shall be listed as an Associate Level or Full Operating Level treatment provider for adult sex offenders;

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

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

Discussion: *Upon written request to the SOMB, reasonable accommodations to the face-to-face requirement of this Standard may be approved in order to allow for extraordinary circumstances.*

(C) DD

The evaluator shall have completed 25% of the supervision hours with a Full Operating Level treatment provider with a developmentally disability specialty listing.

D. Within the past five (5) years, the applicant shall have at least: Ten (10) hours of the fifty (50) specialized training hours required for Associate Level treatment providers specifically related to the sex offense specific evaluations of adult sex offenders with developmental disabilities.

These training hours may be utilized to meet the qualifications for both adult and juvenile evaluators. Please see the list of training categories with examples in section 4.900;

(D) DD

Of the fifty (50) training hours, the evaluator shall have completed ten (10) hours specifically addressing the sex offenses specific evaluation of adult sex offenders with developmental disabilities.

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

F. The applicant shall provide satisfactory references as requested by the SOMB. The SOMB may also solicit such additional references as necessary to determine compliance with the *Standards*. These references shall relate to the work the applicant is currently providing;

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

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

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

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

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

A. The evaluator at the Associate Level shall complete a minimum of ten (10) adult sex-offense specific evaluations in the three (3) year period;

(A) DD

Of the ten (10) required sex offense specific evaluations, two (2) sex offense specific evaluations shall be completed on adult sex offenders with developmental disabilities.

B. The evaluator shall complete a minimum of forty (40) hours of continuing education every three (3) years in order to maintain proficiency in the field of sex offender treatment and evaluation and to remain current on any developments in the assessment, treatment, and monitoring of sexual offenders. Eight (8) of the hours shall come from the area of victimology, and ten (10) of the hours shall be specific to the sex offense specific evaluation of adult sex offenders.

These training hours may be utilized to meet the qualifications for both adult and juvenile treatment providers. Please see the list of training categories in section 4.900;

(B) DD

Of the forty (40) hours of continuing education, the evaluator shall have completed ten (10) hours specific to sex offense specific evaluation of adult sex offenders with developmental disabilities.

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

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

Discussion: *Upon written request to the SOMB, reasonable accommodations to the face-to-face requirement of this Standard may be approved in order to allow for extraordinary circumstances.*

(C) DD

The evaluator shall have completed 25% of the supervision hours with a Full Operating Level treatment provider with a developmentally disability specialty listing status.

D. The evaluator shall provide satisfactory references as requested by the SOMB. The SOMB may also solicit such additional references as necessary to determine compliance with the *Standards*. These references shall relate to the work the applicant is currently providing;

E. The evaluator shall not have a conviction of, or a deferred judgment for, a municipal ordinance violation, misdemeanor, felony, or have accepted by a court a plea of guilty or nolo contender to a municipal ordinance violation, misdemeanor, or felony if the municipal ordinance violation, misdemeanor, or felony is related to the ability of the approved applicant to practice under these *Standards* as reviewed and determined by the Application Review Committee. A

certified copy of the judgment from a court of competent jurisdiction of such conviction or plea shall be conclusive evidence of such conviction or plea;

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

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

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

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

4.520 Movement to Full Operating Level: Associate Level evaluators wanting to move to Full Operating Level status shall complete and submit documentation of all of the requirements listed in Standard 4.600, as well as a letter from the evaluator's supervisor indicating the evaluator's readiness to move to Full Operating Level status.

4.600 EVALUATOR: Adult Full Operating Level: A Full Operating Level evaluator may evaluate adult sex offenders without supervision and may supervise an evaluator operating at the Associate Level. To qualify to provide sex offender evaluations at the Full Operating Level under Section 16-11.7-106 C.R.S., an evaluator must meet all the following criteria:

A. The evaluator shall have attained the underlying credential of licensure or certification and not be under current disciplinary action as a physician, psychologist, clinical social worker, professional counselor, marriage and family therapist, or clinical psychiatric nurse specialist;

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

C. Within the last five (5) years, the evaluator shall have completed a minimum of thirty (30**)** adult sex-offense specific evaluations as defined in section 2.000 of these *Standards*;

(C) DD

Of the required thirty (30) sex offense specific evaluations, the evaluator shall have completed seven (7) sex offense specific evaluations on adult sex offenders with developmental disabilities.

Discussion: Evaluations accumulated for approval as an Associate Level evaluator status may be included for Full Operating evaluator approval.

D. Within the past five (5) years, the evaluator shall have at least:
Twenty (20) hours of the one hundred (100) specialized training hours required for Full Operating Level treatment providers related to the sex offense specific evaluation of adult sex offenders.

These training hours may be utilized to meet the qualifications for both adult and juvenile treatment providers. Please see the list of training categories in section 4.900;

Discussion: For those evaluators who conduct Parental Risk Assessments, specific training on the procedures and administration of Parental Risk Assessments is necessary.

(D) DD

Of the required one hundred (100) training hours, the evaluator shall have completed twenty (20) hours related to the sex offense specific evaluation of adult sex offenders with developmental disabilities.

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

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

Discussion: Upon written request to the SOMB, reasonable accommodations to the face-to-face requirement of this Standard may be approved in order to allow for extraordinary circumstances.

(E) DD

The evaluator shall have completed 25% of the supervision hours with a Full Operating Level evaluator with a developmentally disability specialty listing status.

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

G. The evaluator shall provide satisfactory references as requested by the SOMB. The SOMB may also solicit such additional references as necessary to determine compliance with the *Standards*. The references shall relate to the work the applicant is currently providing;

H. The evaluator shall not have a conviction of, or a deferred judgment for, a municipal ordinance violation, misdemeanor, felony, or have accepted by a court a plea of guilty or nolo contender to a municipal ordinance violation, misdemeanor, or felony if the municipal ordinance violation, misdemeanor, or felony is related to the ability of the approved applicant to practice under these

Standards as reviewed and determined by the Application Review Committee. A certified copy of the judgment from a court of competent jurisdiction of such conviction or plea shall be conclusive evidence of such conviction or plea;

I. The evaluator shall submit to a current background check (Section 16-11.7-106 (2) C.R.S.);

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

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

4.610 FIRST RE-APPLICATION. Continued Placement of Full Operating Level Adult on the Provider List: Using a current re-application form**,** evaluators shall apply for continued placement on the list every three (3) years by the date provided by the SOMB. Requirements are as follows:

A. The evaluator shall have the underlying credential of licensure or certification and not be under current disciplinary action as a Psychiatrist, Psychologist, Clinical Social Worker, Professional Counselor, Marriage and Family Therapist, Clinical Psychiatric Nurse Specialist or Licensed Addiction Counselor;

B. The evaluator may re-apply for listing as a Full Operating Level Adult treatment provider and evaluator. In this case, the evaluator shall accumulate a minimum of six hundred (600) hours of clinical experience every three (3) years, three hundred (300) hours or which shall be direct face-to-face clinical contact including consultation, evaluation or therapy with adult sex offenders. The evaluator shall complete a minimum of twenty (20) adult sex-offense specific evaluations in the three (3) year period;

Or

The evaluator shall discontinue their listing as a Full Operating Level adult treatment provider and be placed on the Provider List as an evaluator only. Evaluators re- applying as evaluators only shall complete a minimum of twenty (20) adult sex offense-specific evaluations in the three (3) year period;

(B) DD

Of the six hundred (600) hours of clinical experience, the evaluator shall accumulate one hundred fifty (150) hours with adult sex offenders with developmental disabilities, and of the one hundred fifty (150) hours, seventy-five (75) hours shall be direct face-to-face clinical contact with adult sex offenders with developmental disabilities.

Of the required twenty (20) adult sex offense specific evaluations, the evaluator shall have completed five (5) sex offense specific evaluations on adult sex offenders with developmental disabilities.

C. The evaluator shall complete a minimum of forty (40) hours of continuing education every three (3) years in order to maintain proficiency in the field of sex offender treatment and evaluation and to remain current on any developments in the assessment, treatment, and monitoring of sexual offenders. Eight (8) of the hours shall come from the area of victimology, and ten (10) of the hours shall be specific to sex offense specific evaluation of adult sex offenders.

These training hours may be utilized to meet the qualifications for both adult and juvenile treatment providers. Please see the list of training categories in section 4.900;

(C) DD

Of the forty (40) hours of continuing education the evaluator shall have completed ten (10) hours specific to the sex offense specific evaluation of adult sex offenders with developmental disabilities.

D. The evaluator shall provide satisfactory references as requested by the SOMB. The SOMB may also solicit such additional references as necessary to determine compliance with the *Standards*. These references shall relate to the work the applicant is currently providing;

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

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

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

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

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

4.620 SECOND AND SUBSEQUENT RE-APPLICATION. Continued Placement of Full Operating Level Adult Evaluators on the Provider List: Using a current re-application form**,** evaluators shall apply for continued placement on the List every three (3) years by the date provided by the SOMB. Requirements are as follows:

A. The evaluator shall have the underlying credential of licensure or certification and not be under current disciplinary action as a Psychiatrist, Psychologist, Clinical Social Worker, Professional Counselor, Marriage and Family Therapist, Clinical Psychiatric Nurse Specialist or Licensed Addiction Counselor;

B. The evaluator may re-apply for listing as a Full Operating Level adult treatment provider and evaluator OR the evaluator may discontinue their listing as a Full Operating Level treatment provider and be placed on the Provider List as an evaluator only. In either case, the evaluator shall stay active in the field through clinical experience, supervision, administrations, research, training, teaching, consultation or policy development;

C. The evaluator shall complete a minimum of forty (40) hours of continuing education every three (3) years in order to maintain proficiency in the field of sex offender treatment and evaluation and to remain current on any developments in the assessment, treatment, and monitoring of sexual offenders. Eight (8) of the hours shall come from the area of victimology, and ten (10) of the hours shall be specific to the sex offense specific evaluation of adult sex offenders.

Please see the list of training categories in section 4.900. These training hours may be utilized to meet the qualifications for both adult and juvenile evaluators. The evaluator may substitute a combination of consulting, research, teaching, training or other equivalent activities that further their proficiency in the field of sex offender evaluation;

(C) DD

Of the forty (40) hours of continuing education the evaluator shall have completed ten (10) hours specific to the sex offense specific evaluation of adult sex offenders with developmental disabilities.

D. The evaluator shall provide satisfactory references as requested by the SOMB. The SOMB may also solicit such additional references as necessary to determine compliance with the *Standards*. These references shall relate to the work the applicant is currently providing;

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

F. The evaluator shall submit to a current background check (Section 16-11.7-106 (2), C.R.S.);

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

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

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

4.630 Period of Compliance: A listed treatment provider or evaluator, who is applying for reapplication, may receive up to one (1) year to come into compliance with any *Standards* revisions, if they are unable to fully comply with the *Standards* at the time of reapplication. It is incumbent upon the treatment provider or evaluator to submit in writing a plan to come into compliance with the *Standards* within a specified time period.

Any new applicants must be in compliance with the *Standards* of practice when they apply.

4.640 The original Adult *Standards*, published in January 1996, allowed for a one-time waiver of the *Standards* regarding the requirement of licensure and/or an academic degree above a baccalaureate for treatment providers and evaluators who could meet the waiver requirements by December 31, 1996. No waivers have been granted since December 31, 1996. The waiver process was not intended to be available at any time after December 31, 1996. The original intent of the waiver was to recognize the work of a small number of treatment providers and evaluators, as identified in the January 1996 *Standards*, on a one-time basis only. Waivers will be recognized for the life of the individual. There is currently no provision for a waiver of the Adult *Standards* for treatment providers or evaluators for any reason.

4.700 POLYGRAPH EXAMINER: Associate Level: An Associate Level polygraph examiner may administer a post-conviction sex offender polygraph test under the supervision of a Full Operating Level polygraph examiner under the *Standards*. To qualify to administer a post-conviction sex offender polygraph test at the Associate Level, an applicant shall meet all of the requirements of a Full Operating Level polygraph examiner, with the exception of the following:

4.700 DD

An Associate Level polygraph examiner with developmental disability specialty listing status may administer a post-conviction sex offender polygraph test to an adult sex offender with developmental disabilities under the supervision of a Full Operating Level polygraph examiner with developmental disability specialty listing status under the *Standards*. Requirements are as follows:

A. The applicant shall obtain supervision from a polygraph examiner at the Full Operating Level under these *Standards* for each remaining post-conviction sex offender polygraph test up to the completion of two hundred (200) polygraph tests as specified in standard 4.800.

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

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

examination reports completed by an Associate Level polygraph examiner under their supervision;

B. The applicant shall have completed all training as outlined in Standard 4.800 of these *Standards*.

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

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

D. The applicant shall provide satisfactory references as requested by the SOMB. The SOMB may also solicit such additional references as necessary to determine compliance with the *Standards*. These references shall include, but not be limited to other members of the community supervision team;

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

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

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

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

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

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

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

- Preparation for a polygraph examination
- Review/live observation of an examination
- Review of video and/or audio tapes of an examination
- Review of other data collected during an examination

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

A. The examiner shall complete a minimum of forty (40) hours of continuing education every three (3) years in order to maintain proficiency in the field of polygraph testing and to remain current on any developments in the assessment, treatment, and monitoring of adult sex offenders. Up to ten (10) hours of this training may be indirectly related to sex offender assessment/treatment/management. It is incumbent on the trainee to demonstrate relevance to sex offender issues if the training is indirectly related to sex offender assessment/treatment/management. The remaining thirty (30) hours shall be directly related to sex offender assessment/treatment/ management and ten (10) of these hours shall be specific to adult sex offenders (see 4.900 for further details). These training hours may be utilized to meet the qualifications for both adult and juvenile polygraph examiners;

(A) DD

Of the required forty (40) hours of continuing education, the examiner shall have completed ten (10) hours of continuing education specially related to polygraph testing of adult sex offenders with developmental disabilities.

B. The examiner shall conduct a minimum of seventy-five (75) polygraph examinations in the three (3) year listing period with adult sex offenders;

(B) DD

Of the required seventy-five (75) polygraph examinations, eighteen (18) shall have been completed with adult sex offenders with developmental disabilities.

C. The examiner shall provide satisfactory references as requested by the SOMB. The SOMB may also solicit such additional references as necessary to determine compliance with the *Standards*, including, but not limited to other members of the community supervision team;

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

E. The examiner shall not have a conviction of, or a deferred judgment for, a municipal ordinance violation, misdemeanor, felony, or have accepted by a court a plea of guilty or nolo contender to a municipal ordinance violation, misdemeanor, or felony if the municipal ordinance violation, misdemeanor, or

felony is related to the ability of the approved applicant to practice under these *Standards* as reviewed and determined by the Application Review Committee. A certified copy of the judgment from a court of competent jurisdiction of such conviction or plea shall be conclusive evidence of such conviction or plea;

F. The examiner shall submit to a current background investigation (Section 16-11.7-106 (2) C.R.S.);

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

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

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

4.730 Movement to Full Operating Level: Associate Level polygraph examiners wanting to move to Full Operating Level status shall complete and submit documentation of:

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

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

4.800 POLYGRAPH EXAMINER - Full Operating Level: Polygraph examiners who administer post-conviction sex offender polygraph tests shall meet the minimum standards as indicated by the American Polygraph Association, the American Society for Testing and Measures, and the Association for the Treatment of Sexual Abusers, as well as the requirements throughout these *Standards*.

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

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

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

B. The examiner shall have conducted at least two hundred (200) post-conviction sex offender polygraph tests on adult sex offenders and juveniles who have committed sexual offenses;

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

(B) DD

Of the required two hundred (200) post-conviction sex offender polygraph tests, fifty (50) shall have been completed on adult sex offenders with developmental disabilities.

C. The examiner shall have completed a total of one hundred (100) hours of specialized clinical sex offender polygraph examiner training.

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

- Pre-test interview procedures and formats
- Valid and reliable examination formats
- Post-test interview procedures and formats
- Reporting format (i.e., to whom, disclosure content, forms)
- Recognized and standardized polygraph procedures
- Administration of examinations in a manner consistent with these *Standards*
- Participation in sex offender community supervision teams
- Use of polygraph results in the treatment and supervision process
- Professional standards and conduct
- Expert witness qualifications and courtroom testimony
- Interrogation techniques
- Maintenance/monitoring examinations
- Periodic/compliance examinations

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

The examiner shall **<u>also</u>** complete sixty (60) hours of specialized training in any of the following areas:

- Behavior and motivation of adult sex offenders
- Juveniles who commit sexual offenses
- Trauma factors associated with victims/survivors of sexual assault
- Overview of assessment and treatment modalities for juveniles or adults who offend
- Sex offender denial
- Clinical and professional ethics

Ten (10) of the sixty (60) hours shall be specific to the treatment of adult sex offenders. These training hours may be utilized to meet the qualifications for

both adult and juvenile polygraph examiners. If an examiner wishes to substitute any training not listed here, it is incumbent on the examiner to write a justification demonstrating the relevance of the training to this standard;

(C) DD

Of these sixty (60) hours of training, the examiner shall have completed fifteen (15) hours specific to adult sex offenders with developmental disabilities.

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

E. The examiner shall provide satisfactory references as requested by the SOMB. The SOMB may also solicit such additional references as necessary to determine compliance with the *Standards*. These references shall include, but not be limited to, other members of the community supervision team;

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

G. The examiner shall submit to a current background investigation (Section 16-11.7-106 (2) C.R.S.);

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

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

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

A. Full Operating Level polygraph examiners shall complete a minimum of forty (40) hours of continuing education every three (3) years in order to maintain proficiency in the field of polygraph testing and to remain current on any developments in the assessment, treatment, and monitoring of adult sex offenders. Up to ten (10) hours of this training may be indirectly related to sex offender assessment/treatment/management. It is incumbent on the trainee to demonstrate relevance to sex offender issues if the training is indirectly related to sex offender assessment/treatment/management. The remaining thirty (30) hours shall be directly related to sex offender assessment/ treatment/ management and ten (10) of these hours shall be specific to adult sex offenders (see 4.900 for

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

(A) DD

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

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

(B) DD

Of the required one hundred (100) post-conviction sex offense polygraph examinations, the provider shall have completed twenty-five (25) with adult sex offenders with developmental disabilities.

C. The examiner shall provide satisfactory references as requested by the SOMB. The SOMB may also solicit such additional references as necessary to determine compliance with the *Standards*, including, but not limited to other members of the community supervision team;

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

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

F. The examiner shall submit to a current background investigation (Section 16-11.7-106 (2) C.R.S.);

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

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

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

4.820 Period of Compliance: A listed polygraph examiner, who is applying for reapplication, may receive up to one (1) year to come into compliance with any *Standards* revisions, if they are unable to fully comply with the *Standards* at the time of reapplication. It is incumbent upon the polygraph examiner to submit in writing a plan to come into compliance with the *Standards* within a specified time period.

Any new applicants must be in compliance with the *Standards* of practice when they apply.

4.900 LIST OF SPECIALIZED TRAINING CATEGORIES

Sex offense specific training may include but is not limited to training from these areas:	**Victim specific training** may include but are not limited to training from these areas:	**Adult specific training** may include but are not limited to training from these areas:	**Juvenile specific training** may include but are not limited to trainings from these areas:	**Developmental Disabilities specific training** may include but are not limited to trainings from these areas:
▪ Sex offender evaluation and assessment ▪ Sex offender treatment planning and assessing treatment outcomes ▪ Community supervision techniques including approved supervisor training ▪ Treatment modalities: • Group • Individual • Family • Psycho-education • Self-help ▪ Sex offender treatment techniques including: ○ Evaluating and reducing denial ○ Behavioral treatment techniques ○ Cognitive behavioral techniques ○ Relapse prevention	▪ Victim impact ▪ Victim treatment ▪ Victims role in the legal system ▪ Secondary and vicarious trauma ▪ Impact of clarification and reunification on victims ▪ Elements of harm, restorative and reparative actions ▪ Secondary victims	▪ Prevalence of sexual offending by adults/victimization rates ▪ Typologies of adult sex offenders ▪ Continuing research in the field of adult sexual offending ▪ Anger management ▪ Healthy sexuality and sex education ▪ Learning theory ▪ Multicultural sensitivity ▪ Understanding transference and counter-transference ▪ Family dynamics and dysfunction ▪ Co-morbid conditions, differential diagnosis ▪ Investigations ▪ Addictions and substance abuse	▪ Prevalence of sexual offending by juveniles/victimization rates ▪ Typologies of juveniles who commit sexual offenses ▪ Continuing research in the field of sexual offending by juveniles ▪ Difference between juveniles and adults ▪ Philosophy of treatment adult vs. juvenile ▪ Clarification and reunification between juveniles who offend on family members ▪ Healthy sexuality and sex education ▪ Multicultural sensitivity ▪ Developmental stages ▪ Understanding	▪ Treatment, evaluation and monitoring considerations for the sex offender with developmental disabilities ▪ Impact of disability on the individual ▪ Healthy sexuality and sex education for the sex offender with developmental disabilities ▪ Statutes, rules and regulations pertaining to individuals with developmental disabilities ▪ Co-occuring mental health issues

Sex offense specific training may include but is not limited to training from these areas:	**Victim specific training** may include but are not limited to training from these areas:	**Adult specific training** may include but are not limited to training from these areas:	**Juvenile specific training** may include but are not limited to trainings from these areas:	**Developmental Disabilities specific training** may include but are not limited to trainings from these areas:
○ Offense cycle ○ Empathy training ○ Confrontation techniques ○ Safety and containment planning ▪ Sex offender risk assessment ▪ Parental Risk Assessment ▪ Crossover ▪ Objective measures including: ○ Polygraph ○ Plethysmograph ○ VRT ▪ Psychological testing ▪ Special sex offender populations including: • Sadists • Psychopaths • Developmentally disabled • Compulsives • Juveniles • Females		▪ Domestic Violence ▪ Knowledge of criminal justice and/or district court systems, legal parameters and the relationship between the provider and the courts ▪ Any of the topics in the above sex offense specific category that is also specific to Adult sex offenders ▪ Philosophy of treatment adult vs. juvenile	transference and counter-transference ▪ Family dynamics and dysfunction ▪ Co-morbid conditions, differential diagnosis ▪ Investigations ▪ Addictions and substance abuse ▪ Partner Violence ▪ Any of the topics in the above sex offense specific category that is also specific to juveniles who sexually offend	

Sex offense specific training may include but is not limited to training from these areas:	**Victim specific training** may include but are not limited to training from these areas:	**Adult specific training** may include but are not limited to training from these areas:	**Juvenile specific training** may include but are not limited to trainings from these areas:	**Developmental Disabilities specific training** may include but are not limited to trainings from these areas:
▪ Family clarification/ visitation/reunification ▪ Pharmacotherapy with sex offenders ▪ Impact of sex offenses ▪ Assessing treatment progress ▪ Supervision techniques with sex offenders ▪ Offender's family stability, support systems and parenting skills ▪ Sex offender attachment styles ▪ Knowledge of laws, policies and ethical concerns relating to confidentiality, mandatory reporting, risk management and offender participation in treatment ▪ Ethics ▪ Philosophy and principles of the SOMB				

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

5.100 Establishment of an Interagency Community Supervision Team

5.110 As soon as possible after the conviction and referral of a sex offender to probation, parole, or community corrections, the supervising officer should convene a team to manage the offender during his/her term of supervision:

A. The purpose of the team is to staff cases, share information, and make informed decisions related to risk assessment, treatment, behavioral monitoring, and management of each offender. The team should use the sex offense-specific evaluation and pre-sentence investigation as a starting point for such decisions;

Discussion: Although policy development is an important function, the primary purpose of the team is individual case management, not policy development.

B. Supervision and behavioral monitoring is a joint, cooperative responsibility of the supervising officer, the treatment provider, and the polygraph examiner.

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.

Discussion: In rural areas, the team members may be the same for each offender. In more highly populated areas, there may be a cluster of teams that include various combinations of supervising officers, treatment providers, and polygraph examiners.

5.120 DD

In addition to the supervising officers from probation, parole or community correction who serve as the team leader, the treatment provider and the polygraph examiner, any of the following team

[9] Please see Standard 5.430 regarding the attendance of polygraph examiners at team meetings.

members, when involved and appropriate, shall be added to teams supervising sex offenders who have developmental disabilities:

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

5.121 DD

Responsibilities of Additional Team Members For Sex Offenders Who Have Developmental Disabilities:

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

Discussion: Team members for sex offenders who have developmental disabilities should have knowledge and understanding specific to this population.

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

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

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

5.130 The team is coordinated by the supervising officer, who determines:

A. The members of the team, beyond the required membership, may include, but are not limited to: guardians, social services, family members, and authorized representatives. The individuals should attend any given meeting;

B. The frequency of team meetings;

C. The content of the meetings, with input from other team members;

D. The types of information required to be released.

5.140 Team members should keep in mind the priorities of community safety and risk management when making decisions about the management and/or treatment of offenders.

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;

D. Team members are committed to the team approach and seek assistance with conflicts or alignment issues that occur.

Discussion: Supervising officers are encouraged to periodically attend group and/or individual treatment sessions to monitor sex offenders under their supervision. Treatment providers are encouraged to allow attendance of supervising officers and prepare sex offenders in the group in advance for the attendance of a supervising officer. Preparation should include notification of the supervising officer's attendance and execution of appropriate waivers of confidentiality if necessary. The visiting supervising officer shall be bound by the same confidentiality rules as the treatment provider and should sign a statement to that effect. It is understood that treatment providers may set reasonable limits on the number and timing of visits in order to minimize any disruption to the group process.

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

5.200 Responsibilities of the Supervising Officer for Team Management

5.201 The supervising officer shall refer sex offenders for evaluation and treatment only to treatment providers who meet these *Standards*. (Section 16-11.7-106 C.R.S.)

Discussion: Supervising officers have a responsibility to ensure that the offender is engaged in appropriate treatment with a provider who is listed on the SOMB's Provider List and that the treatment program is consistent with SOMB Standards. It is the supervising officer's responsibility to refer to evaluators and treatment providers who will best meet the sex offenders' treatment/ evaluation needs and the need for community safety.

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

- Releases of information to treatment providers, including information from any treatment program in which the offender participated at the Department of Corrections;
- Releases of information to case management team members, including collateral information sources, as indicated, such as the child protection agency, the treatment provider, the polygraph examiner, the victim's therapist, and any other professionals involved in the treatment and/or supervision of the offender;

- Releases of information to the victim's therapist, the guardian ad litem, custodial parent, guardian, caseworker, or other involved professional, as indicated. Such information may be used in the victim's treatment and/or in making decisions regarding reunification of the family or the offender's contact with the victim.

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

Discussion: Supervising officers have a responsibility to ensure that the offender receives polygraph examinations from a polygraph examiner who is listed on the SOMB's Provider List and that the examinations are consistent with SOMB Standards. It is the supervising officer's responsibility to refer to polygraph examiners who will best meet the sex offenders' treatment and evaluation needs and the need for community safety.

Exceptions to the requirement to use the polygraph shall be made only with the unanimous agreement of the case management team and the reasons for the exception shall be recorded in the sex offender's file.

Discussion: Although deceptive findings on a polygraph test are not in and of themselves a violation of probation or parole, they can be considered in determining the intensity and conditions of supervision. Pre-and post-test admissions, however, may be used in a revocation hearing. An offender's failure to take a polygraph as directed should be considered a violation of probation, parole, or community corrections.

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

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

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

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

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

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

5.210 Recognizing that sex offenders present a high risk to community safety, probation/parole/community corrections officers should base their field work on the supervision plan, relapse prevention plan, and offense cycle of an offender.

5.211 The supervising officer should not request early termination of sex offenders from supervision.

5.212 On a regular basis, the supervising officer should review each offender's specific conditions of probation, parole, or community corrections and assess the offender's compliance, needs, risk, and progress to determine the necessary level of supervision and the need for additional conditions.

5.213 If contact is allowed, the supervising officer should limit and control the offenders' authority to make decisions for minors or to discipline them.

5.214 If necessary and possible, the supervising officer should request an extension of supervision to allow an offender to complete treatment.

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

5.216 The supervising officer should discuss treatment issues and progress with offenders during office visits and other contacts.

5.217 The supervising officer/agency should impose or request criminal justice sanctions for offenders' unsatisfactory termination from sex offender treatment, including revocation of probation or parole.

5.218 The supervising officer should require sex offenders who are transferred from other states through an Interstate Compact Agreement to agree in advance to participate in offense-specific treatment and specialized conditions of supervision contained in these *Standards*.

5.219 The supervising officer should not allow a sex offender who has been unsuccessfully discharged from a treatment program to enter another program unless the new treatment program and case management arrangement will provide greater behavioral monitoring and increased treatment in the areas the sex offender "failed" in the previous program.

Discussion: The purpose of this standard is to discourage movement among treatment providers by offenders as a way of avoiding doing the work of therapy.

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

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

- Offender denial
- Special populations of sex offenders
- Cultural and ethnic awareness

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

5.220 DD

Supervising officers should have specialized training specific to sex offenders who have developmental disabilities.

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

5.222 The successful completion of training required in guidelines 5.222 and 5.223 is necessary prior to the supervising officer attending any individual or group treatment sessions of sex offenders under his/her supervision (See Standard 5.150).

5.300 Responsibilities of the Treatment Provider within the Team

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

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

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

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

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

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

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

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

5.400 Responsibilities of the Polygraph Examiner within the Team

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

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

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

5.500 Conditions of Community Supervision

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

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

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

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

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

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

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

G. Sex offenders shall not consume or possess alcohol;

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

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

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

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

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

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

5.600 Behavioral Monitoring of Sex Offenders in the Community

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

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

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

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

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

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

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

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

   (b) Cessation of sexually deviant behavior;

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

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

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

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

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

1. The offender is experiencing stress or crisis;

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

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

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

5.700 Sex Offenders' Contact with Victims and Potential Victims

5.710 Sex offenders shall have no contact with any child under the age of 18 or adult/ child victims of the offender's sex offenses until the Community Supervision Team unanimously agrees that the offender has met the corresponding criteria listed in Standard 5.741 through 5.742, Section A, B, or C as applicable. Additionally, offenders shall not meet any of the Exclusionary Criteria listed in Standard 5.720.

Contact is intended to refer to any form of interaction including:

- Physical, face-to-face, or any verbal contact;
- Being in a residence with a child or victim;
- Being in a vehicle with a child or victim;
- Visitation of any kind;

- Correspondence (both written and electronic), telephone contact (including messages left on a voice mail or answering machines), gifts, or communication through third parties;
- Entering the premises, traveling past or loitering near the child or victim's residence, school, day care, or place of employment;
- Frequenting places used primarily by children, as determined by the Community Supervision Team.

Prohibition of contact does not impact an offender's responsibility to pay child support.

The rationale for contact restrictions involves both known and unknown factors regarding the offender's risk for sexual recidivism. The accuracy of risk prediction is limited to available information even when a sex offense specific evaluation has been completed. The offense for which a person is convicted is not necessarily a reliable indicator of the offender's risk to children or victims[10]. As an offender participates in treatment and supervision, a more accurate assessment can be made to determine his/her specific risks to children and victims with whom he/she may request contact. An important aspect of ongoing risk assessment is measuring an offender's ability to comply with the requirements of treatment and supervision[11].

A growing body of research indicates most sex offenders supervised by the criminal justice system have more extensive sex offending histories, including multiple victim and offense types, than is generally identified in their criminal justice records[12]. Some of this research has been conducted with convicted sex offenders in Colorado. Research also indicates that children and victims are particularly vulnerable and are unlikely to report or re-report abuse[13].

The SOMB recognizes the significance of the relationship between a parent and his/her child and also recognizes the risk that a sex offender can pose to his/her own children. There are multiple factors that must be considered in making a determination of an offender's risk to his/her own children. When contact between a sex offender and a child under the age of eighteen (18) who meets the definition of "own child" in this document is being considered, the offender shall complete the Parental Risk Assessment (PRA) as described in this document in order to assess whether child contact is appropriate. This assessment will result in a determination of risk level and make recommendations in an individualized plan for level and type of contact, if any, with the offender's own children. No sex offender will have any contact with his/her own children until he/she has undergone a Parental Risk Assessment and has been determined to be an acceptably low risk. Please see section 5.740 A for further information.

Discussion: For offenders who have already been sentenced and have non-victim children under the age of 18 with whom they desire contact, it is important for the offender to participate in the Parental Risk Assessment in order to determine appropriateness and level of contact.

Community Supervision Teams should plan for changes in risk level and recognize that offenders will always present with some level of risk for sexual re-offending. Progress in treatment may not be consistent over time. The team should also consider that changes in child development

[10]Knopp, F.H. (1984); Freeman-Longo, R., Blanchard, G. (1998); Ahlmeyer, S., Heil, P., McKee, B., and English, K. (2000); English, K. (1998); Heil, P., Ahlmeyer, S., Simons, D. (2003); Ahlmeyer, S. (1999); Becker, J., and Coleman,E. (1987); Abel, G., Rouleau, J. (1990); Office of Research and Statistics, Division of Criminal Justice, Colorado Department of Public Safety (2000); Tanner, J. (1999); Hanson, R., Harris, A. (1998); Hindman, J. (1989).

[11] Hanson, R.K., Harris, A. (1998).

[12] Knopp, F.H. (1984); Freeman-Longo, R., Blanchard, G. (1998); Ahlmeyer, S., Heil, P., McKee, B., and English, K. (2000); English, K. (1998); Heil, P., Ahlmeyer, S., Simons, D. (2003); Ahlmeyer, S. (1999); Becker, J., and Coleman, E. (1987); Abel, G., Rouleau, J. (1990); Office of Research and Statistics, Division of Criminal Justice, Colorado Department of Public Safety (2000); Weinrott, M. & Saylor, M. (1991).

[13] Marshall, W. (1998); Hanson, R.F., et al. (1999); (1992). *Rape in America: A Report to the Nation*; Underwood, R., Patch, P., Cappelletty, G., Wolfe, R. (1999); Hindman, J. (1989); Colorado Coalition Against Sexual Assault (1998); Cardarelli, A. (1998).

characteristics or adult victim characteristics may affect offenders' risk level. Approval of situations that involve contact with children under the age of eighteen shall be continually reviewed and changed by the Community Supervision Team based on current risk.

It is the responsibility of treatment providers, evaluators and other community supervision team members to follow these *Standards*. Treatment providers, particularly after a Parental Risk Assessment has been completed, have the most expertise and are in the best position to accurately assess an offender's risk to his own children and are ethically obligated to ensure child safety remains the highest priority. This may result in decisions that are difficult for both the offender and the criminal justice system. While the court has authority and discretion in sentencing matters, the treatment provider is an independent entity who is responsible to maintain best clinical practices. In rare instances, the referring agency may request services that are in conflict with the *Standards* due to a court order. It is important to recognize that treatment under unsafe conditions is not beneficial to the offender or others in the treatment program and undermines treatment program integrity[14].

In order to maintain program integrity, treatment providers and evaluators who receive referrals for offenders in circumstances which conflict with these *Standards* should refuse to accept or continue to treat offenders who do not agree to comply with the requirements in the *Standards* regarding restricted contact. The referral source should be informed in writing of the reasons for the refusal and of the possible risk to the involved children or victims.

Discussion: During any time that an offender is not in treatment, the supervising officer should maximize the use of surveillance, monitoring and containment methods including more frequent use of polygraphs. The supervising officer may obtain additional information during this period of time, which should be brought back to the court for additional guidance and/or sentencing conditions.

Sections 5.741 through 5.742 A, B, and C of this Standard state the requirements for contact with children. This contact shall be supervised unless the offender has met the criteria in Standard 5.750 for unsupervised contact. See *Standards* 5.760-5.763 for Approved Supervisor requirements.

5.720 Exclusionary Criteria

Due to extreme risk, when any of the following are present, the community supervision team shall ensure that the offender is **not** considered for <u>any</u> type of contact with children.

A clinical diagnosis by an approved evaluator or treatment provider:

- Pedophilia (Exclusive Type, per DSM IV-TR, i.e. attracted only to children)
- Psychopathy or Mental Abnormality per the psychopathy checklist revised (PCL-R) or per the MCMI III (85 or more on each of the following scales: Narcissistic, Antisocial and Paranoid)
- Sexual sadism, as defined in the DSM IV-TR

  <u>or</u>
- A Colorado court or parole board has ruled the offender is a Sexually Violent Predator.

5.730 Parental Risk Assessment (PRA)

When a sex offender has any children under the age of eighteen (18) who meet the definition of "own child" in this document, the offender wants to have contact with his/her children, none of them are his victims, it does not appear that he or she has more than one item on Tier I on the PRA Flowchart, and it does not appear that the offender will be sentenced to the Department of

[14] Quinsey, V.L., Harris, G.T., Rice, M.E., Cormier, C.A. (1998).

Corrections, a Parental Risk Assessment as described in this document shall be initiated in order to assess the appropriateness of child contact. This assessment shall be initiated at the time of the offense specific evaluation. The assessment will result in a determination of risk level and a recommendation for an individualized plan regarding level and type of contact, if any, with the offender's own children. It is important to acknowledge that risk levels can change and that the plan must be continually assessed and revised as necessary throughout the period of criminal justice supervision. For offenders in the Department of Corrections, when a PRA has not been completed, the Department of Corrections treatment team should conduct a PRA.

The Parental Risk Assessment should occur after a plea has been entered, after conviction or upon acceptance of an Interstate Compact case and shall be completed by a listed SOMB Evaluator/Treatment Provider. Contact with an offender's children shall be prohibited prior to, and during, the offense specific evaluation. A recommendation regarding an offender having contact with his/her own children cannot be made until a Parental Risk Assessment has been completed as part of the offense specific evaluation. If the Parental Risk Assessment does not occur during the offense specific evaluation, it may be completed at a later time; however, the offender should not have contact with his/her own children until the Parental Risk Assessment has been completed.

Discussion: The SOMB recognizes that in cases involving DHS, where a criminal case has not been filed, it may be useful to conduct an evaluation similar to a PRA in order to make informed decisions regarding child contact. This standard is not intended to preclude that from occurring.

Discussion: Ideally, the sex offender should not have contact with his/her own children until a PRA is completed and finds contact is appropriate. However, if a court has allowed contact absent the completion of a PRA, it should not preclude a PRA from being completed.

Discussion: If all components of the Parental Risk Assessment have not been completed within a six month period of time, portions of the testing may need to be re-administered. Additionally, if an offender yields deceptive or inconclusive results on the polygraph exam, he/she may retest in a timely manner and have those results incorporated into the Parental Risk Assessment

If the Parental Risk Assessment, which includes a polygraph, indicates **high risk** with regard to his/her own children, the offender shall meet the criteria in *Standards* 5.741 through 5.742 (A) before contact can be initiated.

If the Parental Risk Assessment, which includes a polygraph, indicates **low risk** with regard to his/her own children and the offender has no known history of sexual behavior with his/her own children, criteria listed in *Standards* 5.741 through 5.742 (A) shall be waived with regard to his/her own children.

If the Parental Risk Assessment, which includes a polygraph, indicates **moderate risk** with regard to his/her own children and the offender has no known history of sexual behavior with his/her own children, teams may use their discretion in allowing written or telephone contact or therapy sessions with the offender's own children prior to the offender meeting all the criteria listed in *Standards* 5.741 through 5.742 (A). If the offender's risk is assessed as moderate based on dynamic factors, (e.g. employment, support systems, etc.) the team may revisit the PRA conclusions if those factors change.

Discussion: In the Parental Risk Assessment, using the PRA Decision Flow Chart in Appendix D, the provider shall render an opinion of high, moderate, or low risk and the results shall be provided and explained to referral sources. If the evaluator believes that aggravating or mitigating factors exist

that impact the outcome indicated by the Decision Flow Chart, such factors should be documented in the PRA report to support a differential opinion regarding risk level. The offender's risk shall be acceptably low or the criteria listed in Standards 5.741 through 5.742 (A) shall be met prior to allowing contact with children.

PARENTAL RISK ASSESSMENT

The Parental Risk Assessment is a series of clinical interviews and standardized tests that will provide information regarding a variety of factors associated with risk. The assessment addresses risk level specifically with regard to the offender's own children. Evaluators should be aware of mandatory child abuse reporting laws, and report accordingly. The information listed in the chart below states the minimum requirements needed to complete the Parental Risk Assessment.

PARENTAL RISK ASSESSMENT

Evaluation Areas – Required	**Evaluation Procedures**
EVALUATE PARENTAL RISK	KEY: • Required ○ Options within a specific category
Offender's Attachment Style	• History of Relationship Attachment ○ Clinical Interviews ○ Collateral sources • Standardized Tests (Must complete a minimum of one of the following): ○ The Attachment Style Questionnaire (ASQ: Feeney, Nollar & Hanrahan, 1994) ○ Batholomew Attachment Inventory ○ Adult Attachment Interview (George, C., Kaplan, N., & Main) ○ The Adult Attachment Projective (AAP: George) ○ Hazan & Shaver Adult Attachment Scale
Offender's Empathy	• History of empathy with Children ○ Clinical Interviews ○ Collateral sources ▪ Standardized Tests: ○ Hanson's Empathy for Children Test
Offenders Ability for Family Stability	• History of stability of relationships and prior absences from the home ○ Clinical interviews ○ Collateral sources • History of domestic violence • Restraining orders • Arrests • Documentation of conviction of a crime of domestic violence, or if none then perform a Standardized Test: ○ SORAG ○ Hanson's Empathy for Women Test ○ Collateral information

Offender's Parenting Skills	• History of payment or non-payment of child support, and reasons for non-payment • Prior access to children in a home environment o Clinical interview o Collateral information • Parenting Ability o Knowledge of child's life o Knowledge of parenting skills o Knowledge of child's developmental stages & needs o Parental boundaries o Empathy o Standardized test o Parenting Perception Scale • Risk of Physical Abuse o History of abuse or maltreatment of children o Social Services records o Collateral Sources o Standardized Test o Child Abuse Potential Inventory (Milner, 1986)
Offender's stability	• Clinical interview & Collateral Information (all of the following are required): o History of compliance with supervision and treatment requirements o History of stable employment o History of frequent moves o Interview regarding family of origin (parental models, family environment and stability, abuse) o Financial o Drug & alcohol history
Offender's Arousal to/Sexual Interest in Children	• Standardized Tests (Minimum of one of the following): o Abel Assessment for sexual interest o Plethysmograph
Offender's Historical Sex Offending Behaviors as verified through official record, polygraph, or any other credible source such as social services records	• Any history of sexually abusing anyone under the age of 18 o Official records o Collateral information o Self report • Polygraphy • Any history of sexual conduct with relatives who were under the age of 18 • Any history of sexual contact with other minors • Any history of sexual contact with animals o Official records o Collateral information o Self report • Assess level of prior access to children

Offender's Criminal Risk - Risk for future criminal/sexual behavior	• Elements of current or previous offenses through interviews and collateral sources ○ Past behaviors from criminal justice and social service records ○ Validated risk assessment instrument
Offender's Cognitive Distortions	• Interview or Standardized Tests (Use any test listed below or equivalent test) ○ Multiphasic Sexual Inventory ○ Abel Assessment for sexual interest Cognitive Distortion Scale ○ Bumby Cognitive Distortion ○ Clinical interview ○ Collateral Information
Offender's Psychological Functioning	• Clinical interview/Collateral Information/ Standardized Tests • Sadistic Behavior Elements of previous offenses/collateral sources • Psychopathy level or Mental Abnormality must do a minimum one of the following tests: ○ Psychopathy Checklist Revised (PCLR) ○ Psychopathy Checklist Screening Version ○ MCMI III (Narcissistic + Antisocial + Paranoid) • Personality disorder (minimum of one below): ○ MMPI 2 ○ MCMI III ○ PAI ○ DSM diagnosis from clinical interview • Other Mental Health Concerns
Offender's Responsibility and Level of Denial	○ Clinical interview ○ Shannon/Brake Levels & Types of Denial ○ Collateral Data

Offender's Support System and Home Environment	• Clinical interview/Collateral Information regarding the following areas when relevant to the offender's risk of contact with children 1. When the non-offending parent/child are willing to be part of the evaluation process, resulting information will be incorporated into the PRA 2. Does the offender's partner or support system believe the offender has committed a sex offense and support compliance with treatment and supervision? 3. Do they acknowledge any possibility of risk to the children? 4. Are they dependent on the offender for financial or emotional support? 5. Are there issues of unequal power and control in the partner/support system relationship? 6. Does partner/support system have any difficulties in confronting the offender? 7. Do any dynamics involving fear and/or power imbalance exist in the partner/support system relationship? 8. Other than the offender, what other support systems does the partner depend on? 9. Assess partner/support system's parenting skills, including strengths and limitations. 10. Assess partner/support system's level and type of attachment to the children. 11. Assess partner/support system's current level of functioning. 12. Assess partner/support system's current problems as a result of the offender's arrest. 13. Assess partner/support system's current ability to recognize and respond to the needs of the children 14. Assess what the partner/support system has told the children about the offender. 15. Assess what the partner/support system feels are the children's most immediate needs. 16. Are they willing and able to be involved in significant other's treatment/education and to have the children participate in treatment/education? 17. Are they willing and able to stop contact if the children are at risk? 18. Review collateral information from other providers involved with the family. 19. Describe any Social Services involvement with the family. Does the partner have a record of Social Services involvement. 20. Known risks presented in neighborhood.

SEE INTRODUCTION TO PRA FLOWCHART AND PRA DECISION FLOWCHART IN APPENDIX F IN ORDER TO MAKE FINDINGS.

Discussion: Individual plans regarding child contact should address whether the offender needs parenting classes.

5.740 Criteria for Contact with Children

Section A - Sex Offenders' Contact with Their Own Children

The following criteria shall apply to a sex offender's supervised contact with his/her own children (see * below) when the children are not the victims of the offender and when the Parental Risk Assessment has indicated the offender is moderate or high risk with regard to his/her own children.

* This includes children with whom the offender has a parental role, including but not limited to, biological, adoptive, and stepchildren.

If any of the offender's children are victims of his/her offenses, Section C shall dictate the offender's contact with all of his/her children. Please refer to Section C for criteria regarding contact issues under those circumstances.

5.741 (A) The treatment provider, in conjunction with the community supervision team, shall:

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

2. Arrange contact in a manner that places the child's safety first. When assessing safety, both psychological and physical well-being shall be considered;

3. Ensure consultation with, and the support of, the custodial parent or guardians of the child prior to authorizing contact. When the child has a therapist, they shall also be involved in the approval process;

4. Ensure that contact does not conflict with any existing court or parole board directives;

5. Ensure the offender has an approved supervisor present within visual and hearing range during all contacts.

5.742 (A) Treatment providers, in conjunction with the community supervision team, shall ensure the offender achieves the following criteria before contact can be initiated. For those offenders assessed through the Parental Risk Assessment as moderate risk to their own children, teams may use discretion in allowing written, telephone or therapeutic contact prior to the completion of these criteria.

1. The offender accepts responsibility for offense related behavior and any significant differences (i.e. regarding the sexual behavior in which the offender has engaged, use of force, and threats) between the offender's statements, the victim's statements and corroborating information about the abuse have been resolved;

2. The offender has yielded non-deceptive results in all the required areas of the sexual history disclosure polygraph process and has yielded non-deceptive results on the most recent maintenance polygraph. The content of the maintenance polygraph shall have addressed behavior that puts victims/children at risk. Furthermore, there shall not be concerns regarding significant risk related behavior.

Some offenders have a history of persistent arousal to minors. Although they may be able to meet 5.742 criteria, because of the likelihood that proximity to children will trigger or increase this arousal, the team shall frequently reassess the offender's ability to maintain a reduced level of arousal[15]. The team shall terminate an offender's approval for contact with minors if there is behavior or other evidence to indicate arousal to minors cannot be managed.

3. Plethysmograph or Abel Screening for Sexual Interest results indicate a reduction in, or absence of, any sexually deviant arousal/interests and the offender consistently demonstrates the use of cognitive and behavioral interventions to interrupt deviant fantasies and behaviors;

4. The offender has disclosed information related to risk and other relevant factors as prescribed by the team. The team will make a determination of who should receive this information;

5. The offender consistently demonstrates an understanding of and has written his/her deviant cycle and accepts the possibility of re-offense. The offender has developed a written relapse prevention plan for intervention to the satisfaction of the community supervision team;

6. The offender consistently demonstrates an understanding of the impact of the abuse on the victim(s) and their family, as evidenced by behavioral accountability and self-regulation;

7. The offender consistently demonstrates an understanding of the impact of his/her behavior on his/her own family, as evidenced by behavioral accountability and self-regulation;

8. The offender consistently demonstrates an understanding of and is willing to respect the child's verbal and non-verbal boundaries and need for privacy;

9. The offender consistently demonstrates an understanding of how to safely participate in having contact with child(ren);

10. The offender is willing to accept limits or prohibitions on contact as established by the community supervision team with input from the child, child's other parent or guardian, or child's therapist and will put the child's needs first;

11. The offender is willing to plan for contact, to develop and utilize an approved safety plan for all contact, to accept supervision during contacts, and to terminate contact when requested by the community supervision team, the approved supervisor, or the child. The safety plan shall be approved in advance and in writing by the team and signed by the offender;

12. The offender consistently demonstrates compliance with supervision conditions;

[15] Davis, G., Williams, L., Yokley, J. (1996); (1999) Sex Offender Treatment and Monitoring Program at the Colorado Department of Corrections.

13. The offender consistently demonstrates satisfactory progress in treatment, including consistent compliance with treatment conditions.

Section B - Sex Offenders' Contact with Persons Under the Age of 18

The following criteria applies specifically to supervised contact with persons under the age of 18 who are not the offender's own children or the victims of the offender. This section shall apply to relatives in a non-parental role. Please refer to sections A and/or C for criteria regarding contact issues under those circumstances.

5.741 (B) The treatment provider, in conjunction with the community supervision team, shall:

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

2. Arrange contact in a manner that places the child's safety first. When assessing safety, both psychological and physical well-being shall be considered;

3. Ensure consultation with, and the support of, the custodial parents or guardians of the child prior to authorizing contact. When the child has a therapist, they shall also be involved in the approval process;

4. Ensure that contact does not conflict with any existing court or parole board directives;

5. Ensure the offender has an approved supervisor present within visual and hearing range during all contacts.

5.742 (B) Treatment providers, in conjunction with the community supervision team, shall ensure the offender achieves the following criteria before contact can be initiated:

1. The offender accepts responsibility for offense related behavior and any significant differences (i.e. regarding the sexual behavior in which the offender has engaged, use of force, and threats) between the offender's statements, the victim's statements and corroborating information about the abuse have been resolved;

2. The offender has yielded non-deceptive results in all the required areas of the sexual history disclosure polygraph process and has yielded non-deceptive results on the most recent maintenance polygraph. The content of the maintenance polygraph must have addressed behavior that puts victims/children at risk. Furthermore, there must not be concerns regarding significant risk related behavior.

   Some offenders have a history of persistent arousal to minors. Although they may be able to meet 5.742 criteria, because of the likelihood that proximity to children will trigger or increase this arousal, the team shall frequently reassess the offender's ability to maintain a reduced level of arousal[16]. The team shall terminate an offender's approval for contact

[16] Davis, G., Williams, L., Yokley, J. (1996); (1999) Sex Offender Treatment and Monitoring Program at the Colorado Department of Corrections.

with minors if there is behavior or other evidence to indicate arousal to minors cannot be managed.

3. Plethysmograph or Abel Screening for Sexual Interest results indicate a reduction in, or absence of, any sexually deviant arousal/interests and the offender consistently demonstrates the use of cognitive and behavioral interventions to interrupt deviant fantasies and behaviors;

4. The offender has disclosed information related to risk and other relevant factors as prescribed by the team. The team will make a determination of who should receive this information;

5. The offender consistently demonstrates an understanding of and has written his/her deviant cycle and accepts the possibility of re-offense. The offender has developed a written relapse prevention plan for intervention to the satisfaction of the community supervision team;

6. The offender consistently demonstrates an understanding of the impact of the abuse on the victim(s) and their family, as evidenced by behavioral accountability and self-regulation;

7. The offender consistently demonstrates an understanding of the impact of his/her behavior on his/her own family, as evidenced by behavioral accountability and self-regulation;

8. The offender consistently demonstrates an understanding of and is willing to respect the child's verbal and non-verbal boundaries and need for privacy;

9. The offender consistently demonstrates an understanding of how to safely participate in having contact with child(ren);

10. The offender is willing to accept limits or prohibitions on contact as established by the community supervision team with input from the child, child's other parent or guardian, or child's therapist and will put the child's needs first;

11. The offender is willing to plan for contact, to develop and utilize an approved safety plan for all contact, to accept supervision during contacts, and to terminate contact when directed by the community supervision team, the approved supervisor, or the child. The safety plan shall be approved in advance and in writing by the team and signed by the offender;

12. The offender consistently demonstrates compliance with supervision conditions;

13. The offender consistently demonstrates satisfactory progress in treatment, including consistent compliance with treatment conditions.

Section C - Sex Offender Contact with Adult and Child Victims as well as Siblings of Victims

5.741 (C) The following criteria applies to any contact with adult or child victims and their non-victim siblings.

Treatment providers, in conjunction with the community supervision team, shall:

1. Support the victim or non-victim siblings' wishes when either does not wish to have contact with the offender;

2. Collaborate, whenever possible, with a victim's therapist or advocate, or guardian, custodial parent, foster parent, and/or guardian ad litem when the victim is under eighteen years of age, in making decisions regarding communication, visits, and reunification;

3. Arrange contact in a manner that places victim safety first. When assessing safety, both psychological and physical well-being shall be considered. When the child has a therapist, they shall also be involved in the approval process;

4. Ensure that contact is not in conflict with any existing court or parole board directives;

5. Before recommending contact with a victim or any non-victim siblings, assess the offender's readiness and ability to refrain from re-victimizing, i.e. to avoid coercive and grooming statements and behaviors, to respect the victim's personal space, and to recognize and respect the victim's indication of comfort or discomfort;

6. Ensure the offender has an approved supervisor present within visual and hearing range during all contacts with child victims and non-victim siblings.

5.742 (C) Treatment providers, in conjunction with the community supervision team, shall ensure the offender achieves the following criteria before contact can be initiated:

1. The offender accepts responsibility for offense related behavior and any significant differences (i.e. regarding the sexual behavior in which the offender has engaged, use of force, and threats) between the offender's statements, the victim's statements and corroborating information about the abuse have been resolved;

2. The offender has yielded non-deceptive results in all the required areas of the sexual history disclosure polygraph process and has yielded non-deceptive results on the most recent maintenance polygraph. The content of the maintenance polygraph must have addressed behavior that puts victims/children at risk. Furthermore, there must not be concerns regarding significant risk related behavior.

   Some offenders have a history of persistent arousal to minors. Although they may be able to meet 5.742 criteria, because of the likelihood that proximity to children will trigger or increase this arousal, the team shall frequently reassess the offender's ability to maintain a reduced level of arousal[17]. The team shall terminate an offender's approval for contact

[17] Davis, G., Williams, L., Yokley, J. (1996); (1999) Sex Offender Treatment and Monitoring Program at the Colorado Department of Corrections.

with minors if there is behavior or other evidence to indicate arousal to minors cannot be managed.

3. Plethysmograph or Abel Screening for sexual interest results indicate a reduction in, or absence of, any sexually deviant arousal/interests and the offender consistently demonstrates the use of cognitive and behavioral interventions to interrupt deviant fantasies and behaviors;

4. The offender has disclosed information related to risk and other relevant factors as prescribed by the team. The team will make a determination as to who will receive this information;

5. The offender consistently demonstrates an understanding of and has written his/her deviant cycle and accepts the possibility of re-offense. The offender has developed a written relapse prevention plan for intervention to the satisfaction of the community supervision team;

6. The offender consistently demonstrates an understanding of the impact of the abuse on the victim(s) and their family, as evidenced by behavioral accountability and self-regulation;

7. The offender consistently demonstrates an understanding of the impact of his/her behavior on his/her own family, as evidenced by behavioral accountability and self-regulation;

8. The offender consistently demonstrates an understanding of and is willing to respect the victim's and non-victim siblings verbal and non-verbal boundaries and need for privacy;

9. The offender consistently demonstrates an understanding of how to safely participate in having contact with the victim and his/her non-victim siblings;

10. The offender is willing to accept limits or prohibitions on contact set by parents or legal guardians, or victim/non-victim sibling's therapist during the time the victim/non-victim siblings is under the age of eighteen and puts the victim's/non-victim siblings needs first. The offender accepts that others will decide about visitation, including the victim/non-victim siblings and the community supervision team;

11. The clarification process has commenced and sufficiently progressed. The primary purpose of the clarification process is to recognize and address past and potential victim harm embedded in the relationship between the offender and the victim. It is not designed to be used primarily for furthering or preventing future contact.

12. The offender is willing to plan for contact, to develop and utilize an approved safety plan for all contact, to accept supervision during contacts, and to terminate contact when requested by the community supervision team, the approved supervisor, or the child. The safety plan shall be approved in advance and in writing by the team and signed by the offender.

13. The offender consistently demonstrates compliance with supervision conditions;

14. The offender consistently demonstrates satisfactory progress in treatment, including consistent compliance with treatment conditions.

5.750 Unsupervised Contact with the Offender's Children (under age 18) *

The criteria listed below are to be used by the community supervision team when considering granting an offender unsupervised contact with his/her own children. Offenders shall not be allowed to have unsupervised contact with children who are not his/her own.

* For those offenders for whom the 5.742 criteria are waived pursuant to the results of the Parental Risk Assessment which includes the polygraph exams, this criteria does not apply, unless new information of concern has arisen.

- Unsupervised contact shall never be allowed for a sex offender diagnosed with any type of pedophilia (per DSM IV-TR).

- In any case where unsupervised contact is being requested, the community supervision team shall consider the child's needs; specifically, the protection and emotional needs of the child.

- Support the child's wishes when he/she does not want to have unsupervised contact with the offender.

- When there is a therapist working with the child the therapist shall be involved in the decision to grant unsupervised visitation. When the child is not currently seeing a therapist, the community supervision team may want to consult with a third party therapist or advocate who has expertise in child sexual abuse to discuss general issues surrounding unsupervised contact.

- The community supervision team shall <u>unanimously</u> agree that unsupervised contact will not place the child in danger and shall not consider unsupervised contact if there are any known or expressed concerns by the child involved. The offender shall develop a safety plan regarding the child involved, which shall be approved in advance and in writing by the Community Supervision Team.

Offenders being considered for unsupervised contact with their children shall:

a) Not have committed any offenses against any of the children in question;
b) Not meet any of the Exclusionary Criteria (as referenced earlier in Standard 5.720);
c) Have met and demonstrated compliance with all criteria in Standard 5.742 (A) for a minimum of six months without evidence of increased arousal or sexual acting out, as verified by ongoing polygraph testing (minimum of the two most recent maintenance polygraph exams being non-deceptive). Not show any deviant arousal to, or interest in, children as confirmed through current clinical and physiological measures;
d) Have demonstrated consistent compliance with supervision conditions;
e) Have demonstrated satisfactory progress in treatment, including consistent compliance with treatment conditions.

Community supervision teams shall thoroughly document reasons for all decisions made regarding an offender's unsupervised contact with his/her children.

The privilege of unsupervised contact shall be immediately revoked upon identification of any risk to the children involved or non-compliance with any of the criteria listed here or in *Standards* 5.740 through 5.742.

5.760 Contact with children shall be in the presence of a trained and approved supervisor with the exception of those offenders who have met the criteria for unsupervised contact with their own children (see Standard 5.750).

Discussion: Team members should never abdicate any part of their authority or responsibility regarding an offender to an approved supervisor. Teams should continually evaluate and assess the performance of the approved supervisor and revoke approved supervisor status if necessary.

5.761 <u>Qualifications</u> of an approved supervisor - Prior to allowing a person to be an approved supervisor, the team shall ensure that he or she has the following qualifications:

1) Is not currently under the jurisdiction of any court or criminal justice agency for a matter that the team determines could impact his/her capacity to safely serve as an approved supervisor;
2) Has no prior convictions, as defined by SOMB Statute, for unlawful sexual behavior or child abuse or neglect. If ever accused of unlawful sexual behavior or child abuse, presents information requested by the team so that the team may assess current impact on his/her capacity to serve as approved supervisor;*
3) Must agree to undergo and pay for a complete criminal history background check;
4) Has no significant cognitive or intellectual impairment;
5) Has no significant mental health or substance abuse problems;
6) Has no significant health limitation that interferes with the performance of his/her duty;
7) Has adequately resolved any issues regarding personal history of victimization;
8) The offender has no history of perpetrating domestic violence or any other form of victimization against the supervisor;
9) Is not hostile toward systems designed to intervene;
10) Is willing to maintain open communication with the team and report offender behavior;
11) Is willing to maintain protection of children as the highest priority and believes this outweighs any offender or family interests;
12) Acceptance by the children and children's custodial parents/guardians;
13) Demonstrates empathy for offender's victims.

5.761 DD

Understands the nature of the disability and that sexual offending behavior exists independent of the disability of the offender.

* In very rare circumstances, the Community Supervision Team may choose to make an exception to the prohibition about a misdemeanor child abuse conviction. The reasons for this exception should be made by the unanimous agreement of the Community Supervision Team and documented in writing.

5.762 The Community Supervision Team shall ensure that the approved supervisor knows the following information:

1) The underlying factual basis of the present offense(s) omitting information pertaining to a victim's identity;
2) The offender's statement of responsibility;
3) The offender's complete and verifiable sexual history disclosure (omitting any victim identity) and does not deny or minimize the offender's responsibility or the seriousness of sexual offending;
4) What constitutes sexual offending and other abusive behavior and the ongoing risk the offender presents to children;
5) The offender's risk factors, deviant sexual arousal patterns, offense cycle, and grooming behaviors;
6) That treatment progress and offender risk is variable over time;
7) The offender's mental health issues without making excuses for his/her behavior;
8) The offender's community supervision conditions, including Standard 5.710, treatment contract expectations, and rules regarding the approved contact;
9) The offender's requirement to provide the team with a written safety plan regarding supervised contact;
10) That the offender may have the ability to manipulate the approved supervisor.

5.763 The treatment provider shall develop a written contract that is signed by the team members and the approved supervisor. The contract shall state the responsibilities and duties of the approved supervisor. The contract shall require the following from the approved supervisor:

Duties and Responsibilities

1) Maintain qualifications and stay current on the knowledge and responsibilities as referenced in *Standards* 5.761 through 5.762;
2) No consumption of alcohol or mind-altering substances while acting as an approved supervisor;
3) Maintain confidentiality regarding victim information;
4) Ensure compliance with all rules as specified by the team;
5) Only allow contact with children approved by the team;
6) Never leave the offender alone with a child or victim and always be within sight and sound of the offender and the child/victim during contact;
7) Intervene when high risk situations or behaviors occur (i.e. terminate contact, report concerns to the community supervision team);
8) Assess the child's emotional and physical safety on a continuing basis and terminate contact immediately if any aspect of safety is jeopardized;
9) Maintain open and honest communication with the team, reporting all of offender's cycle-related behaviors and attitudes, responding to inquiries by the team, and when requested, meet with the team;
10) Provide documentation of contacts to the team as required;
11) Express any concerns to the team regarding the offender's behaviors, including but not limited to, non-compliance with the contract or treatment conditions, cycle behavior, etc.).

The following shall be specified in the written contract:

- Names of children with whom the approved supervisor is allowed to oversee any type of contact;
- Type of contact allowed (face-to-face, physical, video, written, phone);
- Locations of contact;
- Time/day of contacts;
- Activity/events in which the offender may participate;
- Other adults who may be present;
- If the approved supervisor is not in compliance with all of the requirements, the community supervision team may discontinue or modify any contact privileges or the approval status of the supervisor;
- An explanation of a supervisor's potential civil liability for negligence in enforcing stated rules and limitations.

5.770 When the offender communicates with any child, the community supervision team shall always screen the offender's communication and ensure that it is appropriate. This Standard can be waived for an offender's own non-victim children once the offender has met the criteria in 5.750.

5.780 Family Reunification – Prior to considering family reunification the offender shall have met the criteria listed in 5.750 and the community supervision team shall unanimously agree that family reunification is appropriate.

* For those offenders for whom the 5.742 (A) criteria are waived pursuant to the results of the Parental Risk Assessment which includes the polygraph exams, this criteria does not apply unless new information of concern has arisen.

Family Reunification is defined as the offender living in the same residence with his/her children.

Due to ongoing risk of re-offense, family reunification in cases of sexual assault or sexual abuse is rarely indicated.

When a child protective agency is involved in a case in which the offender is on probation or parole, any efforts toward family reunification should be carefully coordinated with the community supervision team as described in these *Standards*.

Family reunification shall never take precedence over the safety of any former victim or the offender's own children. If reunification is indicated, after careful consideration of the potential risks over an extended period of time, supervising officers and treatment providers shall carefully monitor the process.

Family reunification shall never be considered when the spouse/partner or caretaker is not actively involved in the offender treatment process and the child(ren)'s treatment process as applicable as recommended by the team. He/she should be willing and able to fully support all conditions imposed by the community supervision team.

5.790 Circumstances Under Which Criteria May Be Waived

Allowing contact prior to fulfillment of the criteria outlined in Section 5.742 of these *Standards* should occur only in **rare** circumstances. In addition, the entire team shall have worked with the offender and agree that there is minimal risk of any crossover or additional crimes of opportunity. While it is not appropriate for the criteria to be waived in its entirety for ongoing contact, there may be parts of the criteria that may be waived or postponed.

Occasionally, the team may approve a broader waiver of 5.742 criteria for a one-time contact only, such as for a child's contact with the offender in a therapy session to assist non-victim children in adjusting to the offender's removal from the home. Any approval for this kind of closure/explanation session shall be in writing and the community supervision team shall determine all the particulars of that session. If the child(ren) has a therapist or an advocate, that person should also be present. The community supervision team shall take every precaution to ensure that the children with whom a sexual offender is doing this kind of closure or explanation session are not his/her primary victims.

Additionally, when victim clarification work is being conducted in a therapist's office between a victim and offender, contact may occur.

In cases where the team determines that it would not be safe to have the offender in a session with his/her child(ren), a video taped or audio taped presentation by the offender might be a suitable alternative. In cases where a face-to-face meeting or a tape is not appropriate, another option for contact with his/her children would be a letter from the offender. The letter shall be approved by the team and if possible by a victim advocate or therapist prior to its presentation to the child(ren). Whenever possible, an advocate or therapist for the child or children should be present when the letter is presented to the child or children.

There may be instances when an adult victim desires contact with an offender prior to 5.742 C. criteria having been achieved. Teams should staff these situations and determine if contact should be allowed and under what circumstances (e.g. with a therapist present, telephone contact, etc.) Victim safety and offender rehabilitation shall remain the priorities.

When making a decision to waive any part of the criteria, there shall be full consensus of the team. An explanation of the specific circumstances and reasons shall be documented, including the potential risk to the community, victim(s), and potential victims involved.

5.791 Potential Adult Victims

The SOMB recognizes that it is not possible to limit a sex offender's contact with all adults in the community. However, care should be taken to limit the offender's access to places and groups where he or she has a history of accessing victims (e.g.: bars, clubs, singles groups, senior centers, medical care facilities, campuses, etc.) or where he or she may present a current risk.

It is also imperative that consideration be given to protecting at-risk adults. Treatment providers and other members of community supervision teams shall not allow sex offenders to have unsupervised contact with adults who are at particular risk for victimization due to mental status, disability, or incapacity. Decisions to allow any contact with at-risk adults should be made using the same criteria as for child contact [See *Standard* 5.742 (B)].

6.000 STANDARDS OF PRACTICE FOR POST-CONVICTION SEX OFFENDER POLYGRAPH TESTING

6.000 Requirement for Post Conviction Polygraph Testing

The polygraph shall be used to add incremental validity to treatment planning and risk management decisions regarding sex offenders in community and institutional settings. The concept of "incremental validity" refers to improvements in decision making through the use of additional information sources. Benefits of polygraph testing include improved decision making, deterrence of problem behavior and access to information that might otherwise not be obtained.

Discussion: Polygraph testing is one of many decision-support tools, and does not replace other forms of behavioral monitoring. The Community Supervision Team (CST) should consider all information from the polygraph examination, including disclosures of information and test results, in making any decisions pertaining to an offender's progress in treatment, activities in the community, and contact with potentially vulnerable persons. Information and results obtained from polygraph examinations should not be used in isolation when making treatment or supervision decisions. Other forms of behavioral monitoring, including drug/alcohol testing, plethysmograph testing, VRT assessment, and traditional investigative practices such as collateral contacts, home visits, work site visits, restrictions and increased supervision and treatment requirements, should be considered whenever polygraph examination results fail to confirm an offender's honesty and compliance with supervision and treatment.

6.001 Expectation for honesty and requirement to resolve all test questions

The CST shall set the expectation of honesty and complete disclosure for the purpose of ensuring community safety and the development of an appropriate treatment plan. If the offender is determined to have unresolved responses to any test questions, all test issues shall be considered unresolved and subject to further investigation.

6.002 Minimum Polygraph Requirements following onset of treatment

Sentencing	Instant Offense	Start of Treatment	Maintenance	Sex History 1	Maintenance	Sex History 2
Deniers	**90 Days**	**0 Days**	**90 Days**	**270 Days**	**270 Days**	**360 Days**

6.010 Types of Post-Conviction Polygraph Examinations

CST members, including polygraph examiners, shall maintain the integrity of the distinct types of post-conviction polygraph examinations, and shall not mix questions among maintenance/monitoring, sexual history, instant offense, and event specific exams. However, all polygraph examinations may include personally relevant questions about integrity and honesty with team members, authority figures and other significant persons.

6.011 Initial/Instant Offense Polygraph Examination

This test shall be required whenever significant discrepancies exist between the victim's and offender's accounts of the offense and whenever the offender denies the offense. When used, the exam shall occur within the first 90 days of treatment, or prior to victim clarification meetings.

Discussion: When the offender admits involvement in the issues under investigation, it may be useful to test the limits or extent of the offender's admitted behaviors. However, testing the limits of

admitted behavior is more complicated compared with testing any involvement in an alleged behavior which the offender completely denies. Team members shall consider the potential impact to a victim to assume we know "everything."

6.012 Sexual History Polygraph Examination

Sexual history polygraph examinations shall be employed to thoroughly investigate the offender's lifetime history of sexual behavior, including identification of victims and victim selection behaviors, numbers of sexual partners, and deviant or compulsive sexual behaviors. An initial sexual history polygraph examination should be administered within the first nine months of treatment and shall be completed within the first eighteen months of entering treatment.

Discussion: The use of the polygraph examination in the treatment and supervision of convicted sex offenders underscores the fact that many offenders keep secrets about their dangerous and abusive lifestyles. Discussions with convicted sex offenders and professionals in the field suggest that the decision to reveal past secrets and all victims of abuse is an essential component in the development of meaningful treatment and containment plans. The use of the polygraph examination combined with the sexual history documentation prepared by the offender as part of the group process underscores the SOMB's expectation for honesty and compliance from offenders who have agreed to participate in supervision and treatment. Resolution of polygraph test questions may provide a reasonable basis to establish a tenuous trust relationship between known sex offenders and persons concerned about the offender.

A. The treatment provider shall ensure that the offender has completed a written sexual history disclosure using the SOMB Polygraph Sexual History Packet prior to the examination date. A sexual history polygraph examination shall not be conducted until the offender has written his/her sexual history and reviewed it in their treatment program. The treatment provider shall ensure that the polygraph examiner has access to a copy of the offender's SOMB Polygraph Sexual History Packet prior to or at the time of the exam. If the packet is not received by the time of the examination appointment, the examiner shall have the discretion of administering a sexual history polygraph examination or another type of examination.

   Discussion: Proper polygraph preparation by the offender involves the thorough review of recent and past behaviors. Offenders must be prepared to be open and honest with the polygraph examiner as the first step of offender accountability and community safety. Effective preparation has been shown to improve an offender's ability to resolve questions and issues of concern.

B. The sexual history polygraph examination process shall cover the following areas:

   1. Sexual contact with underage persons (persons younger than age 15 while the offender is age 18 or older);

   2. Sexual contact with relatives whether by blood, marriage, or adoption, or where a relationship has the appearance of a family relationship (a dating or live-in relationship exists with the person(s) natural, step or adoptive parent);

   3. Use of violence to engage in sexual contact including physical restraint and threats of harm or violence toward a victim or victim's family members or pets, through use of a weapon, or through verbal/non-verbal means;

   4. Sexual offenses (including touching or peeping) against persons who appeared to be asleep, were drugged, intoxicated or unconscious, or were mentally/physically helpless or incapacitated.

C. At the discretion of the CST, additional polygraph investigation may be necessary to explore the offender's history of involvement in other paraphilias including sexually compulsive behaviors, other sexually deviant activities, or unlawful sexual behaviors.

Discussion: CST members may direct the offender to address his or her sexual history polygraph examination requirements in a series of narrowly focused examinations instead of broader examination methods.

D. Failure to verify the offender's sexual history via non-deceptive polygraph results within twelve months after the onset of sex offense specific treatment shall result in a face-to-face or telephone staffing to determine the reasons for the offender's non-compliance with this requirement, and any steps necessary to effect more complete disclosure and satisfaction of this requirement. Structured intervention approaches, such as the polygraph decision grid in Appendix C-4, shall be used to address and correct these situations. For offenders whose sexual history polygraph examination results remain unresolved following this time-frame (12 months after onset of treatment), the CST shall respond to the offender's risk level in a manner consistent with offenders who are highly impulsive with prominent deviancy, compulsivity, and widely varied offending behaviors. Offenders who reside in highly restrictive institutional settings may be subject to programmatic time-lines that differ from community based programs.

Discussion: Sexual history polygraph examinations should generally be delayed for offenders who are denying significant aspects of the instant offense, including any substantial discrepancies between the victim's and offender's account of the abuse. Proper procedure dictates that denial surrounding the details of the instant offense be satisfactorily resolved before proceeding to a more general sexual history polygraph. However, when history examinations do occur prior to resolving the index offense, test questions shall exclude reference to the victim(s) of the instant offense.

E. Under rare circumstances, the CST can waive the SOMB requirements for fully resolved sexual history polygraph examination results – such as when an offender has already made substantial disclosures in all areas of inquiry and when additional information is unlikely to more fully inform the community supervision team about risk level, sexual deviancy or compulsivity patterns, and related treatment needs.

6.013 Maintenance/Monitoring Polygraph Examination

Maintenance/monitoring polygraph examinations shall be employed to periodically investigate the offender's honesty with community supervision team members and compliance with supervision. Maintenance/monitoring polygraph examinations shall be implemented every four to six months, starting within the first 90 days of treatment and then periodically thereafter. A minimum of two maintenance/monitoring polygraphs shall occur on an annual basis. Maintenance/monitoring polygraphs shall be employed more frequently with those offenders who present as high-risk, have previously unresolved examination results, or may benefit from more active monitoring. Any follow up examination to resolve deceptive or inconclusive results shall be regarded as part of the initial examination and does not replace the minimal requirement for two maintenance polygraph examinations during each 12 month period.

Discussion: The polygraph conducted in the absence of any new allegations or incidents of concern can be an effective deterrent to high risk or non-compliant behavior. Research suggests the use of the polygraph can reduce involvement in ongoing sexually deviant behaviors and improves outcomes in supervision and treatment programs. Research and experience with other forms of deterrent interventions (e.g., drug screening) suggest that random vs. scheduled periodic testing may present a more effective deterrent effect in some situations. For this reason, community supervision team

members should consider the possible deterrent benefits of randomly scheduled maintenance/monitoring exams for some offenders.

A. Maintenance/monitoring polygraph examinations shall cover a wide variety of sexual behaviors and compliance issues that may be related to victim selection, grooming behaviors, deviancy activities or high risk behaviors. Maintenance/ monitoring polygraph examinations shall prioritize the investigation and monitoring of the offender's involvement in any non-compliance, high-risk, and deviancy behaviors that may change over time and would signal an escalating risk level prior to re-offending. Narrowing the scope of maintenance/monitoring examinations can sometimes be helpful to address concerns about possible re-offending, and may be useful to resolve the concerns of the community supervision team. Waiting to catch the offender after re-offense is too late to prevent another person from being victimized.

Discussion: It is generally understood in testing sciences that broader screening examinations, regarding multiple or mixed issues, offer greater screening utility through sensitivity to a broader range of possible concerns, while more narrowly focused tests offer greater diagnostic specificity to support action or intervention in response to known incidents or specific allegations.

B. Maintenance/monitoring polygraph testing shall continue regardless of the timing of other polygraph testing such as sexual history, instant offense, or event specific investigations. The frequency of maintenance/monitoring testing may be accelerated if the offender's sexual history remains unresolved following 12 months after beginning sex offense specific treatment.

C. The CST shall prioritize the investigation of more recent behaviors when evaluating the offender's present stability or acute/short-term risk level. The CST should generally require that all test questions and all time periods are satisfactorily resolved before moving on to another maintenance/monitoring exam with different questions or time-frames.

D. When offenders fail to resolve a maintenance polygraph, the community supervision team shall manage the offender as a high risk offender.

6.014 Event-Specific Polygraph Examination

Event-specific (specific issue) polygraph examinations shall be used to investigate the details of an offender's involvement in a known or alleged incident, or to resolve any discrepancies or inconsistencies in the offender's account of a known incident or allegation. Due to the critical nature of these issues, the CST may convene a staffing to determine the necessity of any treatment or supervision interventions (see Sanctions Grid in Appendix C-4) in response to any deceptive or unresolved test results.

Discussion: The CST should not conduct event specific polygraph examinations on active criminal investigations, unless by agreement with the investigators.

6.015 Parental Risk Assessment Polygraph Examination

Parental risk assessment (PRA) polygraph examinations shall be used to assist the community supervision team in making recommendations about contact with the offender's own children who are not already known to be victims or siblings of victims. The PRA polygraph shall occur prior to the completion of the parental risk assessment (pursuant to Standard 5.7). This examination is conducted in the absence of known or alleged offenses against the offender's own children, and is conducted for the purpose of gathering information to assist in the assessment of the offender's potential risk to offend against his/her own children.

6.020 Use of Polygraph by the Community Supervision Team (CST)

Results and information from polygraph examinations shall be used to assist CST members in tailoring more effective intervention and containment strategies. Timely administration of polygraph examinations assists the CST in effectively monitoring offenders in the community.

6.021 Communication with the offender

CST members shall not advise offenders of specific test questions prior to the scheduled appointment, although offenders can be informed regarding the type of examination.

6.022 Communication with the examiner

CST members shall confer and convey to the examiner the type of exam to be administered as well as any specific areas of concern.

6.023 Examiner responsibility for test questions

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

6.030 Responding to Polygraph Examination Results

All CST members shall review the test report, and respond to any unresolved test results by sanctioning the offender per, but not limited to, the sanctions grid in Attachments A and B.

Discussion: Research demonstrates that the use of the polygraph with convicted sex offenders is most effective when sanctions, including consequences, restrictions and increased treatment relevant to any disclosed high-risk behaviors or unresolved test results are imposed quickly. Use of structured interventions, such as the Polygraph Decision Grid, when responding to test results is essential to safely managing the offender and facilitating success in treatment and supervision.

6.031 Follow-up examinations

Deceptive or inconclusive test results, or attempts to manipulate the test results, shall be addressed through follow-up examination within a short period of time, and the community supervision team has discretion regarding increased containment while awaiting resolution.

A. Follow-up examinations shall occur within 60 days and can be conducted as early as 48 hours after the initial examination. The time frame for testing shall be prioritized based on the offender's level of threat to the community and can be adjusted based upon the offender's preparedness to address and resolve any remaining issues of concern.

B. Resolution of remaining concerns upon follow-up testing shall be regarded as satisfactory resolution of the earlier test results, and follow-up examinations shall be regarded as a component of the earlier unresolved examination. In most cases it is recommended that follow-up examinations be completed with the same examiner.

   Discussion: Non-deceptive test results are considered conclusive and the issue(s) under investigation shall be considered satisfactorily resolved. However, non-deceptive test results alone do not ensure safety on the part of the offender, nor should they automatically result in reduced monitoring on the part of the community supervision team.

C. New admissions or the presence of deceptive reactions at the time of follow-up testing shall require the initial examination to be regarded as unresolved and therefore re-investigated in its entirety.

6.032 Preventing splitting and triangulation

Team members shall not allow splitting or triangulating behaviors, and splitting efforts by the offender shall be communicated to other team members. Treatment providers and supervising officers shall not offer the offender excuses or justifications for deceptive or unresolved reactions to polygraph test questions; it is the offender's responsibility to explain such reactions to the team.

6.033 Technical expertise of the examiner

Questions regarding the technical aspects of the polygraph shall be referred to the polygraph examiner. CST members shall not attempt to educate offenders regarding how to pass or defeat the polygraph test, but shall limit their discussion to the need for honesty and disclosure. When any team member has difficulty understanding or interpreting written polygraph reports or results, he or she shall contact the polygraph examiner for clarification and refrain from interpreting polygraph results beyond what is contained in the report.

6.100 Administration of the Polygraph Examination

Polygraph examiners shall adhere to the established ethics, standards, and practices of the American Polygraph Association (APA) and the American Society for Testing and Materials (ASTM).

6.110 Equipment and instrumentation

Examiners shall use a computerized polygraph system consisting of five or more channel polygraph instrument that will simultaneously record the physiological phenomena of abdominal and thoracic respiration, electro-dermal activity, changes in cardiovascular activity, and additional component sensors to monitor and record in-test behavior.

6.120 Duration of examination

Each examination (including the pre-test, in-test, and post-test phases) shall be scheduled for a minimum of 90 minutes in duration. Examiners shall not conduct more than five post-conviction examinations per day.

6.130 Adherence to recognized standards

Polygraph examiners shall conduct all polygraph examinations in a manner that is consistent with the accepted standard of practice within the professional polygraph community.

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

6.140 Testing procedures

Examiners shall use examination techniques recognized by the American Polygraph Association (APA) as acceptable for Post-Conviction Sex Offender Testing (PCSOT).

6.141 Authorization and release

The examiner shall obtain the offender's agreement, in writing or on the audio/video recording, to a standard waiver/release statement. The language of the statement shall minimally include the offender's voluntary consent to take the test, that all information and results will be released to professional members of the community supervision team, an advisement that admission of involvement in unlawful activities will not be concealed from authorities, and a statement regarding the requirement for audio/video recording of each examination.

6.141 DD

For offenders with a developmental disability, the examiner shall obtain the written agreement of the offender with a developmental disability, and if applicable, the legal guardian, for participation in the polygraph examination and the release of information authorization.

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

6.142 Case background information

The examiner shall request and review all pertinent and available case facts within a time frame sufficient to prepare for the examination.

Discussion: The supervising officer or treatment provider should ensure that the polygraph examiner conducting the current exam receives a copy of the Pre-Sentence Investigation Report (PSIR) and/or police report(s), the sexual history disclosure packet, the sex offense specific evaluation, the most recent polygraph report(s), and information relevant to clarifying a previously deceptive or unresolved examination (in addition to any other pertinent information about the purpose of the current examination).

6.143 Offender background information

Prior to beginning the examination, the examiner shall elicit relevant personal information from the offender consisting of brief personal and demographic background information, case background information, and medical/psychiatric health information (including medications) pertaining to the offender's suitability for polygraph testing.

6.144 Review of testing procedures

The testing process shall be explained to the offender, including an explanation of the instrumentation used.

6.145 Pre-test interview

The examiner shall conduct a thorough pre-test interview, including a detailed discussion of each issue of concern. There shall be an open dialogue with the offender to confirm his/her version of all issues under investigation.

6.146 Test questions

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

A. Question construction shall be:

- Simple, direct and easily understood by the examinee;
- Behaviorally descriptive of the offender’s involvement in an issue of concern (questions about knowledge, truthfulness, or another person's behavior are considered less desirable);
- Time limited (date of incident or time-frame);
- Absent of assumptions about guilt or deception;

- Free of legal terms and jargon;
- Avoid the use of mental state or motivational terminology.

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

6.147 Number of test charts

Three to five primary test charts shall be administered on the exam issue(s).

6.148 Post-test review

The examiner shall review initial test results with the offender. Offenders shall be given the opportunity to explain or resolve any reactions or inconsistencies.

6.149 Examination recording

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

6.150 Examination results

All testing data shall be hand scored by the examiner. Computerized scoring algorithms may be used for comparative purposes and quality assurance in the field.

6.151 Test results

The examiner shall render an empirically based opinion regarding the examinee's truthfulness or deception to each test question.

A. Examiners shall render an empirically based opinion that the test results indicate the examinee was deceptive whenever there are significant physiological responses that meet established criteria;

B. Examiners shall render an empirically based opinion that the test results indicate the examinee was non-deceptive (i.e., truthful) whenever there are no significant physiological responses that meet established criteria;

C. Examiners shall render "no opinion" whenever test results yield "inconclusive" scores, or whenever the overall set of test data do not allow the examiner to render an empirically based opinion regarding individual test questions. Examiners shall note in the examination report whenever it is suspected that an examinee has attempted to falsify or manipulate the test results, and whether the examinee was forthcoming in explaining his or her in-test behavior.

Discussion: "No opinion" is synonymous with "inconclusive."

6.152 Test results based on all available information

Consistent with other professional standards, the examiner shall be responsible for rendering an empirically based opinion regarding a polygraph examination. The opinion shall be based on all information gathered during the examination process. The computer algorithm shall never be the sole determining factor in any examination.

6.153 Prohibition against mixed results

To reduce the likelihood of erroneous test results, examiners shall not conclude the offender is deceptive in response to one or more test questions and non-deceptive in response to other test questions within the same examination.

6.160 Examination report

Examiners shall issue a written report to all members of the community supervision team within fourteen days of the examination. The report shall include factual and objective accounts of the pertinent information developed during the examination, including statements made by the examinee during the pre-test and post-test interviews.

6.161 Content of the examination report

All polygraph examination written reports shall include the following information:

- Date of examination;
- Beginning and ending times of examination;
- Reason for examination;
- Referring or requesting agents/agencies (all members of the CST);
- Name of offender;
- Location of offender in the criminal justice system (probation, parole, etc.);
- Case background (instant offense and conviction);
- Any pertinent information obtained outside the exam (collateral information if available);
- Brief demographic information (marital status, children, living arrangements, occupation, employment status, etc.);
- Statement attesting to the offender's suitability for polygraph testing (medical/psychiatric/developmental);
- List of offender’s medications;
- Date of last post-conviction examination (if known);
- Summary of pre-test and post-test interviews, including disclosures or other relevant information provided by the offender;
- Examination questions and answers;
- Examination results;
- Reasons for inability to complete exam (if applicable);
- Any additional information deemed relevant by the polygraph examiner (e.g., behavioral observations or verbal statements).

6.162 Raw data and numerical scores

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

6.163 Information released only to professionals

Written polygraph reports and related work products shall be released only to CST members, the court, parole board or other releasing agency, or other professionals at the discretion of the community supervision team.

6.164 Communication with the examiner after testing

Following the completion of the examination and post-test review, examiners shall not discuss polygraph results with the offender, or the offender's family members, unless done in the context of a formal case staffing.

6.170 Quality assurance

Examiners shall seek peer review of at least two examinations per year using the protocol. Additional peer reviews may be requested by the community supervision team. Quality assurance reviews shall consist of a systematic review of the examination report, test data, test questions, scored results, computer score (if available), audio/video recording, and collateral information. Documentation of six quality assurance peer reviews shall be submitted to the SOMB at the time of re-application. The purpose of the Quality Assurance Protocol shall be to facilitate a second professional opinion regarding a particular examination, to gain professional consensus whenever possible, and to formulate recommendations for the community supervision team.

Discussion: The Quality Assurance Protocol is intended to advise members of the CST on the polygraph test about the strengths and limitations of a particular test, and to provide examiners with a formal vehicle for gaining professional feedback and consensus. Quality assurance activities include: compliance with standards of practice, certification requirements, ongoing training, supervision and oversight, options for recourse in the event of identified problems, and program evaluation. Quality assurance activities take place at varying levels of formality, including informal data checks via audio/video recording, procedural or follow-up case-staffing with the examiner, collaborative peer review, blind review, panel review, or referral to an outside agency for quality assurance review.

6.171 Initiating the quality assurance review

With the exception of exams required for reapplication purposes, quality assurance reviews shall be initiated by a member of the community supervision team. Quality assurance reviews may be initiated in response to a variety of circumstances, including but not limited to:

A. A formal or informal complaint regarding non-compliance with these *Standards*, or when critical decisions may be influenced by the information or results from the polygraph test.

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

C. When an examiner determines the test subject has attempted to use manipulative techniques to alter the test results. The purpose of the review is to confirm the offender's use of

manipulative techniques prior to the imposition of sanctions or consequences for non-cooperation. This review may not be necessary when the offender admits non-cooperation, explains his or her in-test behavior, and is forthcoming in discussing his or her knowledge of the polygraph technique. In these cases the test results may be regarded as inconclusive or unresolved until the issues are subject to re-examination.

6.172 Selection of the reviewing examiner

When initiating a quality assurance review, the CST members shall contact the original examiner and, together with the original examiner, select an independent, full-operating level polygraph examiner to complete an objective peer review.

The reviewing examiner shall contact the original examiner with any questions and feedback, and shall complete the Quality Assurance Protocol and the one-page Quality Assurance Summary Report together with the original examiner.

Discussion: It should not be assumed that a reviewer or reviewers present more expertise than the original examiner. Studies have found that results obtained by original examiners have outperformed those of subsequent reviewers (National Academy of Sciences, 2003). Quality assurance reviews serve only to offer an additional professional opinion to further advise community supervision team members regarding a polygraph test whose decisions may be affected by the information and results obtained.

6.173 Conclusions from the quality assurance review

Community supervision team members shall include the one-page Quality Assurance Summary Report in the offender's treatment and supervision files. Quality assurance reviewers shall refrain from making global or generalized conclusions regarding an examiner's work or competence (which cannot be done based upon a single examination). Unless an empirical flaw is identified, the reviewing examiner shall endorse the original examiner's reported results, and shall limit professional opinions to the following conclusions:

A. Examination is supported - results shall be accepted;

B. Examination is not supported - results shall be set aside;

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

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

6.200 Use of the polygraph with special considerations

The CST shall address any special considerations, such as severe medical, psychiatric, or developmental conditions that may affect an offender's suitability for polygraph testing. When deciding whether to use polygraph testing with such offenders, the CST shall consider the probable benefits of testing, including improved decision-making, deterrence of problem behavior, and the value of additional disclosed information that might otherwise not be obtained.

6.210 Determination of suitability for testing

The CST shall have the authority to determine whether to use polygraph testing when there are special considerations. In dealing with special considerations, the CST shall consult with the examiner before deciding whether to employ polygraph testing. Polygraph examinations shall not be employed with such offenders unless the CST determines that such testing would add incremental validity to important treatment decisions. Offenders who are acutely psychotic, suicidal, or have un-stabilized serious mental health conditions, including dementia, are generally not suitable for polygraph testing. In addition, offenders suffering from serious injury or illness, or under the influence of non-prescribed controlled substances are generally not suitable for polygraph testing. Offenders' mental status results indicating a lack of clear awareness of the concepts of truthfulness or lying, or a lack of capacity to anticipate consequences for telling the truth or lying, based on a mental or emotional condition, may not be suitable for polygraph testing. Polygraph examiners shall not test offenders who present as clearly unsuitable for polygraph testing at the time of the examination. The CST shall periodically review each offender's suitability for polygraph testing. In cases where the offender is determined to be unsuitable for polygraph testing, the CST shall consider other forms of behavioral monitoring.

6.211 Documentation of special considerations

The polygraph examiner shall obtain and note in the examination report a list of the offender's prescription medication, any medical or psychiatric conditions, and any other special considerations as identified in this section. The CST shall advise all offenders to continue taking prescription as directed by their medical or psychiatric professional.

Discussion: The CST may consult with the offender's physician or psychiatrist before employing polygraph examinations in such cases. Use of prescribed medication for either a medical or psychiatric condition may or may not impact an offender's suitability for polygraph testing. Persons who function optimally while taking prescribed medication may also produce polygraph data of optimal interpretable quality. However, persons who take multiple prescription medications may be more likely than others to exhibit polygraph test data of marginal interpretable quality.

6.212 Release of information

Offenders with special considerations, and if applicable their legal guardian, shall be required to execute appropriate authorizations so that the CST can consult with and obtain records from professionals who are treating or who have treated in the past those offenders suffering from medical, mental or emotional conditions.

6.213 Sensitivity to special considerations

If the CST determines that it is appropriate to use a polygraph examination with an offender who presents with special considerations, the examiner shall conduct the examination in a manner that is sensitive to the offender's physical, mental, or emotional condition. The examiner shall note in the examination report those conditions that may have affected the offender's suitability for testing.

Discussion: Polygraph examinations completed on special population offenders (see definition in Definitions section) may be regarded as "qualified" and the test results should be viewed with caution. In this context, "qualified" means that the test results may not have the same level of validity as test results that are not complicated by special considerations.

6.214 Language barriers

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

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

6.215 Selection of interpreters

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

6.216 Cultural awareness

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

6.217 Managing offender manipulation of special consideration

The CST shall convene a staffing and case review for all offenders who are determined to be malingering, feigning, or exploiting their special considerations as described in this section for purposes of avoiding polygraph examinations. The purposes of the staffing are to determine whether sanctions should be employed, whether additional behavioral restrictions are employed, or in extreme cases whether removal from community supervision should be considered.

7.000
STANDARDS FOR PLETHYSMOGRAPHY

7.100 Standards of Practice for Plethysmograph Examiners

7.110 A plethysmograph examiner shall adhere to the "Guidelines for the Use of the Penile Plethysmograph,"[18] published by the Association for the Treatment of Sexual Abusers, ATSA Practitioner's Handbook. (See Appendix C) and shall demonstrate competency according to professional standards and conduct plethysmograph examinations in a manner that is consistent with the reasonably accepted standard of practice in the plethysmograph examination community.

7.120 Plethysmograph examiners shall adhere to the following specific procedures during the administration of each examination:

A. The examiner shall obtain the informed assent of the offender for the plethysmograph examination, and shall inform an offender of the examination methods, how the information will be used, and to whom it will be given. The examiner shall also inform the offender about the nature of the evaluator's relationship with the offender and with the court. The examiner shall respect an offender's right to be fully informed about the examination procedures, and results of the examination should be shared with the offender and any questions clarified;

B. The examinee shall also sign a standard waiver/release of information statement. The language of the statement should be coordinated prior to the plethysmograph examination with the therapist, probation/parole officer, community corrections case manager, or prison treatment provider;

C. The examiner shall elicit relevant biographical and medical history information from the examinee prior to administering the actual plethysmograph examination;

D. The testing process shall be completely explained to the examinee, including an explanation of the instrumentation used and causes of general nervous tension;

E. Test results shall be reviewed with the examinee;

F. The examiner must have received all pertinent and available case facts within a time frame sufficient to prepare for the examination.

7.130 Plethysmograph examinations should never be used in isolation. The results must be utilized in conjunction with other evaluative measures or as a part of a treatment program to effectively assess risk.

[18] Plethysmographic testing measuring physiological changes associated with sexual arousal are also available for female sex offenders.

8.000
DENIAL OF PLACEMENT ON PROVIDER LIST

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

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

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

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

D. The applicant has been convicted or received a deferred judgment for any criminal offense;

E. The applicant has been found to engage in unethical behavior by any licensing or certifying body or has had a license or certification revoked, canceled, suspended or been placed on probationary status by any professional oversight body;

F. The applicant is addicted to or dependent on alcohol or any habit forming drug as defined in section 12-22-102, C.R.S., or is a habitual user of any controlled substance as defined in section 12-22-303, C.R.S., or any alcoholic beverage;

G. The applicant has a physical or mental disability which renders the applicant unable to treat clients with reasonable skill and safety or which may endanger the health or safety of persons under the individual's care;

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

9.000
CONTINUITY OF INFORMATION

Discussion: Standards for continuity of information are necessary to reduce the fragmentation and/or duplication of information in case files and to provide a full record of a sex offender's history of offending and history of compliance.

9.010 The pre-sentence investigation report should include police report(s), including victim statements, sex offense-specific evaluation, and child protection reports when the victim is a child or when any child lives in the offender's residence. The pre-sentence investigation report for any sex offender placed in the custody of the Department of Corrections (DOC) should be forwarded to the DOC's Denver Reception Diagnostic Center.

9.020 When an offender is placed in the custody of DOC, the DOC should request the probation or community corrections file for any offender who has been on probation or community corrections for a sexual offense in the past.

9.030 When a sex offender is released from the DOC on parole or accepted into Community Corrections, DOC shall send all records which:

- Describe the offender's level of cooperation and institutional behavior
- Describe the offender's participation in treatment
- Suggest specific conditions of parole
- Indicate ongoing risk

In addition, DOC should forward information on the treatment status of the offender, a copy of the discharge contract if the offender is in treatment, a copy of the sex offense-specific evaluation, and notification if the offender refused treatment.

9.040 When an offender is released on parole or community corrections, the parole officer or community corrections case manager shall request the probation file for any offender who has been on probation for a sexual offense in the past.

9.050 Discharge information to be recorded by the supervising officer at the termination of community supervision should be available in the file and should include records of the offender's:

- Treatment progress
- Successful or unsuccessful completion of treatment
- Auxiliary treatment
- Community stability
- Residence
- Compliance with supervision plan and conditions of probation/parole/community corrections
- Most current risk assessment

9.060 Discharge information to be recorded at the termination of a prison sentence should be available in the file and should include records of the offender's:

- Involvement in sex offender treatment
- Successful or unsuccessful completion of treatment
- Auxiliary treatment
- Relapse prevention plan, if available
- Level of risk

10.000 RECOMMENDATIONS FOR MANAGEMENT AND INFORMATION SHARING ON ALLEGED SEX OFFENDERS PRIOR TO CONVICTION

Discussion: Following are recommendations for the management of alleged sex offenders prior to conviction. Although the Sex Offender Management Board has no authority to set standards for alleged sex offenders prior to conviction, the SOMB strongly recommends that these guidelines be followed in order to establish both the data and practices to support the later assessment, treatment, and behavioral monitoring of convicted sex offenders.

1. Investigation of reports to law enforcement and child protection services.

Information that will contribute to the future assessment of an alleged sexual offender and preserve evidence is best obtained through a thorough and objective investigation in which the well-being of the alleged victim is of primary importance.

Investigations that preserve the well-being of the alleged victim include such approaches as:

- Providing immediate medical referral
- Minimizing the number of interviews of children
- Using a child advocacy center to interview children; increasing the comfort level of the adult alleged sexual assault victim being interviewed as much as possible
- Removing the alleged perpetrator, rather than the child alleged to be a victim of sexual abuse from the home
- Using forensic medical examinations that meet the standards set by the Colorado Coalition Against Sexual Assault[19]
- Providing emotional support (and victim advocacy services) to the alleged victim
- Using community-based protocols for the response to alleged victims of sexual abuse[20]

2. Documentation of sexual abuse.

Complete documentation will assist in developing future treatment and supervision plans and in protecting the alleged victim and the community. Both child protection and law enforcement investigative reports should provide detailed information on the behavior of the alleged perpetrator related to and including the sexual offending behavior.

Investigative reports should include information that describes:

- The dynamics of the alleged abuse
- Alleged offender patterns of grooming (preparing) the victim

[19]For copies of the *Colorado Sexual Assault Forensic Examination Protocol*, which also includes valuable appendices such as the numbers of rape crisis hotlines in Colorado, contact the Colorado Coalition Against Sexual Assault, P.O Box 18633, Denver, CO 80218.

[20] For a victim-center protocol for responding to sexual assault, please see *Looking Back, Moving Forward: A Guidebook for Communities Responding to Sexual Assault*, published by the National Victim Center, 2111 Wilson Boulevard, Suite 300, Arlington, VA 22201, (703) 276-2880.

- The ways in which the alleged offender discouraged disclosure
- Presence of child pornography
- Amount of violence and/or coercion
- Any direct or indirect corroboration of the offense
- Evidence of other sexual misconduct

Such information will not only assist in the prosecution of the case but will also contribute to assessment by the pre-sentence investigator, the judge, and the treatment provider/evaluator who will conduct a sex offense-specific evaluation. Such documentation can also assist in confronting offender denial and can establish a modus operandi in the event of future crimes by the offender.

3. Specialized job duties and training.

Whenever possible, investigation and prosecution of sexual assault cases should be assigned to individuals specifically trained to work in this area. Trained individuals are least likely to cause additional trauma to the alleged victim and their investigations are most likely to result in a prosecutable case.

4. Teamwork among law enforcement, child protection services and prosecution.

A team approach to the investigation, review, and case management of sexual abuse reports is vital to the successful prosecution of alleged sexual offenders. Regular meetings of the team enhance community safety and increase the effectiveness of the team. Information should be routinely updated on the status of dependency/neglect petitions, which cases are being criminally filed, and the status of placement decisions.

5. Removal of the perpetrator from the home in intra-familial sexual abuse cases.

Whenever possible, the perpetrator, not the alleged victim should be removed from the home.

6. Family Reunification is dangerous.

In child sexual abuse cases, family reunification is dangerous. When family reunification is a goal of the child protection agency, family reunification should be avoided until after disposition of the criminal case. Before recommending contact with a child victim or any potential victims, responsible parties shall assess the offender's readiness and ability to refrain from revictimizing, i.e. to avoid coercive and grooming statements and behaviors, to respect the child's personal space, and to recognize and respect the child's indication of comfort or discomfort.

A. In addition, the following criteria be met before visitation can be initiated:

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

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

3. The offender accepts responsibility for the abuse;

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

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

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

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

8. The clarification process is complete;

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

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

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

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

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

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

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

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

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

4. Special consideration should be given when selecting visitation supervisors. The visitation supervisor shall have some relationship with the child, be fully aware of the offense history including patterns associated with grooming, coercion, and sexual behaviors and be capable and willing to report any infractions and risk behaviors to the community supervision team

members. If the supervisor is not known to the child, then the child's current caregiver should be available. The potential supervisor must complete training addressing sexual offending and safe and effective visitation supervision.

7. Referrals for sex offense specific evaluations.

When an alleged sexual offender is referred for evaluation and assessment, the referral should be to an evaluator/provider who meets the *Standards* for the evaluation of sex offenders. (Section 16-11.7-106 C.R.S requires the Department of Human Services to refer *convicted* sex offenders to evaluators who meet these *Standards*.) However, such an evaluation often will not take the place of the sex offense-specific evaluation required at the pre-sentence investigation, if the individual is convicted in a criminal case.

8. Forwarding of child protection services reports to the pre-sentence investigator.

In cases where the report of an intra-familial sexual assault results in a conviction, the child protection agency should provide the probation department, upon request and with a signed release of information by the offender, with copies of the intake report and the sex offense-specific evaluation in time for the court date.

9. Pre-trial conditions.

With the exception of offense-specific treatment requirements, bond supervision conditions should be similar to the specialized conditions of probation or parole, particularly the prohibition of contact with the alleged victim and, if the victim is a child, with the alleged victim and all other children.

Appendix A
RISK ASSESSMENT

Risk assessment refers to an evaluation of the client's overall risk of sexual re-offense. Risk assessments are typically done as part of the evaluation but should reoccur regularly throughout treatment and post-treatment if legal supervision continues.

The following factors should be reviewed in estimating a client's level of risk:[21]

A. Admission of offenses
   1. Level of denial vs. omission about referral offense
   2. Level of denial vs. omission about past offenses
   3. Admission of undocumented offenses
   4. Disclosure of detail not on record and degree of consistency between self-reports and victim statements*

B. Accountability *
   1. Degree of personal responsibility for offenses assumed
   2. Degree of disowning behaviors
   3. Degree of cognitive distortions to justify the offenses
   4. Assumes responsibility for the after effects of offense on the victim

C. Cooperation
   1. Overall attitude in evaluation process
   2. Willingness to divulge information
   3. Actively participates in interview
   4. Presence or absence of passive-aggressive or covert resistance

D. Offense history and victim choice
   1. Number of offenses/length of time offending
   2. Number of victims
   3. Male, female, or dual gender choice of victims
   4. Type of offenses and escalation pattern
   5. Age/vulnerability of target victims
   6. Violence, sadism, or physical harm in offending
   7. Age of onset of deviant arousal/behaviors *
   8. Nature and extent of coercion and manipulation to gain victim compliance during offense and regarding non-disclosure. *
   9. Offender's intended outcome and desired response from victim. *

E. Sexual deviancy and arousal pattern
   1. Frequency of deviant fantasies
   2. Frequency of masturbation to deviant fantasies
   3. Assessment of response to fantasy content and level of deviance

[21] This list of risk assessment factors is adapted from the "adult sexual offender assessment packet", published by the safer society press, Brandon, VT.

* Any modifications to the original are noted by an asterisk.

4. Frequency of masturbation to non-abusive fantasies *
5. Arousal to violence or sadism
6. Presence of sexual dysfunction
7. Use of pornography/seeking sexualized atmospheres
8. Results of phallometric measures
9. Practicing responsible sexual behavior
10. Connects sexuality with caring relationship

F. Social Interest
1. Level of general victim empathy
2. Empathy for own victims
3. Expressions of awareness and authentic regret regarding abusive traumatic and/or harmful nature of behavior to victim(s) and others *
4. Range and congruence of affective expression *
5. Expressions of guilt regarding victim harm *
6. Responds in a pro-social manner to social interaction *

G. Lifestyle Characteristics
1. Degree of antisocial behavior (victimizing, control seeking, exploits others, criminal thinking, etc.)
2. Degree of narcissistic behavior (grandiose, egocentric, demanding, inconsiderate)
3. Degree of borderline behavior (impulsive, erratic, markedly moody, possessive, unstable relationships, etc.)
4. Degree of schizoidal behavior (avoidant, flat affect, withdrawn, lacking social skills)
5. Attachment style *
6. Degree of sexualization of relationships *

H. Psychopathology *
1. Psychotic episodes *
2. Frequency and lethality of suicidal ideation *
3. Personality disorder *
4. Affective disorder *
5. Obsessive/compulsive disorder *
6. PTSD symptoms *
7. Other concurrent psychiatric diagnosis *

I. Developmental Markers *
1. Competency *
2. Deficits *
3. Resilience *
4. Organicity *

J. Substance abuse and other addictive patterns *
1. Alcohol use/abuse pattern, duration, treatment
2. Other drug (legal or illegal) use/abuse pattern, duration, treatment
3. Connection between substance abuse and offenses

K. Criminal History
1. Extent of documented/undocumented criminal history
2. Type/number of criminal offenses
3. Violence history

4. Ritualistic and/or bizarre bases for offenses
5. History of childhood or adolescent delinquency *

L. Prior treatment history *
1. Success/failure of prior sex offense specific treatment*
2. Success/failure of prior non-sex offense specific treatment (may be psychotherapy or pharmacological treatment)*
3. Attitude about prior treatment*

M. Social support systems
1. Degree of functional social skills
2. Presence/absence of social relationships
3. Type and quality of relationships
4. Presence of dysfunctional relationships
5. Relationships supporting denial or minimization of offending
6. Problems and stresses within support system relationships

N. Overall control and intervention
1. Understanding of deviant cycle
2. Understands triggers and cues
3. Demonstrates motivation to avoid and interrupt cycle
4. Demonstrates ability to avoid and interrupt cycle
5. Recognizes thinking errors
6. Actively corrects thinking errors as they arise
7. Has replacement behaviors
8. Controls inappropriate sexual behavior

O. Motivation for treatment and recovery
1. Over concern with prison/legal consequences
2. Superficial motivations
3. Presents facade v. genuine, authentic presentation
4. Level of commitment to stop own offending
5. Willingness to complete any needed treatment/recovery tasks

P. Self-structure
1. Base of self worth *
2. Ways to get self worth *
3. Self esteem *
4. Level of confidence
5. Lacks sense of inferiority
6. Ability to appropriately cope with failures

Q. Disowning behaviors
1. Level of defensiveness
2. Projects blame
3. Displacement of anger
4. Irrational beliefs
5. Criminal thinking distortions

Appendix B-1
THE USE OF PHYSIOLOGICAL MEASUREMENTS

From the Ethical Standards and Principles for the Management of Sexual Abusers, the Association for the Treatment of Sexual Abusers.

CONSIDERATIONS FOR PENILE PLETHYSMOGRAPHY AND POLYGRAPHY

Based on the potential unreliability of self-report among sexual abusers, the use the phallometry and polygraphy has become widespread in the identification, treatment and management of sexual abusers. Several studies have linked the history of sexually deviant behavior and deviant sexual arousal to risk and recidivism. Therefore, instruments that promote the collection of data in these areas are deemed to have significant clinical value. However, with any psychophysiological instrument, care must be taken to avoid misuse or over reliance on the instrument, procedure or the resulting data. Clinicians using polygraphy or phallometry must be aware of the limitations of the instruments and current methodology. Clinicians should also be knowledgeable about the current research regarding interpretation and validity.

A) Informed consent should always be obtained prior to engaging clients in a physiological assessment.

B) Neither of the physiological assessments is appropriate for determination of guilt or innocence related to a specific crime.

C) Neither of the physiological assessments should be used as the sole criterion to determine a client's release from prison and/or a treatment program.

D) Physiological measurements should always be used in conjunction with other data including police reports, victim statements and other psychometric testing and should not be used as the only means to assess sexual abusers.

E) Physiological assessments should only be conducted by specifically trained clinicians and examiners. These professionals should maintain membership in appropriate professional organizations and participate in regular relevant continuing educational opportunities. The examiners should adhere to the established practices, ethics and standards of their respective fields and professional organizations.

F) In order to promote the advancement and efficacy of physiological measures with sexual abusers, professionals engaged in either polygraphic or plethysmographic examinations with sexual abusers should have specific training in the dynamics and assessment of sexual abusers.

G) Physiological assessments should only be conducted with the appropriate instruments and by using accepted procedures and methodologies.

H) Physiological assessment data can be helpful in confronting a client who denies deviant sexual behavior, deviant sexual fantasies and/or deviant sexual arousal.

I) Physiological assessments are useful in monitoring treatment compliance and progress. Methods such as electronic surveillance, drug testing, support group reports, and probation/parole supervision can be used to corroborate information gained from the physiological test results.

J) Failure to respond during physiological testing occurs for several reasons including intentional response suppression. A variety of medications, mental illnesses and physical conditions can also impact assessment results. Pre-test interviews should include questions regarding medical and psychological conditions.

K) Some individuals may not test accurately on a variety of psychometric and physiological measurements. Individuals who are severely developmentally disabled, anti-social, psychotic, experiencing current dissociative symptoms, severely depressed or under extreme stress should be carefully screened prior to being assessed and, if assessed, caution should be used when interpreting the physiological test results.

L) As part of the determination to use physiological assessment with juveniles, clinicians should be able to clearly justify and explain the reasons for incorporating the procedure(s) to parents or legal guardians.

Appendix B-2
PLETHYSMOGRAPH EXAMINATION

From the Ethical Standards and Principles for the Management of Sexual Abusers, the Association for the Treatment of Sexual Abusers.

The purpose of the phallometric assessment of sexual arousal is to provide objective data regarding sexual preferences. It may also promote self disclosure and reduce minimization and denial of sexual offenses. Additionally, it can assist in monitoring changes in sexual arousal patterns which have been modified by treatment.

1. **USES**
   - Physiological assessment can be used to identify the need to reduce and control deviant sexual arousal.

2. **LIMITATIONS**
   - Phallometric assessment data should not be used as a sole measure to predict risk of engaging in deviant sexual behavior.
   - Failure to develop significant responses to deviant sexual themes cannot be used to demonstrate innocence of a specific allegation of sexually deviant behavior.
   - Development of significant arousal to deviant themes cannot be used to demonstrate guilt of a specific allegation of sexually deviant behavior.
   - It is inappropriate to use erection responses to determine or make statements about whether or not someone has engaged in a specific sexual behavior or whether someone fits the "profile of a sexual abuser."
   - Extreme caution should be used in interpreting erection responses to non-standardized sets of stimuli.

3. **JUVENILES**
   - Phallometry should only be used with juveniles younger than 14 years of age when the clinician needs more information than is currently available via other, more traditional sources.
   - For individuals under the age of 14, or for those who may not have attained the maturational level associated with puberty, clinicians should seek interdisciplinary or institutional review of the physiological procedures.
   - Use of phallometric assessment with prepubertal youth is not recommended.
   - The relationship between phallometric arousal and clinical characteristics appears weaker in an adolescent population than in an adult population. Caution should be used in interpreting adolescent data in a manner parallel to that of adult data.
   - Adolescents appear more fluid in their sexual interests and patterns of behavior than adults and may not show as high a degree of correspondence between measured arousal patterns and reported offense histories.

4. **DEVELOPMENTALLY DELAYED**
   - Although there is an absence of empirically based data, clinical impressions indicate that a higher percentage of developmentally delayed clients tend to respond with uniformly high arousal. Therefore, the arousal profile is not necessarily indicative of sexual arousal to the described behavior or a reflection of deviant arousal.

- Developmentally delayed clients may respond to the sexual words and/or to the tone of voice used rather than the content of the description.
- Developmentally delayed clients may have more difficulty accurately perceiving visual stimuli.
- In spite of these limitations, phallometric assessments can offer valuable information to those service providers working with the developmentally delayed population.

5. **PRELIMINARY PROCEDURES**
   - The examiner should gather supportive information, such as marital and family history, criminal history, present life situation, legal status, sexual history, mental health contacts, and the reason for referral.
   - It is the responsibility of the examiner to screen the client for contamination factors, such as drug use, medication, last sexual activity, emotional state, physical impairment, etc.
   - Prior to the examination, the examiner should take steps to ensure that the examination will not be interrupted.
   - No client with an active sexually transmittable disease or parasite should be tested. The client should sign a disclaimer of any knowledge of a current sexually transmitted disease.

6. **LEGAL CONCERNS/INFORMED CONSENT**
   - Consent forms regarding the penile plethysmograph procedure should be read, signed, and dated by the client.

     Discussion: The Standards in this document require informed assent.

   - When plethysmography is used with persons under the age of 15, this procedure should be reviewed by a community or institutional advisory group.

     Discussion: The Standards in this document apply only to adult sex offenders; however, if plethysmography is indicated for any adult deemed incompetent to give the informed assent required in the Standards due to developmental disabilities or learning disabilities, the procedure regarding review by a community or institutional advisory group (or the court) should be applied.

   - Release forms allowing for both the receipt and dissemination of information should be obtained.
   - Raw data forms must provide information for retrieval of specific stimulus materials that were used in the assessment.

7. **LAB EQUIPMENT**
   - Plethysmograph equipment should provide either continuous chart paper readout or, with computerized equipment, a printed readout of response levels to each stimulus.
   - Equipment should be used as designed. See users' documents.
   - An armchair or lounge chair with cleanable surface must be provided. A reclining lounge chair is preferable.
   - A disposable cover on the chair seat and on the arms of chair is required for each client.
   - Mercury-in-rubber, Indium-gallium, or Barlow gauges may be used and each gauge must be tested and calibrated before each use. Documentation of gauge calibrations should be provided.
   - A calibration device or cone is required in ½ cm increments with a minimal range of 6 cm.
   - Security devices must ensure client's privacy, but must also include emergency entrance and exit with the safety of the client in mind.
   - Slide projector for visual material should be capable of projecting images spanning a 35 degree visual angle.

- An intercom system should be used to provide communication between client and examiner.
- Clinician must have a protocol for fitting gauges, trouble-shooting equipment, breakdowns, and malfunctions.
- Plethysmograph equipment should be used as designed, according to the user documents.
- The penile plethysmograph should be isolated from AC with a DC converter.

8. **LAB SETTING AND CLIENT SPACE REQUIREMENTS**
   - Client space must be separated from the clinician's work area by at least an opaque partition that is a minimum of 7 feet high, to ensure client's privacy. A stationary wall is preferred to maintain maximum privacy.
   - Client space is recommended to be approximately 7 feet by 8 feet in dimension. The minimal requirement for this space is 4 feet by 6 feet.
   - An intercom system must be used when the client is in a stationary enclosure.
   - A constant room temperature must be maintained between 76-80 degrees Fahrenheit.
   - The client room should have adequate ventilation; adjustable lighting is desirable.
   - Sound-deadening measures should be used in order to ensure that the client's space is as sound-proof as possible.
   - Security measures must be provided for the laboratory and stimulus material.
   - It is recommended that a system be devised for the examiner to be able to determine when and if the client is attending to the stimuli being presented.
   - The door separating the client room from the examiner's work area should have an inside lock that the client can control.

9. **CALIBRATION PROCESS**
   - The strain gauge must be stretched adequately to obtain continuous variation. The mercury gauge requires 20% (slightly stretched on the cone) of its full scale. The Barlow gauge also requires moderate stretching.
   - The stretched gauge is then placed on a cone allowing measurement of at least ½ centimeter increments. The gauge is moved down the cylinder until 3 cm of stretch is obtained (6 steps). This should be considered 100%, and sensitivity is then set on the plethysmograph.
   - The steps are then checked for linearity (each step on the cone equals proportionate steps on the plethysmograph). If a variation of greater than 25% occurs between steps, the process should be repeated. If a 25% or greater variation remains, discard the gauge and repeat the process.
   - If linearity cannot be obtained with multiple gauges, the plethysmograph is not functioning properly.
   - If the first or last step of the calibration procedure yields 25% or greater variation, the gauge was not fitted properly to the circumference device, or the gauge is faulty.
   - After the gauge is fitted to the client and adequate time has elapsed for detumescence, the sensitivity should be set at the "0" point.
   - At the completion of the assessment process, if the client achieved a full erection, then that level of change becomes 100%.
   - The penile plethysmograph should be calibrated.
   - Prior to each assessment, gauges should be calibrated over a minimum of six steps using an accurate calibration device.
   - Care should be exercised to avoid rolling the gauge while placing on the calibration cone.

10. **FITTING THE PENILE TRANSDUCER**
    - Placement of the gauge should be at midshaft of the penis.
    - Client should place gauge on his own penis.

- Examiner should assure that wiring has some slack next to the transducer or clinical error may result. Clothing should not touch penis or transducer.
- Recording of full penile tumescence should be obtained whenever possible. The examiner should ensure that sufficient arousal has been recorded to accurately interpret data. When data is to be interpreted as a percentage of full erection, it is important to request the client to achieve full erection.
- The client should be instructed to exercise care to avoid rolling the gauge while placing it on his penis.
- Proper fit can be determined by:
  a) Setting the plethysmograph at zero before the client places the gauge on his penis.
  b) Ensuring the gauge has stretched at least 20% after being placed on the penis.
  c) Ensuring the gauge has not stretched more than 40%.
- If the gauge has stretched more than 40%, the gauge is too small. If the gauge has stretched less than 20%, the gauge is too big.
- After proper fit has been determined, the plethysmograph is reset to zero.

11. **STIMULUS MATERIAL**
- The examiner will have available a range of sexual stimulus material depicting various Tanner Stages of development for both males and females, including culturally diverse subject material. Stimulus materials should also be available to differentiate between consenting, coercive, forcible, sadistic and aggressive themes with both adults and children.

Visual Stimuli
- Efforts should be made to use new technology which does not make use of human subjects.
- Visual stimuli should be devoid of distracting stimuli.
- Multiple stimulus presentations should be used for each Tanner stage.
- Both sexes should be represented.
- Stimulus duration should be consistent with research that has demonstrated validity.
- The examiner should be satisfied detumescence has occurred and at least thirty seconds have elapsed before presenting new stimulus.

Audio Stimuli
- Audio stimuli should be sufficient to clearly differentiate minors from adults.
- Stimuli should clearly differentiate consenting, coercive, forcible, sadistic and aggressive sexual themes.
- Every effort should be made to use standardized stimuli reflecting the client's deviant sexual behavior.
- Multiple stimuli presentations representing various normal and deviant sexual activity should be available.

12. **DOCUMENTING ASSESSMENT DATA**
- Physiological assessments should be interpreted only in conjunction with a comprehensive psychological examination.
- Written reports may include:
  a) A description of the method for collecting data.
  b) The range of physiological responses exhibited by client.
  c) Any indication of suppression or falsification.
  d) An indication of the validity of the data and validity controls used.
  e) The types of stimulus materials used.
  f) Summary of highest arousal in each category.

g) Client emotional state.
h) Level of client cooperation.
i) Interpretation of data.
j) Any confounding physical or emotional inhibitors to sexual arousal.

13. **DISINFECTANT PROCEDURES**

- Gauges will be disinfected prior to use, utilizing an accepted liquid immersable or other accepted laboratory disinfection procedures.
- A disposable covering will be used for protection over the chair seat and arms of the chair.
- Client will place gauge in receptacle after use of the gauge and before leaving the testing room. Client will also dispose of protective coverings before leaving testing room.
- Clinician should use disposable gloves and anti-bacterial soap after contact with gauges. Any items or articles that have been in contact with the client should also be disinfected.

ATTACHMENT A: COLORADO DEPARTMENT OF CORRECTIONS POLYGRAPH SANCTIONS GRID

DURING THE POLYGRAPH EXAM

ADMISSIONS DURING THE POST TEST

		Admissions Prior to Pretest **1** Admission in sexual history addendum and/or other addendum	**Admissions During Pretest** **2** Admissions to the polygraph examiner during the pretest interview	**Admissions to Non-deceptive / Post test** **3** Admissions during post test; all responses must be non-deceptive, or inconclusive	**Admissions to Deception / Post Test** **4** Admissions of related behavior during post test with at least one deceptive response	**No Admissions to Deception** **5** No admissions / explanations not related to the behavior during the post test
P A S T	**<u>PAST</u> Behavior: Offenses / High Risk** **A** Behavior that occurred before being placed under community supervision and/or treatment	Behavior(s): None	Behavior(s): None	Behavior(s): Low	Behavior(s): Moderate	Behavior(s): Moderate
P R E S E N T	**<u>PRESENT</u> New High Risk Behaviors & Behavior Lapses** **B** New offense cycle behavior that occurs after placement in community supervision and/or treatment	Behavior(s): Low	Behavior(s): Low	Behavior(s): Low	Behavior(s): Moderate	Behavior(s): High
	<u>PRESENT</u> New Major Violations **C** New behavior that violates the rules after being placed on community supervision and/or treatment	Behavior(s): Moderate	Behavior(s): Moderate	Behavior(s): High	Behavior(s): High	Behavior(s): Severe
	<u>PRESENT</u> New Offenses (or refused Exams) **D** Felony or misdemeanor offenses after being placed on community supervision and/or treatment	Behavior(s): Severe	Behavior(s): Severe	Behavior(s): Severe	Behavior(s): Severe	Behavior(s): Severe

IF SANCTIONING AT A HIGHER LEVEL THAN INDICATED ON THE GRID, PLEASE FILL OUT THE SANCTIONS OVERRIDE SECTION

ATTACHMENT A: FAILED POLYGRAPH SANCTIONS

<u>Purposeful</u> non-cooperation will result in a re-test paid by the offender within 30 days.

Please circle the sanction(s) employed and the sanctions that <u>would</u> have been employed if available in the offender's jurisdiction:

LOW:

YES	UNAVAILABLE	POLYGRAPH IN 3 TO 6 MONTHS – OFFENDER PAYS
YES	UNAVAILABLE	ADDITIONAL HOMEWORK
YES	UNAVAILABLE	CURFEW OR GEOGRAPHICAL RESTRICTIONS
YES	UNAVAILABLE	ADDITIONAL COLLATERAL CONTACTS
YES	UNAVAILABLE	CONTACT WITH OFFENDER'S SUPPORT NETWORK TO DISCUSS EXAM
YES	UNAVAILABLE	START UA'S OR INCREASE FREQUENCY
YES	UNAVAILABLE	ANTABUSE AND / OR SOBRIETER
YES	UNAVAILABLE	INCREASE TREATMENT CONTACTS (INDIVIDUAL OR FAILED POLYGRAPH GROUP)
YES	UNAVAILABLE	OTHER:_____

MODERATE:

YES	UNAVAILABLE	POLYGRAPH RE-TEST FREQUENCY INCREASED (OFFENDER PAY)
YES	UNAVAILABLE	INCREASED TREATMENT CONTACTS (INDIVIDUAL/FAILED POLYGRAPH GROUP)
YES	UNAVAILABLE	INCREASED PROBATION VISITS
YES	UNAVAILABLE	STAFFING WITH PO, THERAPIST AND OFFENDER (OFFENDER PAYS)
YES	UNAVAILABLE	ADDITIONAL HOMEWORK
YES	UNAVAILABLE	COMMUNITY SERVICE
YES	UNAVAILABLE	DRUG / ALCOHOL TREATMENT, DOMESTIC VIOLENCE, OR ANGER MANAGEMENT
YES	UNAVAILABLE	SEARCH RESIDENCE (IF REASONABLE GROUNDS EXIST)
YES	UNAVAILABLE	NO TRAVEL PERMITS FOR VACATION
YES	UNAVAILABLE	NO COMMUNITY ACTIVITIES
YES	UNAVAILABLE	SPECIFIC SAFETY PLANS FOR COMMUNITY ACTIVITIES
YES	UNAVAILABLE	ELECTRONIC HOME MONITORING (EHM) OR PAGER
YES	UNAVAILABLE	ACCOUNTABILITY AND CONTACT LOGS
YES	UNAVAILABLE	CURFEW
YES	UNAVAILABLE	INCREASE MONITORING & FIELD CONTACTS
YES	UNAVAILABLE	NO COMPUTER / INTERNET
YES	UNAVAILABLE	NO DRIVING
YES	UNAVAILABLE	I.D. SELF –CLOTHES OR CAR

YES UNAVAILABLE CONTRIBUTION TO A VICTIMS PROGRAM
YES UNAVAILABLE DAY REPORTING
YES UNAVAILABLE TECHNICAL VIOLATION BOARD
YES UNAVAILABLE OTHER: _____

HIGH:

YES UNAVAILABLE INCREASE SUPERVISION LEVEL
YES UNAVAILABLE INCREASE SUPERVISION TO ISP
YES UNAVAILABLE CONTACT LAW ENFORCEMENT FOR SURVEILLANCE
YES UNAVAILABLE SUMMONS TO COURT
YES UNAVAILABLE TECHNICAL VIOLATION BOARD
YES UNAVAILABLE POLYGRAPH RE-TEST FREQUENCY INCREASED (OFFENDER PAYS)
YES UNAVAILABLE COMMUNITY SERVICE
YES UNAVAILABLE WORKENDERS (JAIL SERVICE)
YES UNAVAILABLE EHM OR PAGER
YES UNAVAILABLE CURFEW WITH DAILY SCHEDULE CALL IN
YES UNAVAILABLE NO COMPUTER / INTERNET
YES UNAVAILABLE I.D. SELF --- CLOTHES OR CAR
YES UNAVAILABLE NO TRAVEL PERMITS
YES UNAVAILABLE NO DRIVING
YES UNAVAILABLE COMBINATION OF LOW & MODERATE SANCTIONS
YES UNAVAILABLE OTHER: _____

SEVERE:

YES UNAVAILABLE COMPLAINT WITH ARREST WARRANT
YES UNAVAILABLE COMPLAINT WITH SUMMONS
YES UNAVAILABLE MOVE FROM HOME
YES UNAVAILABLE EHM OR PAGER
YES UNAVAILABLE MORE INTENSIVE TREATMENT / ACCOUNTABILITY PROGRAM
YES UNAVAILABLE DAY REPORTING
YES UNAVAILABLE HOME LOCKDOWN
YES UNAVAILABLE COMBINATION OF LOW, MODERATE & HIGH SANCTIONS
YES UNAVAILABLE OTHER: _____

Therapist: _____ **Polygraph Examiner:** _____

Probation Officer: _____ **Date form Complete: _____/_____/_____**

Probationer: _____

ATTACHMENT A: SANCTIONS OVERRIDE

(Please Mark Only One Result)

_____ Multiple similar violations and / or deceptions to high risk behaviors or offenses.
(OVERRIDE TO NEXT HIGHEST SANCTIONS)

_____ History of sadistic or lethal behavior / offenses.
(OVERRIDE TO THE NEXT HIGHEST SANCTIONS)

_____ Sabotage exam.
(OVERRIDE TO THE NEXT HIGHEST SANCTIONS)

_____ No probable cause for remediation or arrest.
(OVERRIDE TO THE NEXT HIGHEST SANCTIONS)

_____ Other: _____
(OVERRIDE TO THE NEXT HIGHEST SANCTIONS)

EXAM QUESTIONS:

Question 1: _____

_____

_____ **Non-deceptive / Deceptive / Inconclusive / Sabotage**

Question 2: _____

_____

_____ **Non-deceptive / Deceptive / Inconclusive / Sabotage**

Question 3: _____

_____

_____ **Non-deceptive / Deceptive / Inconclusive / Sabotage**

Question 4: _____

_____

_____ **Non-deceptive / Deceptive / Inconclusive / Sabotage**

FOLLOW-UP QUESTIONS:

Question 1: _____

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Question 2: _____

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Question 3: _____

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Question 4: _____

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ATTACHMENT A: POLYGRAPH SANCTION GRID – USE INSTRUCTIONS

1) **LOOK FOR ADMISSIONS MADE DURING THE PRETEST INTERVIEW.**
   - IF THE ADMISSION IS TO BEHAVIOR BEFORE BEING PLACED ON PROBATION, START AT THE ROW ON THE SANCTIONS GRID THAT IS LABELED **"PAST"** AND DETERMINE WHICH BOX IN THAT ROW BEST APPLIES.
   - IF THE ADMISSION IS TO BEHAVIOR SINCE BEING PLACED ON PROBATION, GO TO THE THREE ROWS THAT ARE LABELED **"PRESENT"** AND DETERMINE WHICH BOX IN THOSE AREAS BEST APPLIES BASESD ON THE TYPE OF BEHAVIOR AND WHEN (IF ANY) ADMISSIONS WERE MADE.

2) **IF THE QUESTIONS ARE DISCLOSURE OR SPECIFIC ISSUE REGARDING A PRIOR BEHAVIOR,** BEFORE BEING PLACED ON PROBATION, GO TO THE ROW THAT IS LABELED **"PAST"** AND DETERMINE WHICH BOX APPLIES BASED ON THE TYPE OF BEHAVIOR AND WHEN (IF ANY) ADMISSIONS WERE MADE.

3) **IF THE QUESTIONS ARE SPECIFIC ISSUE OR MONITORING BEHAVIOR** SINCE THE LAST POLYGRAPH, OR SINCE BEING PLACED ON PROBATION, GO TO THE ROWS THAT ARE LABELED **"PRESENT"** AND DETERMINE WHICH BOX APPLIES BASED ON THE TYPE OF BEHAVIOR AND WHEN (IF ANY) ADMISSIONS WERE MADE.

4) **MARK THE APPROPRIATE BOX AND DETERMINE THE LEVEL OF SANCTION TO BE APPLIED (NO SANCTION TO SEVERE).**

5) **PICK THE APPROPRIATE SANCTION(S) FROM THE FAILED POLYGRAPH SANCTIONS LIST (PAGES 3, 4 and 5) AND HAVE THE DEFENDANT SIGN THE SANCTION SHEET.**

6) **DETERMINE THE AREAS THAT YOU NEED TO COVER IN THE POLYGRAPH.** THE COMMUNITY SUPERVISION TEAM SHOULD WORK ON THIS. THE POLYGRAPHER HAS THE FINAL CALL AS TO WHETHER OR NOT A QUESTION IS APPROPRIATE.

7) **IF THE OFFENDER FAILS THE POLYGRAPH,** THE NEXT POLYGRAPH SHOULD BE DONE WITHIN 3 MONTHS AND THE QUESTIONS SHOULD BE DESIGNED TO ADDRESS THE DECEPTIVE OR INCONCLUSIVE AREAS.

8) **FOR RESEARCH PURPOSES,** ON MAINTENANCE POLYGRAPHS, THE POLYGRAPH THAT IS SET IN 6 MONTHS SHOULD ASK THE SAME QUESTIONS AS THE FAILED POLYGRAPH BUT COVER THE TIME PERIOD FROM WHEN SANCTIONS WERE APPLIED TO THE CURRENT TIME. DISCLOSURE AND SPECIFIC ISSUE POLYGRAPHS THAT ARE FAILED CAN BE RETAKEN AT ANY TIME AFTER SANCTIONS ARE APPLIED.

IF SANCTIONING AT A HIGHER LEVEL THAN INDICATED ON THE GRID, PLEASE FILL OUT THE SANCTIONS OVERRIDE FORM.

ATTACHMENT B: COLORADO DEPARTMENT OF CORRECTIONS POLYGRAPH SANCTIONS GRID

DURING THE POLYGRAPH EXAM

ADMISSIONS DURING THE POST TEST

		Admissions Prior to Pretest **1** Admission in sexual history addendum and/or other addendum	**Admissions During Pretest** **2** Admissions to the polygraph examiner during the pretest interview	**Admissions to Non-deceptive / Post test** **3** Admissions during post test; all responses must be non-deceptive, or inconclusive	**Admissions to Deception / Post Test** **4** Admissions of related behavior during post test with at least one deceptive response	**No Admissions to Deception** **5** No admissions / explanations not related to the behavior during the post test
PAST	**<u>PAST</u> Behavior: Offenses / High Risk** **A** Behavior that occurred before being placed under community supervision and/or treatment	Behavior(s): None	Behavior(s): None	Behavior(s): Low	Behavior(s): Moderate	Behavior(s): Moderate
PRESENT	**<u>PRESENT</u> New High Risk Behaviors & Behavior Lapses** **B** New offense cycle behavior that occurs after placement in community supervision and/or treatment	Behavior(s): Low	Behavior(s): Low	Behavior(s): Low	Behavior(s): Moderate	Behavior(s): High
	<u>PRESENT</u> New Major Violations **C** New behavior that violates the rules after being placed on community supervision and/or treatment	Behavior(s): Moderate	Behavior(s): Moderate	Behavior(s): High	Behavior(s): High	Behavior(s): Severe
	<u>PRESENT</u> New Offenses (or refused Exams) **D** Felony or misdemeanor offenses after being placed on community supervision and/or treatment	Behavior(s): Severe	Behavior(s): Severe	Behavior(s): Severe	Behavior(s): Severe	Behavior(s): Severe

IF SANCTIONING AT A HIGHER LEVEL THAN INDICATED ON THE GRID, PLEASE FILL OUT THE SANCTIONS OVERRIDE SECTION

ATTACHMENT B: FAILED POLYGRAPH SANCTIONS

Please circle the sanction(s) employed and the sanctions that <u>would</u> have been employed if available in the offender's jurisdiction:

LOW:

YES	UNAVAILABLE	**ADDITIONAL HOMEWORK**
YES	UNAVAILABLE	NO EARNED TIME
YES	UNAVAILABLE	INCREASE TREATMENT CONTRACTS
YES	UNAVAILABLE	CURFEW OR GEOGRAPHICAL RESTRICTIONS
YES	UNAVAILABLE	ADDITIONAL COLLATERAL CONTACTS
YES	UNAVAILABLE	CONTACT WITH THE OFFENDER'S SUPPORT NETWORK TO DISCUSS EXAM
YES	UNAVAILABLE	**INCREASE FREQUENCY OF UA'S**
YES	UNAVAILABLE	**SEXUAL HISTORY/TC ADDENDUM**
YES	UNAVAILABLE	**$3.00 CO-PAY FOR POLYGRAPH EXAMINATION**
YES	UNAVAILABLE	**ONE DAY LOSS OF EARNED TIME**
YES	UNAVAILABLE	OTHER:_____**(STAFF APPROVED)**

MODERATE:

YES	UNAVAILABLE	INCREASE PAROLE OFFICE VISITS
YES	UNAVAILABLE	**SPECIFIC ISSUE POLYGRAPH (30-60 DAYS)**
YES	UNAVAILABLE	PAROLEE PAYS FOR SPECIFIC ISSUE EXAM WITHIN 90 DAYS
YES	UNAVAILABLE	**ATTEND SEXAHOLICS ANONYMOUS/NA/AA GROUPS**
YES	UNAVAILABLE	**TC COMMUNITY SERVICE**
YES	UNAVAILABLE	ADDITIONAL PAROLE DIRECTIVES
YES	UNAVAILABLE	STAFFING BY TREATMENT TEAM PAID BY OFFENDER
YES	UNAVAILABLE	**OFFENDER REGRESSED ONE TREATMENT LEVEL**
YES	UNAVAILABLE	NO EARNED TIME
YES	UNAVAILABLE	ADDITIONAL HOMEWORK
YES	UNAVAILABLE	**OFFENDER WILL NOT BE RECOMMENDED FOR COMMUNITY CORRECTIONS OR PAROLE**
YES	UNAVAILABLE	**RATIONAL RECOVERY SUPPORT GROUP**
YES	UNAVAILABLE	**INITIATE SEARCH OF RESIDENCE OR CELL**
YES	UNAVAILABLE	**CONTACT SUPPORT NETWORK**
YES	UNAVAILABLE	**ATTEND L.O.P. GROUP**
YES	UNAVAILABLE	**PROBATION (ORANGE VEST)**
YES	UNAVAILABLE	**LOSS OF PROGRAM PRIVILEGES**
YES	UNAVAILABLE	**OFFENDER PLACED WITH TC SUPPORT TEAM**

YES UNAVAILABLE **TWO DAYS LOSS OF EARNED TIME**
YES UNAVAILABLE RE-MEDIATION FOR COMMUNITY CORRECTIONS INMATE
YES UNAVAILABLE REGRESSION FOR COMMUNITY CORRECTIONS INMATE
YES UNAVAILABLE OTHER:_____**(STAFF APPROVED)**

HIGH:

YES UNAVAILABLE INCREASE SUPERVISION TO ISP
YES UNAVAILABLE CONTACT LAW ENFORCEMENT FOR SURVEILLANCE
YES UNAVAILABLE INCREASE CLASSIFICATION OF SUPERVISION LEVEL
YES UNAVAILABLE SUMMONS TO PAROLE BOARD IF PROBABLE CAUSE OF PAROLE VIOLATION
YES UNAVAILABLE POLYGRAPH RE-TEST FREQUENCY INCREASED (OFFENDER PAYS)
YES UNAVAILABLE OFFENDER PLACED ON TREATMENT PROBATION
YES UNAVAILABLE **OFFENDER PLACED ON "ON NOTICE"**
YES UNAVAILABLE **OFFENDER REGRESSED ONE TREATMENT LEVEL**
YES UNAVAILABLE RE-MEDIATION FOR COMMUNITY CORRECTIONS INMATE
YES UNAVAILABLE REGRESSION FOR COMMUNITY CORRECTIONS INMATE
YES UNAVAILABLE **THREE DAYS LOSS OF EARNED TIME**
YES UNAVAILABLE OTHER:_____**(STAFF APPROVED)**

SEVERE:

YES UNAVAILABLE **TERMINATION FROM TREATMENT – NONCOMPLIANT**
YES UNAVAILABLE **LOSS OF FACILITY PRIVILEGES**
YES UNAVAILABLE ARREST, IF PROBABLE CAUSE OF PAROLE VIOLATION
YES UNAVAILABLE FILE COMPLAINT OR NOTICE OF CHARGES #:_____
YES UNAVAILABLE REGRESSION FOR COMMUNITY CORRECTIONS INMATE
YES UNAVAILABLE OTHER:_____**(STAFF APPROVED)**

IF APPLICABLE:

Therapist:_____**Polygraph Examiner:**_____

Date form Complete: _____/_____/_____

THE CONSEQUENCES FOR MY PERFORMANCE ON THIS POLYGRAPH EXAMINATION HAVE BEEN REVIEWED WITH ME TO MY SATISFACTION AND I UNDERSTAND WHAT IS EXPECTED OF ME.

Signature: _____ **Date: _____/_____/_____**

ATTACHMENT B: SANCTIONS OVERRIDE

(Please Mark Only One Result)

_____ Multiple similar violations and / or deceptions to high risk behaviors or offenses.
(OVERRIDE TO NEXT HIGHEST SANCTIONS)

_____ History of sadistic or lethal behavior / offenses.
(OVERRIDE TO THE NEXT HIGHEST SANCTIONS)

_____ Sabotage exam.
(OVERRIDE TO THE NEXT HIGHEST SANCTIONS)

_____ No probable cause for remediation or arrest.
(OVERRIDE TO THE NEXT HIGHEST SANCTIONS)

_____ Other: _____
(OVERRIDE TO THE NEXT HIGHEST SANCTIONS)

EXAM QUESTIONS:

Question 1: _____

_____

_____**Non-deceptive / Deceptive / Inconclusive / Sabotage**

Question 2: _____

_____

_____**Non-deceptive / Deceptive / Inconclusive / Sabotage**

Question 3: _____

_____

_____**Non-deceptive / Deceptive / Inconclusive / Sabotage**

Question 4: _____

_____

_____**Non-deceptive / Deceptive / Inconclusive / Sabotage**

FOLLOW-UP QUESTIONS:

Question 1: _____

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Question 2: _____

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Question 3: _____

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Question 4: _____

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Appendix C
RESEARCH SUPPORTING RESTRICTED CONTACT WITH CHILDREN June 2004

The following is a summary of the research that supports the statements listed below, which are found in 5.700 of these *Standards*.

I. *"The offense for which a person is convicted is not necessarily a reliable indicator of the offender's risk to children or victims."*

A. Knopp, F.H. (1984). *Retraining Adult Sex Offenders: Methods and Models*, Brandon, VT: Safer Society Press.

Gene Abel et. al. conducted a breakthrough study in 1983 which gave us information on the frequency and variety of sexual offending behaviors sex offenders have committed. He received a federal certificate of confidentiality to study sex offenders. Individuals in this study could admit to current offending behaviors without fear that the information would be reported to law enforcement. He studied 411 sex offenders and found that on average over a twelve year period each offender had attempted 581 crimes, completed 533 crimes, had 336 victims, and committed an average of 44 crimes a year. These crimes included hands off sex offenses such as exposing, peeping and obscene phone calls. Additionally, he found that 50.6% of the rapists involved in the study had also molested children.

B. Freeman-Longo, R., Blanchard, G. (1998). *Sexual Abuse in America: Epidemic of the 21st Century*. Brandon, VT: Safer Society Press.

In 1985, Rob Freeman-Longo reported on a group of 23 rapists and 30 child molesters involved in an institutional forensic mental health sex offender program. Arrest records indicated rapists had an average of 1.9 offenses each for a group total of 43 arrests for sex offenses. The 23 rapists as a group admitted committing a total of 5090 various incidents of sex offending behaviors, which included 319 child molestations and 178 rapes. Arrest records indicated child molesters had an average of 1.5 arrests each. While in treatment, the 30 child molesters as a group admitted 20,667 offenses which included 5891 sexual assaults on children and 213 rapes on adult women.

C. Ahlmeyer, S., Heil, P., McKee, B., and English, K. (2000). The Impact of Polygraphy on Admissions of Victims and Offenses of Adult Sex Offenders, *Sex Abuse: A Journal of Research and Treatment*, Vol. 12 (2).

The Colorado Department of Corrections Sex Offender Treatment Program has found similar patterns to those reported by Gene Abel with the sex offenders participating in treatment and polygraph assessment. The program collected data in 1998 on the number of known victims of the first 36 sex offenders to participate in two polygraph evaluations. On average, for each offender there were 2 known victims documented in official records. After the first polygraph exam inmates disclosed on average 165 victims per offender. By the second polygraph exam the

same inmates, on average, disclosed 184 victims per offender. These crimes included hands-on sex offenses such as rape and pedophilia as well as hands-off sex offenses such as exhibitionism, voyeurism and obscene phone calls. Approximately 80% of these offenders were still deceptive on their polygraph examinations, suggesting that even more offenses were committed.

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Between 1995 and 2001, crossover sexual offenses were analyzed in a larger sample of 223 incarcerated and 266 paroled sexual offenders who participated in polygraph evaluations at the Colorado Department of Corrections. *The majority of incarcerated offenders admitted to sexually assaulting both children and adults from multiple relationship types. In addition, there was a substantial increase in offenders admitting to sexually assaulting victims from both genders. In a group of incarcerated offenders who sexually assaulted children, the majority of offenders admitted to sexually assaulting both relatives and nonrelatives, and there was a substantial increase in the offenders admitting to assaulting both male and female children* (Heil, et al., 2003).

1) Ahlmeyer, S. (1999). Poster Presentation at the Association for the Treatment of Sexual Abusers 18th Annual Research and Treatment Conference, Lake Buena Vista, Florida 1999.

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- It was determined that 71% of the total sample acknowledged crossing over in the age of the victims they assaulted.
- Of the offenders who were only known to have child victims in official records, 82% later admitted to also having adult victims.
- Of the offenders who were only known in official records to have adult victims, 50% later admitted to having child victims during the process of polygraph examination.

- It was determined that 51% of the sample acknowledged crossing over in the sex of the victims they assaulted.
- Of the offenders who were only known to have male victims in official records, 58% later admitted to having female victims.
- Of the offenders who were only known to have female victims, 22% later admitted to having male victims.
- It was determined that 86% of the sample acknowledged having victims in two or more of the following categories: relative, stranger, acquaintance, or position of trust.
- Of those offenders who were only known to have offended against non-relative victims, 62% admitted to also having victims who were relatives.

Again the majority of the individuals in this sample (82%) were still scoring deceptive on some areas of their polygraph evaluations, indicating that the percent of cross over may be higher than the numbers self reported by these offenders.

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In 1983, Abel et. al. studied incest offenders who had involved themselves sexually with female children. He found that 44% of these offenders had offended against unrelated female children, 11% had offended against unrelated male children, 18% had committed rapes, 18% had committed exhibitionism, 9% had engaged in voyeurism, 5% had engaged in frottage, 4% had engaged in sadism, and 21% had other paraphilias. In this study it was determined that 59% of the child molesters developed deviant sexual interest during adolescence.

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Diagnosis	Number of Subjects	Number of Paraphilias 1	2	3	4	5+
Pedophilia (non incest) female	224	15.2%	23.7%	19.2%	14.7%	27.2%
Pedophilia (non incest) male	153	19.0%	26.8%	19.6%	12.4%	22.2%
Pedophilia (incest) female	159	28.3%	25.8%	17.0%	5.7%	23.3%
Pedophilia (incest) male	44	4.5%	15.9%	20.5%	18.2%	40.9%
Rape	126	27.0%	17.5%	19.0%	12.7%	23.8%
Exhibitionism	142	7.0%	20.4%	22.5%	15.5%	34.4%
Voyeurism	62	1.6%	9.7%	27.4%	14.5%	46.8%
Obscene phone calling	19	5.3%	5.3%	21.1%	21.1%	47.5%
Public Masturbations	17	5.9%	17.6%	0.0%	17.6%	58.8%

H. Office of Research and Statistics, Division of Criminal Justice, Colorado Department of Public Safety, March 2000.

The Colorado Division of Criminal Justice (2000), under a National Institute of Justice research grant, analyzed data from 180 sex offender case files in three states that had implemented the post-conviction polygraph to varying degrees (Texas, Oregon, and Wisconsin). The sample included both probation and parole cases. Their research found that polygraph combined with treatment significantly increases the known rate of offending and crossover in sex offenders. After treatment and polygraph, nearly 9 out of 10 sex offenders who were identified as having sex offenses against adults also admitted committing sex offenses against children. Based on a file review, 35 offenders were initially identified as having victims over the age of 18. Prior to treatment and polygraph only 18 (48.6%) of these offenders were identified as having victims under the age of 18. After treatment and polygraph 80 offenders admitted to victims over the age of 18. Seventy of these 80 offenders (87.5%) also admitted to committing a sex offense against someone under the age of 18. Sixty one (76.3%) of the 80 offenders admitted to having victims age thirteen and under.

I. Tanner, J. (1999). Incidence of Sex Offender Risk Behavior During Treatment, Research Project Final Report.

In 1998, Jim Tanner conducted a research study on the polygraph results of 128 sex offenders who were under supervision and participating in offense specific treatment in the community. The sample consisted of 99 offenders with a current charge for a crime against a child and 29 offenders with a current charge for a crime against an adult. Each of the offenders had participated in one baseline and at least one maintenance polygraph examination. The study looked at the offender's behavior between the time period of the baseline polygraph and maintenance polygraph. Based on the polygraph examination results, 31% of the offenders had sexual contact with a minor during the maintenance polygraph time period. The percent of sex

offenders with a current charge for a crime against a child who admitted to or was deceptive to sexual contact with a child was 35%. The percent of sex offenders with a current charge for a crime against an adult who admitted to or were deceptive to sexual contact with a child was 17%. Since the majority of the offenders with crimes against adults were not asked on the polygraph exam whether they had sexual contact with a child, the percent who had sexual contact with a child may be under represented.

In addition, 25% of the offenders in this study had unauthorized contact with a minor. Twelve percent of the offenders had forced someone to have sex since the baseline examination. Forty one percent were engaging in new sex offense behaviors. Overall, 86% of this sample were engaging in new high risk behaviors and/or new crimes at least 18 months into treatment. On average, each offender was engaging in 2.5 different high risk behaviors.

J. Hanson, R., Harris, A. (1998). Dynamic Predictors of Sexual Recidivism, Department of the Solicitor General Canada.

In 1997, Karl Hanson and Andrew Harris conducted research on dynamic predictors of sexual reoffense. The following factors were significantly associated with reoffense: General excuses/justifications/low victim empathy, sexual entitlement, attitudes tolerant of rape, attitudes tolerant of child molesting, sees self as no risk, sexual risk factors (pornography, excessive masturbation, deviant sexual fantasies, preoccupation with sex), access to victims, and negative social influences.

K. Hindman, J. (1989). *Just Before Dawn*, Alexandria Association.

In her book, Just Before Dawn (1989), Jan Hindman cites research she conducted over 15 years involving 543 victims of child sexual abuse. She found that even in the most severe cases of sexual abuse, child victims frequently are asymptomatic. It may be years before symptoms are triggered in future developmental stages. Hindman's findings also indicate that ongoing demands for a relationship with the offender or his support system, without the benefit of significant intervention, contribute to severe and ongoing traumatic impact as the victim matures. "Sex offenders typically want to create certain elements in the sexually abusive scenario that will reduce their guilt and responsibility. Effort may be exerted to have the victim feel as though he/she has caused the offender to act inappropriately. While this attitude may help the offender rationalize the deed, it has a profound effect on the trauma bonding (continued demands for a relationship with the perpetrator or those significant to the perpetrator, interfering with the victim's capacity to resolve the abuse and feelings about the perpetrator) felt by the victim." "Even if the perpetrator was incapacitated, incarcerated or absent, the victim remained connected and in a trauma bond."

II. ***"An important aspect of ongoing risk assessment is measuring an offender's ability to comply with the requirements of treatment and supervision."***

A. Hanson, R.K., Harris, A. (1998). Dynamic Predictors of Sexual Recidivism. Department of the Solicitor General Canada. http://www.sgc.gc.ca

Karl Hanson and Andrew Harris (1998) conducted research on dynamic predictors of sexual recidivism. Data were collected for this study through interviews with supervising officers of approximately four hundred sex offenders and a review of the officers' case notes. The results indicated that both recidivists and non-recidivists were equally likely to attend sex offense specific treatment programs; however, recidivists were more likely to have dropped-out of the treatment program. In addition, officers described the non-recidivists as more cooperative with supervision than the recidivists. Recidivists were also more often disengaged from treatment and community supervision and missed more scheduled appointments than the non-recidivists.

III. ***"A growing body of research indicates most sex offenders supervised by the criminal justice system have more extensive sex offending histories, including multiple victim and offense types, than is generally identified in their criminal justice records."***

A. Knopp, F.H. (1984). *Retraining Adult Sex Offenders: Methods and Models,* Brandon, VT: Safer Society Press.

Gene Abel et. al. conducted a breakthrough study in 1983 which gave us information on the frequency and variety of sexual offending behaviors sex offenders have committed. He received a federal certificate of confidentiality to study sex offenders. Individuals in this study could admit to current offending behaviors without fear that the information would be reported to law enforcement. He studied 411 sex offenders and found that on average over a twelve year period each offender had attempted 581 crimes, completed 533 crimes, had 336 victims, and committed an average of 44 crimes a year. These crimes included hands off sex offenses such as exposing, peeping and obscene phone calls. Additionally, he found that 50.6% of the rapists involved in the study had also molested children.

B. Freeman-Longo, R., Blanchard, G. (1998). *Sexual Abuse in America: Epidemic of the 21st Century*. Brandon, VT: Safer Society Press.

In 1985, Rob Freeman-Longo reported on a group of 23 rapists and 30 child molesters involved in an institutional forensic mental health sex offender program. Arrest records indicated rapists had an average of 1.9 offenses each for a group total of 43 arrests for sex offenses. The 23 rapists as a group admitted committing a total of 5090 various incidents of sex offending behaviors which included 319 child molestations and 178 rapes. Arrest records indicated child molesters

had an average of 1.5 arrests each. While in treatment, the 30 child molesters as a group admitted 20,667 offenses which included 5891 sexual assaults on children and 213 rapes on adult women.

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I. Weinrott, M. & Saylor, M. (1991). Self-Report of Crimes Committed by Sex Offenders, *Journal of Interpersonal Violence*, 6 (3) 286-300.

Data from a self-report survey regarding past criminal behavior was analyzed from over 90 institutionalized sex offenders. Included in this sample were both rapists and child molesters who had been mandated to receive specialized treatment. Results from this study showed both high rates and varieties of non-sexual offenses, and, high rates of previously undetected sexual

aggression. In addition, the 99 sex offenders who completed the survey reported that nearly 20,000 non-sexual crimes were committed during the year prior to being institutionalized (rapists contributed to a disproportionate share).

IV. *"Research also indicates that children and victims are particularly vulnerable and are unlikely to report or re-report abuse."*

A. William Marshall has reported findings from an unpublished project conducted within child protective agencies in Ontario in the mid-1970's. The project was unsystematic in the sense that some, but not all, victims of incest over approximately a three year period were contacted. A child protective services caseworker located a number of children who had reported molestation by a relative. She found that many cases were recanted when the family did not believe the victim, or when the victim was believed but was poorly treated by family members. Once the children had been located, the caseworker asked the children if they would report the incident if they were molested again. Almost 100% answered "no". The reasons they gave included the following: Practically no one believes them when they tell or, if they do believe, they become hostile to the victim for getting the perpetrator in trouble and removing him from where he was needed; the child held him/herself responsible for the father's absence from the family; or the outcome almost always ended up being more devastating to the child than to the perpetrator. (Information presented at the Association for the Treatment of Sexual Abusers Annual Research and Treatment Conference; personal communication with William Marshall 11/6/98)

B. In 1995, Marshall reported that family reunification provides the following risks: Victims may not want the family to reunify, but may feel pressured into it; even after treatment, 80% of families separate within 5 years; there is an increased chance the victim will not report if victimized again; or the victim may get the impression that the family is important and that he/she is not. (Wisconsin Sex Offender Treatment Network, Inc. training tapes; personal communication with William Marshall 11/6/98)

C. Hanson, R.F., et al. (1999). Factors Related to the Reporting of Childhood Rape, *Child Abuse & Neglect*, 23 (6).

The National Women's Study surveyed a representative sample of 4009 adult women in the United States in 1990. They re-interviewed the women in 1991 and in 1992. During the survey 341 women identified that they had been the victim of a childhood rape prior to the age of 18. Rape was defined as any non-consentual sexual penetration of the victim's vagina, anus, or mouth by a perpetrator's penis, finger, tongue, or an object, that involved the use of force, the threat of force, or coercion. Only 44 (13%) of the women ever reported a childhood rape to authorities. Two hundred ninety seven (87%) of the women did not report any of their childhood rapes to authorities. In looking at the victims who did report the rape, a higher percent involved physical injury or life threat. In addition, reported cases were twice as likely to involve an offender who was a stranger to the victim. Unreported cases were more likely to involve an offender who was a relative or an acquaintance of the victim. This is similar to previous research which has found that victims are less likely to report the abuse when the offender is a relative or acquaintance. (Arata, 1998; Ruback, 1993; Williams, 1984; Wyatt & Newcomb, 1990). Whether or not the rape was

reported, one third of the victims of childhood rape met the criteria for PTSD-lifetime and one half met the criteria for Major Depression-lifetime.

D. (1992). Rape in America: A Report to the Nation, National Victim Center and Crime Victims Research and Treatment Center, Dept. of Psychiatry and Behavioral Sciences, Medical University of South Carolina.

Rape in America: a Report to the Nation, in 1992 reports findings of a phone survey of 4009 women across the United States. Based on the results of this survey, 1 out of 8 women are estimated to have been the victim of forcible rape sometime in their lifetime. It was determined that 78% of the rapes were committed by someone known to the victim. Only 16% of these rapes were ever reported to the police. Only 30% of the rapes resulted in the victim being physically injured. But, when compared to women who were never sexually assaulted, female sexual assault victims were 3.4 times more likely to have used marijuana; 5.3 times more likely to have used prescription drugs non-medically; 6.4 times more likely to have used hard drugs; 3 times more likely to have had a major episode of depression; 6.2 times more likely to have developed PTSD; 5.5 times more likely to have current PTSD; 4.1 times more likely to have contemplated suicide; and 13 times more likely to have attempted suicide. The majority of these women had not abused alcohol or drugs prior to their sexual assault.

E. Underwood, R., Patch, P., Cappelletty, G., Wolfe, R. (1999). Do Sexual Offenders Molest When Other Persons Are Present? A Preliminary Investigation, *Sexual Abuse: A Journal of Research and Treatment*, Vol. 11(3).

In 1999, Underwood, Patch, Cappelletty, and Wolfe reported on a sample of 113 child molesters. On average, each offender committed 88.6 offenses. Many of the offenders in the sample acknowledged molesting a child while a non-collaborating person was present. The following percentage of the sample engaged in the listed behaviors:

- Molested one child when another child was present - 54%; another adult was present - 23.9%; a child & adult were present - 14.2%
- Molested a child when they knew the other person was awake - 44.3%
- Molested a child when another child was in the same bed - 25.7%; when another adult was in the same bed - 12.4%; when another adult and child were in the same bed - 3.5%
- The child molesters listed the following reasons for molesting a child while a non-collaborating person is present: increased excitement - 77%; sense of mastery - 77%; compulsive sexual behavior - 75.2%; and stupidity -38.9%.

F. Hindman, J. (1989). *Just Before Dawn*, Alexandria Association.

In her book, Just Before Dawn (1989), Jan Hindman cites research she conducted over 15 years involving 543 victims of child sexual abuse. She found that even in the most severe cases of sexual abuse, child victims frequently are asymptomatic. It may be years before symptoms are triggered in future developmental stages. Hindman's findings also indicate that ongoing demands for a relationship with the offender or his support system, without the benefit of significant intervention, contribute to severe and ongoing traumatic impact as the victim matures. "Sex

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G. Colorado Coalition Against Sexual Assault, http://www.ccasa.org/statistics.cfm

"Twenty-four percent (1 in 4) of Colorado women and 6% (1 in 17) Colorado men have experienced a completed or attempted sexual assault in their lifetime. This equates to over 11,000 women and men each year experiencing a sexual assault in Colorado (*Sexual Assault in Colorado: Results of a 1998 Statewide Survey. 1998. Colorado Department of Public Health and Environment and Colorado Coalition Against Sexual Assault).* One thousand seven hundred ninety-four (1,794) rapes were reported to Colorado law enforcement in 1997. If compared to the 1998 Statewide Survey, these reports constitute only 16% of sexual assaults."

H. Cardarelli, A. (1998). Child Sexual Abuse: Factors in Family Reporting, NIJ Reports, No. 209, May/June.

Data involving 156 sexually abused children who were treated at a Family Crisis program associated with Tuft's New England Medical Center in Boston were analyzed. Sixty-two percent of the sample chose not to report the abuse to the police. Of the individuals who did report the abuse, very few were the victims (they were mostly parents or primary caretakers).

V. *"It is important to recognize that treatment under unsafe conditions is not beneficial to the offender or others in the treatment program and undermines treatment program integrity."*

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

Quinsey, Harris, Rice, and Cormier (1998) reported on numerous studies on clinical judgment in regard to prediction of violence. His overall conclusion to these studies was that "clinical intuition, experience, and training at least as traditionally conceived are not helpful in either prediction or treatment delivery. Although discouraging, this conclusion is not nihilistic. Training, in the sense of knowing the empirical literature and relevant scientific and statistical techniques, must improve the selection of appropriate treatments, treatment program planning, and evaluation."

Articles/Professional Opinions that support this statement:

1. *O'Connell, M.A., E. Leberg, Donaldson, C.R. (1990).* Working with Sex Offenders: Guidelines for Therapist Selection. *Newbury Park, CA: Sage Publications, pp 13-16, 52-53, 94-96, 101-103.*

2. *(2000). Community Supervision of the Sex Offender: An Overview of Current and Promising Practices. Center for Sex Offender Management, January, 2000.*

3. *Salter, A. (1988).* Treating Child Sex Offenders & Victims, *Newbury Park, CA: Sage Publications, pp.84 – 86.*

4. *Scott, L. (1997). "Community Management of Sex Offenders". In* The Sex Offender, Vol II, *Schwartz, B., Cellini, H., eds., Kingston, NJ: Civic Research Institute, p.16-2 through 16-5.*

5. *Freeman-Longo, R., Knopp, F. (1992). State of the Art Sex Offender Treatment: Outcome and Issues,* Annals of Sex Research, *Vol. 5 (3).*

6. *(1997). "Ethical Standards & Principles for the Management of Sexual Abusers" ATSA, p.11, 2.02*

7. *Kercher, G., Long, L. (1998)* Supervision & Treatment of Sex Offenders, *Huntsville, TX: Sam Houston Press, pp47-49, & 123-126.*

8. *Cumming, G., Buell, M. (1997).* Supervision of the Sex Offender, *Brandon, VT: Safer Society Press, pp 91-92.*

VI. ***"Some offenders have a history of persistent arousal to minors. Although they may be able to meet 5.742 criteria, because of the likelihood that proximity to children will trigger or increase this arousal, the team shall frequently reassess the offender's ability to maintain a reduced level of arousal. The team shall terminate an offender's approval for contact with minors if there is behavior or other evidence to indicate arousal to minors cannot be managed."***

A. Davis, G., Williams, L., Yokley, J. (1996). An Evaluation of Court-Ordered Contact Between Child Molesters and Children: Polygraph Examination as a Child Protective Service. Paper presented at 15th Annual ATSA Conference, November, 1996.

In a 1996 study by Gary Davis, Laura Williams and James Yokley, 142 child molesters were polygraphed to determine if they were having deviant fantasies and masturbating while thinking about a known minor. Only 3% of offenders who were not permitted contact with children were having deviant fantasies and masturbating while thinking about a known minor. Of the child sex offenders who were permitted supervised contact with children, 59.5% were having deviant fantasies and masturbating while thinking about a known minor.

B. In 1999, the Sex Offender Treatment and Monitoring Program at the Colorado Department of Corrections compiled polygraph testing responses to questions regarding contact with children in the prison visiting room. The study involved a sample of 36 offenders who were polygraphed while participating in the second phase of the Sex Offender Treatment and Monitoring Program. The sex offenders were asked whether they had ever masturbated to thoughts of a known child they had seen in the prison visiting room. Eight offenders (22%) denied masturbating to thoughts of a known child and were nondeceptive on the polygraph exam. Sixteen offenders (44%) admitted to or were deceptive to questions on the polygraph exam, which would indicate the offender had masturbated to thoughts of known child they had seen in the visiting room. Twelve offenders (33%) were deceptive to other questions on the polygraph test and as a result it could not be determined whether they had masturbated to thoughts of a child seen in the visiting room.

Appendix D
PARENTAL RISK ASSESSMENT'S DECISION FLOW CHART

The following introductory points are offered to aid the evaluator in understanding and using the Parental Risk Assessment and the Decision Flow Chart.

1. Holistic approach

A holistic approach to evaluating risk should be used in the service of assessing on offender's level of risk to one's own child(ren). Children's well-being requires that any form of detectable risk be considered material in the PRA, not limited to risk for sexual re-offense against a child.

2. Aspects of low risk

A) Low risk reflects an evaluator's determination that an offender does not present a consistent physical or psychological threat to his own child(ren), and that the offender presents a consistent capacity and inclination to provide healthy parental nurturance to his/her own child(ren), despite having been convicted of a sex offense.

B) Low risk, for the purposes of the PRA, means that the sex offender is assessed as having a discrete, versus a pervasive, problem regarding sexual acting out, and that such problem does not include the likelihood of sexually offending one's own child(ren).

C) Low risk means that a very low level of monitoring and external control of the offender, represents the best supervision and management decision for the well-being of the offender's child(ren).

3. Method of assessment

Completion of the Parental Risk Assessment and Decision Flow Chart is accomplished through testing, observation, file review and contact with collateral information sources.

The evaluator is required to search for indicators of risk, and/or any information that would preclude a determination that an offender presents a low risk for harm to his/her own child(ren).

An Evaluator may conclude that an offender presents a low level of risk of harming his/her own child(ren) only upon the absence of finding relevant indicators of risk.

4. Determining *not low risk* – then, determining medium or high risk.

The decision flow chart guides the evaluator to make discriminating decisions between the three categories of risk (i.e., high, medium and low). It should be noted that the first decision to be made throughout the flow chart is whether or not the sex offender is "low risk."

If an offender presents with sufficient risk-predictive features to warrant a determination of "not low risk," the determination of medium or high risk status is completed secondarily.

5. Management team members should be able to explain all positions taken by the management team.

Because teams make decisions which substantially impact the lives of offenders, their families and victims, it is crucial that team members understand the rationale for all decisions and are able to support and articulate that rationale based on the identified risk factors and characteristics in a given case. Individual team members who are unable to articulate the rationale for decisions should not depend on a simplistic reliance on rules to explain themselves but should consult with supervisors and other team members rather than offering incomplete or inadequate explanations to offenders, family members or victims.

6. PRA instrument and tool selection

The instruments and tools selected for the PRA are chosen based upon general utility, research and best practices. The Decision Flow Chart is designed to enhance evaluator consistency, reliability and accuracy when determining the level of risk to the sex offender's own child(ren).

7. The 3-Tier approach in the Decision Flow Chart

A three-tiered approach was incorporated into the Decision Flow Chart because some issues offer greater or more obvious certainty regarding risk, and will function in a stand-alone fashion. Items in Tier I are sufficient, in and of themselves, to determine that an offender is "not low risk" (i.e., that a very low level of monitoring and external control does *not* represent the best supervision and management decision for a sex offender, specifically regarding his/her own child(ren)). Less obvious or less certain (though no less important) issues of concern are required in combination to determine that an offender is "not low risk," with less certain information required in greater volume and variety to make such a determination. A determination of "high risk" may be made when there is a substantial volume of risk-predictive information.

When scoring the PRA, the evaluator must refer to detailed information from the Parental Risk Assessment as described in Standard 5.730. The Decision Flow Chart should not be used alone.

8. Use of the PRA and Decision Flow Chart in the context of accusations and/or admissions of sexual contact with the child(ren)

The PRA and Decision Flow Chart are not intended to be used with offenders who have been accused of sexually offending the child or children with whom the offender desires contact. The PRA and Decision Flow Chart are not intended for investigative purposes. Accusations of sexual contact with a child should be reported to the appropriate authorities for investigation. Any admission of sexual contact with any of the offender's own child(ren) must result in a determination of "high risk," with regard to all of his/her children.

PARENTAL RISK ASSESSMENT – DECISION FLOW CHART

Instruction:

The evaluator must refer to information from the Parental Risk Assessment as described in 5.730

Tier I

- Sexual arousal/interest to prepubescent children (self report or test data, pretreatment or baseline)
- Sexual history with prepubescent children (self report or offense history)
- Mental Health Sex Offense Evaluation indicates **High Risk** (written report)
- History of 3 or more different types of statutorily defined unlawful sexual bx (self report, collateral information, and/or official records)

Advisory: The PRA & Decision Flow Chart should be completed only in the absence of any accusation or admission of sexual contact with the offender's own child. Any admission of sexual contact must result in a determination of "high risk".

More than one item from Tier I → High Risk

Only one Item from Tier I → Any item from Tier I and any 2 items from Tier II

None

Tier II

- Sexual compulsivity (causes distress in interpersonal or lifestyle functioning) other than behavior already identified in Tier I
- Recent pattern of drug or alcohol abuse
- History of DV behavior (official record, collateral info, self report)
- Personality Disorder
- Cognitive distortions re sexual behavior with children
- Attachment deficits (Ambivalent or Anxious)
- Empathy deficits towards children in abusive situations
- Unresolved polygraph (re: anyone under the age of 18)
- Any statutorily defined unlawful sexual behavior with a person under the age of 18, not already reported in Tier I

Any item from Tier I and any 2 items from Tier II

Yes. → High Risk

No. Less than 2 items from Tier II → Any item from Tier I and 4 items from Tier II and Tier III

Two or More items from Tier II → Any 5 items from Tier II and Tier III

One or Zero

Yes. → High Risk

No. Less than 4 items (3 or less) items from Tier III → Moderate Risk

Tier III

- Lack of parental skills and parental involvement with the child
- General instability (living, relationships, employment, criminal history, antisocial lifestyle)
- Psychological instability (Axis I or II)
- Lack of adequate support system
  - Support system for offender
  - Support system for the child
- History of 2 or more different types of statutorily defined unlawful sexual bx (self report, collateral information, and/or official records), if not indicated in Tier I

Any 5 items from Tier II and Tier III

Yes. → High Risk

No. Less than 2 items (one or none) from Tier III → Moderate Risk

Three or more items from Tier II and Tier III → Moderate Risk

Less than 3 (total) from Tier II and Tier III → Low Risk

Exclusionary Criteria (no contact permitted)	High Risk	Moderate Risk	Low Risk
• Pedophilia – exclusive type • Sexual Sadism • Sexually Violent Predator • Psychopathy/Mental Abnormality	No contact until conditions of 5.742 are satisfied	Professionally supervised visits and telephone and mail contact may be established at the team's discretion while the offender is working to achieve 5.742 criteria	5.742 criteria shall be waived

Appendix E
SPECIAL POPULATIONS

From the Ethical Standards and Principles for the Management of Sexual Abusers, the Association for the Treatment of Sexual Abusers

There is a growing awareness of the importance of designing and implementing specific treatment programs sensitive to diverse populations. Many of the evaluation and treatment procedures currently being used have been developed by the majority culture and do not reflect awareness or sensitivity to differences within minority populations. It is incumbent upon the service providers in this field to modify and adapt the generally accepted treatment techniques, standards, and principles to those special populations that they serve.

a) Where differences of age, gender, race, ethnicity, national origin, religion, sexual orientation, disability, language or socioeconomic status significantly differ from the service provider's experience and/or orientation, it is imperative that the treatment provider obtain the training and/or supervision necessary to ensure the adequacy of the services provided.

b) If it is not feasible to obtain training and/or supervision to adequately provide services to a special clientele, referral to a service provider who does possess the necessary knowledge and skills is necessary.

c) Emphasis should be placed on the development of specific programs and treatment plans that address the sexually deviant behavior within the context of the minority group culture.

d) Service providers must acknowledge and educate themselves about their own ethnic, cultural, racial and/or professional biases and assumptions.

e) Special care and attention should be given to the environment in which the abuser will spend most of his or her time, both during and following treatment intervention.

Appendix F
SEX OFFENDER MANAGEMENT BOARD ADMINISTRATIVE POLICIES February 2000

A. The period for individuals placed on the Provider List before June 30, 1997 shall terminate on December 31, 1999. Individuals placed on the Provider List after June 30, 1997 shall be notified of a deadline that approximates a three year period.

B. Individuals on the Provider List who work for or with a particular sex offender treatment program shall notify the SOMB in writing if they leave the program and continue to provide sex offender treatment. In such cases, individuals shall be required to provide updated information on the treatment provider/client contract, a description of program services and any other information pertinent to the change in employment.

C. The SOMB may periodically conduct criminal history and grievance board checks on providers found on the Provider List and reserves the right to conduct a review of standards compliance and references as necessary.

D. Individuals who are at the associate level on the Provider List shall notify the SOMB in writing when they have obtained the required experience or qualifications to be listed on the Provider List at the full operating level. Documentation of such experience or qualifications must be submitted. Such notification shall be accompanied by a letter from the applicant's supervisor, indicating that they are qualified for placement on the Provider List at the full operating level.

E. In assessing references for placement on the Provider List provided to and solicited by the Sex Offender Management Board, the Application Review Committee shall weigh many factors, including the following:

1. The relevance of the information to compliance with the *Standards*;

2. The degree to which there is a difference of opinion among references;

3. Apparent reasons for differences of opinion;

4. How recently the reference has had contact with the applicant and the extent of contact with the applicant;

5. Whether the reference has had direct contact with the applicant or is reporting third hand information;

6. Whether the applicant has recently changed a particular practice to conform with the *Standards*;

7. The motivation of the reference.

F. The applicant shall be given an opportunity to respond and provide additional information to concerns and questions of the Application Review Committee prior to the determination regarding placement on the Provider List. The only exception to this practice shall be when non-compliance with the *Standards* is clear and could not be re-mediated by additional information.

G. Any applicant who is denied placement on the Provider List will be supplied with a letter from the SOMB outlining the reasons for the denial and notifying them of their right to an appeal.

H. Any provider who is denied placement on or removed from the Provider List shall not provide any services to convicted adult sex offenders in Colorado without written permission from the SOMB.

No listed provider shall use any provider denied placement on or removed from the Provider List to provide any services to convicted adult sex offenders in Colorado without written permission from the SOMB.

I. Any applicant who is denied placement on the Provider List by the Application Review Committee may appeal the decision to the full SOMB. Appeals will be conducted in the following manner:

1. The applicant must submit an appeal in written form within 30 days after receiving notification of denial of placement on the Provider List.

2. The SOMB will consider only information that addresses the reasons for denial outlined by the SOMB in the denial letter. Other information will not be considered by the SOMB in the appeal process.

3. The applicant may request either a hearing or a conference call with the SOMB in addition to the submission of the written appeal. The request must be made in writing at the time the written appeal is submitted. Hearings or conference calls will be scheduled in conjunction with regular SOMB meetings. An applicant may bring one representative to the appeal. Hearings or calls will be 30 minutes; 15 minutes for a verbal presentation by the provider and 15 minutes for questions from the SOMB.

4. The SOMB will consider appeals in open hearing and audio record the proceedings for the record.

5. The applicant will be notified in writing of the SOMB's decision regarding the appeal.

6. The decision of the SOMB will be final.

J. When a complaint is made to the Sex Offender Management Board about a treatment provider, evaluator, plethysmograph or Abel Screen examiner or clinical polygraph examiner listed on the Provider List or not, the complaint shall be made in writing to the SOMB. The SOMB will furnish a form to the complainant which must be completed for the SOMB to consider the complaint.

All complaints will be initially screened by the vice chair of the SOMB, or other SOMB member as appointed by the Chair, to determine appropriateness for Sex Offender Management Board intervention. The vice chair will review his/her recommendation with the Application Review Committee and a decision will be made regarding Sex Offender Management Board intervention.

Complaints determined to be more appropriate to intervention by another oversight agency (such as the state mental health grievance board) will be referred to the appropriate oversight agency.

Complainants will be notified in writing of any such referrals. Some complaints may be appropriate for both referral to another oversight agency and intervention by the Sex Offender Management Board.

Complaints regarding treatment providers, evaluators, plethysmograph examiners and clinical polygraph examiners who are not listed on the Provider List are not appropriate for Sex Offender Management Board intervention. The SOMB will inform complainants that it does not have the authority to intervene in these cases. The SOMB will send a copy of the *Standards and Guidelines for the Assessment, Evaluation, Treatment and Behavioral Monitoring of Adult Sex Offenders* to the provider not listed on the Provider List identified in these complaints for informational purposes.

Complaints appropriate for Sex Offender Management Board intervention are those complaints against sex offender treatment providers, evaluators, plethysmograph examiners and clinical polygraph examiners who are listed on the Provider List when the complainant identifies that the *Standards* developed by the Sex Offender Management Board have been violated. These complaints will be addressed in the following manner:

1. The Application Review Committee in conjunction with the vice chair of the SOMB, or other SOMB member identified by the chair, will have the responsibility for reviewing and responding to complaints.

2. When the vice chair and the Application Review Committee determine that a complaint is appropriate for Sex Offender Management Board intervention the complainant will be notified in writing that their complaint has been received and the identified provider will be notified that a complaint against them has been received.

3. As a part of the investigation of the complaint the SOMB may:

    a) Request more information from the complainant
    b) Request a response from the identified provider
    c) Initiate and carry out or cause to be carried out an investigation of the complaint either directly or through staff, investigators or consultants.
    d) Hold a hearing before the committee requesting both parties to appear.
    e) The committee will consider complaints in executive session.

The Sex Offender Management Board reserves the right to determine the extent of investigation needed to determine a finding regarding the complaint.

The following are possible findings and actions by the Sex Offender Management Board regarding complaints:

1. Dismissal of the complaint, identifying it as unfounded and taking no action.

2. Contacting the provider and/or the complainant to determine if the complaint can be resolved through mutual agreement. If mutual agreement is reached, the decision regarding the agreed upon action will be documented and placed in the provider's file as a determination of the outcome of the complaint.

3. Finding a complaint valid and placing a letter of admonition in the provider's file. The SOMB may recommend changes in the provider's services or additional training or supervision. The

letter of admonition and the provider's response to the SOMB's suggestions will be taken into consideration when the provider is reviewed for placement on the Provider List.

4. Finding a complaint valid and removing a provider from the Provider List. In these cases, referral sources will be notified of the provider's removal from the Provider List.

5. Written notice of the SOMB's findings and the reasons for those findings will be provided to the complainant and the identified provider along with a notice of the right to file a written appeal within 30 days.

K. Any complainant or identified provider who wishes to appeal a finding on a complaint may appeal the decision to the full SOMB. Appeals regarding findings on complaints will be conducted in the following manner:

1. The applicant must submit their appeal in writing within 30 days after receiving notification of the finding of the SOMB.

2. The SOMB will consider only information that addresses the reasons for the finding outlined by the SOMB in their letter.

3. Either the party requesting the appeal or the other party may request either a hearing with the SOMB or a conference call with a group of SOMB Members identified by the SOMB as a part of their appeal. The request must be made in writing at the time of the appeal. Hearings or conference calls will be scheduled in conjunction with regular SOMB meetings. Either party may bring one representative with them. Hearings or calls will be 45 minutes long; 15 minutes for a verbal presentation by each party and 15 minutes for questions from the SOMB.

4. The SOMB will consider appeals in open hearing and audio record the proceedings for the record.

5. The SOMB will notify both parties of its decision in writing.

6. The decision of the SOMB will be final in the appeal process.

Colorado Sex Offender Management Board

LIFETIME SUPERVISION CRITERIA

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

700 Kipling Street, Suite 3000
Denver, CO 80215
(303) 239-4442

June 1999

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INTRODUCTION

In 1998, the Colorado General Assembly passed legislation directing the Sex Offender Management Board (hereafter SOMB), in collaboration with the Department of Corrections, the Judicial Branch and the Parole Board to establish the criteria by and the manner in which a sex offender who is subject to lifetime supervision may demonstrate that he or she would not pose an undue threat to the community if released on parole or to a lower level of supervision while on parole or probation or if discharged from parole or probation and the methods of determining whether a sex offender has successfully progressed in treatment (Section 16-13-809 (1) (a) and (b) C.R.S.). The court and the parole board may use these Criteria to assist in making decisions concerning release of a sex offender, reduction of the level of supervision for a sex offender, and discharge of a sex offender.

Supervising parole and probation officers and treatment providers should utilize these Criteria in making recommendations to the court and or the parole board regarding release, reduction in levels of supervision and discharge of sex offenders.

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These Criteria do not stand alone. They are based on the Guiding Principles of the *Standards and Guidelines for the Assessment, Evaluation, Treatment and Behavioral Monitoring of Adult Sex Offenders* (hereafter, *Standards*), located in the front section of this publication. The highest priority of the existing *Standards* and of these Criteria is community safety.

Treatment for sex offenders under lifetime supervision must be consistent with the existing *Standards*. Standard 3.140 F, in particular, outlines the content of sex offense-specific treatment.

Progress in treatment is not linear, incremental, static, nor reliable and must be consistently re-assessed. Progress is multi-dimensional; high risk can exist despite progress on many dimensions. Risk in any single dimension must be taken seriously. Concerns expressed by any individual member of the community supervision team should also be taken seriously. Progress indicated by repetitive testing over extended periods of time may be invalid due to deception, habituation, and socially desirable responsiveness. Consequently, results of such tests should not stand alone and multiple measures should always be used to indicate risk.

In order to best ensure community safety, the full continuum of containment options should be available for all offenders. The most effective management of sex offender risk begins with interventions that offer the highest levels of containment which may include supervised residential settings and intensive supervision programs.

The intent of the lifetime supervision of sex offenders is to reduce risk to the community. Although these Criteria are written in a format that indicates what offenders must do to be released, moved to lower levels of supervision, discharged or to demonstrate successful progress in treatment, this does not imply that any or all sex offenders on lifetime supervision will be able to meet the criteria for any of these reductions in levels of containment or complete treatment. Progress in treatment and assessment regarding whether or not these criteria are met must be measured by behavior that indicates lessened risk, not by any passage of time.

In some cases there may be overlap among the Criteria. This is a natural outcome of the community supervision team structure and the interplay between the team members. This overlap in supervision and monitoring duties helps to ensure adequate containment for sex offenders over time.

For the purposes of these criteria, successful progress in treatment indicates an active plan to continue treatment; successful completion of treatment indicates active, consistent participation in a treatment aftercare program. Offenders who indicate that they no longer need any treatment, behavioral monitoring or aftercare of any kind have **not** successfully progressed in treatment or completed it. These offenders continue to pose a risk to the community and should not be discharged from lifetime supervision.

Just as an offender can be progressed through the levels of supervision, an offender can be regressed or revoked for certain behaviors. If an offender is consistently failing to meet criteria for progression, the team should evaluate whether the current level of supervision is intensive enough to adequately contain the offender. In such cases, regression to a higher level of supervision should be considered. Other conditions under which regression may occur include but are not limited to: deceptive polygraph results, drug or alcohol use, non-compliance in treatment, unstable residence or employment, or evidence of having taken steps to develop victim access or a victim pool.

Like the original *Standards,* these criteria are based in best practices known today for managing and treating sex offenders. To the extent possible, the SOMB has based these Criteria on current research in the field. Materials from knowledgeable professional organizations have also been used to direct them.

The management and treatment of sex offenders is a developing, highly specialized field. Many decisions regarding the Criteria must be made in the absence of clear research findings. Such decisions will be directed by the governing philosophy of public safety and a common sense interpretation of the guiding principles in the original *Standards*. The SOMB will remain current on the emerging literature and research in the field and will modify the Criteria periodically on the basis of new findings.

ADDITIONAL GUIDING PRINCIPLES FOR WORKING WITH SEX OFFENDERS ON LIFETIME SUPERVISION

These Guiding Principles serve as a part of the philosophical foundation of these Criteria. They are not to be used alone. They are intended to be used in conjunction with the Guiding Principles in the *Standards and Guidelines for the Assessment, Evaluation, Treatment and Behavioral Monitoring of Adult Sex Offenders,* located in the front section of this publication.

LS1. Because of the long term nature of the work with sex offenders on lifetime supervision, and the concomitant risks to supervising officers and treatment providers, there is greater risk of complacency and inaccurate risk assessment. Supervising officers, treatment providers and their employing agencies should take steps to ensure the following:

- **Adequate clinical and administrative supervision;**
- **Regular case audits;**
- **Critical incident debriefings;**
- **Support for trauma reactions;**
- **Methods for transferring cases as needed; and**
- **Adequate self care.**

LS 1.00
CRITERIA FOR RELEASE FROM PRISON TO PAROLE

1.010 In order to demonstrate that the sex offender would not pose an undue threat to the community if released from prison to parole, he or she must meet the criteria in each of the following areas of focus:

A. Criminal Behavior Past and Present

1. The offender acknowledges and takes full responsibility for the crime of conviction.
2. The offender has adequate plans to address components of the crime(s) that pose current risk as identified in the mental health sex offense-specific evaluation, treatment plan or relapse prevention plan. Such components may be, but are not limited to:

- Initial charge versus the conviction or plea
- Facts and circumstances of the crime
- Premeditation, grooming or predatory behavior
- Nature of the crime was incidental to another crime or was spontaneous
- The use of threats, violence or weapons
- Age of victim(s) or the presence of any mental or physical disability in the victim(s)
- Any conviction other than the instant offense for a violent crime per CRS 16-11-309

B. Sentence Failures

1. The offender acknowledges reasons for sentence failures (which could include, but are not limited to deferred prosecutions or judgements, probation, community correction, or parole), as verified by official record, and has made progress in addressing those reasons or demonstrates the presence of a plan that addresses those issues.

C. Participation in Programs

1. Required participation in the Sex Offender Treatment and Management Program (SOTMP). SOTMP program staff report offender compliance with recommended program plan and sufficient progress in treatment.

2. Demonstrated participation in all recommended programs. Positive participation and recommendations from staff of each program (based on program compliance) or a clearly established plan to obtain recommended programming in the community where placement in the community does not pose an undue risk.

3. If the offender is placed in community corrections, he or she has demonstrated positive participation and progress as indicated by recommendation from Community Corrections staff and SOMB approved sex offense-specific treatment provider.

D. Code Of Penal Discipline Rules Convictions, Escapes or Absconds

Discussion: Non compliance with rules in a highly structured environment like DOC is highly related to risk of re-offense.

1. No COPD rules convictions in the last 12 months.

2. No drug violations and demonstrates all clean UAs for the last 12 months.

3. No sexual violations in DOC for a minimum period of the last 2 years.

E. Classification Level Changes

1. The offender has had no increase in classification level in the last 12 months.

F. Risk Assessment

1. The offender has completed the SOTMP evaluation (in adherence to SOMB *Standards* and including the administration of the DCJ Sex Offender Risk Scale) and has a recommendation from the SOTMP program staff, which is based on the evaluation, for release to parole.

G. Victim Input (Pursuant to 17-22.5-404 (2) (a) (I) this may include the victim or a relative of the victim)

1. The offender has had no contact with the victim, other than therapeutically approved contact. (Contact means any kind of communication either direct or indirect by the offender with the victim and includes but is not limited to physical proximity, written correspondence, electronic, telephone or through third parties.)

2. The offender is not engaging in victim blaming.

3. The offender is not engaging in harassment, manipulation or coercion of the victim.

4. Offender has demonstrated support for the victim's recovery, minimally at the level of no contact, as verified by SOTMP staff.

H. Age of Offender at Offense vs Date of Parole Hearing

1. The offender demonstrates the emotional maturity necessary to predict a successful release to parole.

I. Parole Plan

1. The offender's Parole plan minimally includes the following:

- No undue level of risk is indicated in any part of the parole plan or recommendations from any DOC staff.
- The offender has an appropriate plan to safely transition back to the community.
- The home living situation is free from former and potential victims.
- The offender has appropriate employment plans with lack of access to potential victims.
- The offender has access to and demonstrates willingness to participate in sex offense specific treatment and other recommended treatment if released on Parole.
- The appropriate level of supervision and containment is available where the offender plans to live.
- The offender has a realistic plan to pay restitution based on a his or her ability to pay.

J. Honesty

1. The offender demonstrates truthful, complete and non-evasive answers to all questions posed by the parole board members.

LS 2.00
CRITERIA FOR REDUCTION IN LEVEL OF SUPERVISION WHILE ON PAROLE AND DISCHARGE FROM PAROLE

2.010 In order to demonstrate that the sex offender would not pose an undue threat to the community if placed on a lower level of supervision while on parole, he or she must meet the reduction in supervision criteria in each of the following areas of focus; in order to demonstrate that he or she would not pose an undue threat to the community of discharged from parole, he or she must meet the discharge criteria in each of the following areas of focus:

A. Community Supervision Team Staffing

Reduced Supervision: The team considers all information below and other appropriate information to make any determination regarding movement to lower levels of supervision. All team members must agree to the reduction in the level of supervision.

No exceptions will be made for reduction in supervision from level 5. Any exception made to the requirements for movement from levels other than level 5 must be made by a consensus of the community supervision team. In such a case, reasons for movement to a lower level of supervision when criteria are not met must be documented as well as any resulting potential risk to the community.

Discharge: In any case when an offender is being considered for recommendation of discharge from lifetime supervision, the offender must demonstrate that he or she would not pose an undue threat to the community if allowed to live in the community without supervision. The team considers all information below and other appropriate information to make any determination regarding discharge from lifetime supervision. All team members must agree to the discharge from supervision.

The supervising officer will document what criteria are met or not met at any consideration of reduction in level of supervision or discharge and the decision of the community supervision team.

Discussion: If an offender is consistently failing to meet criteria for progression, the team should evaluate whether the current level of supervision is intensive enough to adequately contain the offender. In such cases, regression to a higher level of supervision should be considered.

B. Polygraphs

Reduced Supervision: The offender must complete at least two consecutive non-deceptive polygraph examinations before moving to the next

lower level of supervision. The examinations must be the two most recent exams each time.

Discharge: The offender must have completed a non-deceptive baseline (sex history) polygraph examination and complete at least two consecutive non-deceptive polygraph examinations for each of the five levels of supervision before discharge.

Any exception made to the requirements for movement from level to level or for discharge must be made by a consensus of the community supervision team. In such a case, reasons for movement when criteria are not met must be documented as well as any resulting potential risk to the community.

C. Progress in Treatment

Reduced Supervision: The sex offender's monthly reports are consistently indicating the following (consistency is defined as 6 months or longer):

- Regular attendance with no un-excused absences in the last 6 months.
- Active participation.
- Progression with the established treatment guidelines.
- Payment.
- The offender acknowledges and takes full responsibility for crime of conviction.
- Completion of a non-deceptive polygraph regarding the offender's sex history.
- The treatment provider reports that any other denial issues are being consistently and adequately addressed in treatment.
- The offender understands the offense cycle.
- The offender has and is utilizing an appropriate relapse prevention plan.
- No unsuccessful terminations.
- Full compliance with established treatment guidelines.
- Full compliance with recommended medications.

Discharge: For discharge from parole, the treatment provider must be reporting successful termination of treatment or successful progress in treatment to date and actively recommending discharge from parole. (Successful completion indicates active, consistent practice of a treatment aftercare program. Successful progress indicates an active plan to continue in treatment.)

D. Employment

Immediately upon release, providing there are no medical, mental or physical problems, the sex offender shall actively seek appropriate full time employment or enroll in an appropriate vocational training program, with consent of supervising officer. Appropriate

employment limits contact with victims and potential victims and allows the supervising officer to consistently locate the offender.

Reduced Supervision: The offender must demonstrate of job stability, longevity and appropriate usage. In addition, a positive evaluation or progress report (written or verbal) is required from the immediate work supervisor.

An exception may be made if the sex offender becomes unemployed for reasons beyond his or her control. Any exception must be agreed to by a consensus of the community supervision team. In such a case, reasons for movement when criteria are not met must be documented as well as any resulting potential risk to the community.

Discharge: The sex offender's employment record shall reflect the ability to seek and maintain appropriate long-term employment with no periods of willful unemployment during the past 5 years.

E. Relationships

Relationships developed in the community shall be appropriate and of positive benefit to the sex offender. The safety of the community shall be considered a priority in all relationships. Appropriate relationships limit contact with all victims and potential victims and include an awareness of the offender's criminal history.

Reduced Supervision: Consideration for progression to a lower level of supervision will be based on the sex offender's ability to articulate the status and benefits of any relationships. The offender shall have had no unauthorized contact with victims or minors in the last 6 months.

Consideration for progression to level 4 will be based on the offender identifying an appropriate community support person who is willing to participate in offense specific education.

In a situation where the offender cohabits with or is in an intimate relationship, the co-habitor or significant other must be supportive of treatment, not supportive of the offenders' denial, and be willing to participate in treatment and sex offense specific education as needed. Significant other(s) and co-habitors, should also be able to articulate the status and benefits of relationship, demonstrate an awareness of the sex offender's criminal history including the current offense and have knowledge and awareness of the sex offender's risk to children and potential victims.

Exceptions may be made and documented when the offender is residing in a residential facility or hospital and it would be inappropriate to disclose the offender's history to all other

residents. In such cases, the safety of the other residents shall be the determining factor regarding disclosure, not the offender's desire for confidentiality. In no case is it appropriate to keep any information regarding the offender and his or her history from staff of any facility in which they are being treated or in which they reside.

Discharge: The sex offender shall have demonstrated, over the course of supervision, the ability to maintain age appropriate, professional and personal relationships that are non-criminal. The sex offender shall demonstrate an understanding of how positive relationships in the community have influenced non-criminal behavior and thinking.

F. Sex Offender Registration

Each sex offender, domestic or interstate, if required by statute to register, shall upon becoming a temporary or permanent resident, register with the law enforcement agency within the jurisdiction where the offender's residence is located.

Reduced Supervision: Consideration for progression to a lower level of supervision will be based on consistent compliance with re-registration requirements, advising law enforcement of current residence, appropriately notifying original jurisdiction and timely filing of a change of residency card with law enforcement when moving to a new jurisdiction.

Progression to a lower level of supervision will not be considered if sex offender is not in compliance with state registration laws.

Discharge: The sex offender must currently be registered and have been in compliance with sex offender registration laws for the (5) five consecutive years immediately preceding consideration for discharge.

G. Leisure Activities:

Immediately upon release, leisure activities engaged in or developed within the community shall be appropriate, legitimate, legal and of benefit to the sex offender. Appropriate leisure activities limit contact with victims and potential victims and allow the supervising officer to consistently locate the offender.

Reduced Supervision: Consideration for progression to a lower level of supervision will be based on sex offenders' ability to identify appropriate leisure activities and the benefit of each activity. In addition, the offender must be able to articulate how the relapse prevention plan is used when engaging in leisure activities.

Discharge: To be considered for discharge, the sex offender must have demonstrated the ability to participate in appropriate, legitimate and legal leisure activities from which he/she has benefited. In addition, the offender must have demonstrated consistent use of a relapse prevention plan as needed during leisure activities.

H. Compliance with Conditions of Supervision

On a regular basis, the sex offender demonstrates compliance with all conditions of supervision.

Reduced Supervision: Consideration for progression to a lower level of supervision will be based on the sex offender's attitude, progress, participation and consistent compliance with all conditions of supervision.

The sex offender will not be considered for progression to a lower level of supervision if not actively in compliance with all offense specific conditions of supervision, or if the offender has a pending summons or complaint for any parole violation(s).

Discharge: To be considered for discharge sex offender must be in compliance with all conditions of supervision including successful discharge from treatment and active participation in an aftercare program.

LS 3.00
CRITERIA FOR REDUCTION IN LEVEL OF SUPERVISION WHILE ON PROBATION AND DISCHARGE FROM PROBATION

3.010 In order to demonstrate that the sex offender would not pose an undue threat to the community if placed on a lower level of supervision while on probation, he or she must meet the reduction in supervision criteria in each of the following areas of focus (For the purpose of these Criteria, reduction in level of supervision while on probation means movement from Sex Offender Intensive Supervision Probation to Regular Probation). For criteria that refer to reduction in levels of supervision while on Sex Offender Intensive Supervision Probation, please refer to the *Sex Offender Intensive Supervision (SOISP) Guidelines and Standards* published by the Colorado Judicial Branch, Office of Probation Services.

In order to demonstrate that the sex offender would not pose an undue threat to the community if discharged from probation, he or she must meet the discharge criteria in each of the following areas of focus:

A. Compliance with the Treatment Contract to the Treatment Provider's Satisfaction

Reduced Supervision: The treatment provider is indicating a recommendation for reduced supervision based on the following indicators of progress in treatment:

- Regular attendance and active participation in sex offense specific treatment.
- Demonstrates increased internal motivation for treatment.
- The offender admits to committing the offense and acknowledges sexual assault intent.
- The offender demonstrates understanding and use of a written offense cycle.
- Completion of a written relapse prevention plan and demonstrated ability to use it.
- The offender appropriately confronts others in group treatment.
- Completion of non-deceptive maintenance polygraph examinations at least every 6 months.
- Completion of all homework assignments and evidence of an attempt to do a quality job.
- No violations of the treatment contract.
- A reduction in attempts to "split" team members.
- Demonstrates increased awareness of victim impact and the development of victim empathy.
- Verification that the offender is using techniques, such as covert sensitization, to interrupt deviant arousal.
- Non-deceptive disclosure polygraph. (Any exception to this criteria must be consistent with the requirements in the SOMB *Standards* located in the front section of this publication.)
- Demonstrates ability to recognize and correct thinking errors.
- Demonstrated the ability to express anger appropriately and without aggression.
- Full and consistent compliance with any medication requirements.

Discharge: For discharge from probation, the treatment provider must be reporting successful termination of treatment or successful progress in treatment to date and actively recommending discharge from probation. (Successful completion indicates active, consistent practice of a

treatment aftercare program. Successful progress indicates an active plan to continue in treatment.)

B. Consistency Between Words and Behavior

Reduced Supervision:

- The offender can identify inconsistencies in his or her words and behavior and makes attempts to correct them.
- Evidence of consistency in what is said to the members of the community supervision team.

Discharge: The offender consistently displays consistency between his or her words and behavior in all areas of his life.

C. Appropriate Relationships and Community Support

Reduced Supervision: The offender recognizes and terminates inappropriate relationships. The offender has establishment of some appropriate social relationships and community support. This may include a community chaperone if deemed necessary by the community supervision team. In a situation where the offender cohabits with or is in an intimate relationship, the co-habitor or significant other must be supportive of treatment, not supportive of the offenders' denial, and be willing to participate in treatment and sex offense specific education as needed. Significant other(s) and co-habitors, should also be able to articulate the status and benefits of relationship, demonstrate an awareness of the sex offender's criminal history including the current offense and have knowledge and awareness of the sex offender's risk to children and potential victims.

Exceptions may be made and documented when the offender is residing in a residential facility or hospital and it would be inappropriate to disclose the offender's history to all other residents. In such cases, the safety of the other residents shall be the determining factor regarding disclosure, not the offender's desire for confidentiality. In no case is it appropriate to keep any information regarding the offender and his or her history from staff of any facility in which they are being treated or in which they reside.

Discharge: The sex offender shall have demonstrated, over the course of supervision, the ability to maintain age appropriate, professional and personal relationships that are non-criminal. The sex offender shall demonstrate an understanding of how positive relationships in the community have influenced non-criminal behavior and thinking.

D. Stable and Safe Residence

Reduced Supervision : The offender shall maintain a stable and safe residence. A safe residence is one that limits the offender's contact with victims, potential victims and minors and where any co-habitors are aware of the offender's criminal history including the current offense and have knowledge and awareness of the sex offender's risk to children and potential victims.

Discharge: The offender shall have demonstrated, over the course of supervision the ability to maintain a stable and safe residence.

E. Stable and Safe Employment

Reduced Supervision: The offender shall demonstrate the ability to maintain stable and safe employment. Safe employment limits contact with victims and potential victims and allows the supervising officer to consistently locate the offender.

Discharge: The offender's employment record shall reflect the ability to maintain stable and safe employment with no periods of willful unemployment during the past 5 years.

F. Substance Abuse Treatment

This criteria applies only to those offenders who are recommended for substance abuse treatment.

Reduced Supervision: The offender has entered a recommended substance abuse treatment program and is making and maintaining consistent progress in the program.

The offender has not used drugs or alcohol for at least 6 months prior to any reduction in level of supervision.

Discharge: The offender has completed any recommended substance abuse program and is actively and consistently involved in any recommended aftercare or maintenance programs.

G. Leisure Activities

Leisure activities engaged in or developed within the community shall be appropriate, legitimate, legal and of benefit to the sex offender. Appropriate leisure activities limit contact with victims and potential victims and allow the supervising officer to consistently locate the offender.

Reduced Supervision: Consideration for progression to a lower level of supervision will be based on sex offenders' ability to identify appropriate leisure activities and the benefit of each activity. In addition, the offender must be able to articulate how the relapse prevention plan is used when engaging in leisure activities.

Discharge: To be considered for discharge, the sex offender must have demonstrated the ability to participate in appropriate, legitimate and legal leisure activities from which he has benefited. In addition, the offender must have demonstrated consistent use of a relapse prevention plan as needed during leisure activities

H. Compliance with Conditions of Supervision

Reduced Supervision: Consideration for progression to a lower level of supervision will be based on the sex offender's attitude, progress, participation and consistent compliance with all conditions of supervision including but not limited to the following:

- Keeps probation and other related appointments and is generally on time.
- Is open to discussing the offense and treatment progress.
- The offender does not try to control the probation officer or content of visits.
- No technical violations within the last 6 months of probation related to the offense cycle.
- No alcohol or drug use at least 6 months preceding a supervision reduction.
- No unauthorized contact with the victim(s) or with minors.
- Full compliance with requirements for registration and DNA Genetic Marker collection.

- Consistent payment of restitution and fines imposed by the court.
- Any community complaints regarding the offender have been adequately addressed to the treatment team's satisfaction.

I. Community Supervision Team Staffing

Reduced Supervision: The team considers all information above and other appropriate information to make any determination regarding movement to a lower level of supervision. All team members must agree to the reduction in the level of supervision.

Discharge: In any case when an offender is being considered for recommendation of discharge from lifetime supervision, the offender must demonstrate that he or she would not pose an undue threat to the community if allowed to live in the community without supervision. The team considers all information below and other appropriate information to make any determination regarding discharge from lifetime supervision. All team members must agree to the discharge from supervision.

The supervising officer will document what criteria are met or not met at any consideration of reduction in level of supervision or discharge and the decision of the community supervision team.

Discussion: If an offender is consistently failing to meet criteria for progression, the team should evaluate whether the current level of supervision is intensive enough to adequately contain the offender. In such cases, regression to a higher level of supervision, or revocation, should be considered.

LS 4.000
CRITERIA FOR SUCCESSFUL PROGRESS IN TREATMENT

4.100 Criteria for Successful Progress in Sex Offense Specific Treatment

4.110 In order to demonstrate successful progress in treatment, the offender must meet the progress criteria in each of the following areas of focus; in order to meet the criteria for successful completion of treatment, the offender must meet all of the progress and completion criteria in each of the following areas of focus.

For the purposes of these criteria, successful progress in treatment indicates an active plan to continue treatment and supervision; successful completion of treatment indicates active, consistent participation in a treatment aftercare program, containment and monitoring to manage lifelong risk.

A. Relapse Prevention Criteria

1. Reduction in Denial

Progress:

- The offender discloses all victim(s) and sexual offending behavior in detail.
- The offender's account must reasonably match or surpass the victim(s) accounts.
- The offender recognizes and admits the purposes of their sexually assaultive/offending behavior including sexual gratification, deviant sexual arousal and power and control.
- The offender completes non-deceptive polygraph examination(s) regarding sexual history.

Completion:

- The offender has met all progress criteria and continues to complete non-deceptive polygraph examinations.
- The offender no longer uses denial of responsibility in any arena of his or her life as a primary coping mechanism.

2. Decreased deviant sexual urges, arousal, and fantasies:

Progress:

- The offender demonstrates knowledge of his or her historical offense and relapse cycles including awareness of thoughts, emotions and behaviors that could facilitate sexual re-offenses or other assaultive behaviors.
- The offender demonstrates knowledge of his or her cognitive distortions and is working to correct them.
- The offender has developed and implemented a plan to alter his or her lifestyle to limit their ability to plan or groom potential victims and has developed skills to interrupt fantasies and inappropriate masturbatory behaviors and utilizes them.
- The offender has developed a comprehensive relapse prevention plan.

- Is, and consistently has been, in compliance with all recommended prescribed psychiatric medications used to reduce arousal or manage behaviors related to risk.
- The offender can identify objectification and inappropriate sexual gratification in relationships and is developing skills to address them.

Completion:

- The offender demonstrates control over arousal or interest through Plethysmograph or Abel Screen "improvement".
- The offender consistently completes non-deceptive polygraphs regarding planning behavior or masturbation to arousal and fantasies.
- The offender consistently demonstrates self motivated use of the relapse prevention plan and has distributed written copies of the plan to any co-habitors or significant others.
- The offender consistently demonstrates self motivated use of a plan for identifying and correcting cognitive distortions.
- The offender demonstrates the development and maintenance of appropriate adult relationships. Appropriate relationships value the quality of the relationship over sexual gratification.
- The offender demonstrates an ongoing commitment to and active engagement in treatment or an aftercare treatment program, containment and monitoring to manage lifelong risk.

Discussion: Demonstrating improvement on these measures does not necessarily indicate reduced risk or that the offender will utilize his or her ability to control arousal or interest appropriately.

B. Environment Management Criteria

Progress:

- The offender demonstrates willing, active and knowledgeable participation in the treatment process and/or a milieu or residential treatment setting.
- The offender demonstrates the ability to identify anti-social behaviors and is working toward pro-social skills to replace them.
- The offender has disengaged from relationships that support his or her denial, minimization, and resistance to treatment.
- The offender is engaged in relationships which are supportive of treatment, and the people engaged in relationships with the offender demonstrate an awareness of the sex offender's criminal history including the current offense and of the sex offender's risk to children and potential victims. These people actively assist in limiting the offender's contact with children and potential victims. Additionally, those who are in either in intimate relationships with the offender or are co-habiting with the offender are willing to participate in treatment and sex offense specific education as needed.
- The offender's support system has been given permission by the offender to question and confront the offender about his or her behavior and to report their concerns to the community supervision team and law enforcement authorities when appropriate.

- The offender has demonstrated consistent and full compliance with all conditions of supervision and the treatment contract.
- The offender has demonstrated consistent ability to avoid high risk environments.

Completion:

- The offender demonstrates willing and active participation in only pro-social behaviors.

C. Community & Victim Responsiveness Criteria

Progress:

- The offender acknowledges the full impact of his or her sexually assaultive and offending behavior.
- The offender understands that the protection of victims and potential victims from unsafe and or unwanted contact with the offender outweighs the needs or desires of the offender.
- The offender changes his or her behavior to prevent unsafe or unwanted contact with victims or potential victims.
- The offender has started to pay restitution and has a realistic plan to continue.
- The offender has demonstrated consistent compliance with all registration, notification, HIV testing and DNA testing requirements and has an active plan to continue.

Completion:

- The offender has successfully completed victim clarification with his or her victims and secondary victims or victim surrogates when victim needs or desires indicate non- participation.
- The offender demonstrates the capacity, knowledge, willingness and ability to empathize.

Discussion: It should be noted that it can be dangerous to attempt empathy work with those offenders who may not have the capacity to develop real empathy (such as psychopaths and sadists). These offenders may utilize information about others' pain as a means to learn how to harm victims more effectively.

D. Offender Criteria

Progress:

- The offender recognizes and acknowledges his or her lifelong risk.
- The offender does not project blame for his or her offending behavior.
- The offender does not present himself or herself as entitled or as a victim.
- The offender has identified cognitive distortions and has demonstrated a consistent ability to change them.
- The offender has been able to demonstrate a primarily positive attitude toward supervision and treatment.
- The offender has identified problems with stress management, social skills and anger management and is developing pro social skills to address them.

- The offender can identify his or her unhealthy attitudes and behavior regarding sex roles and sexuality and is working to change them.
- The offender can identify his or her misuse of power and control and is working to eliminate it.

Completion:

- The offender consistently maintains a positive attitude toward supervision and treatment.
- The offender is committed to permanently altering his or her lifestyle to reduce and control his or her lifelong risk.
- The offender does not project blame or minimize personal responsibility.
- The offender assumes full and appropriate responsibility for his or her actions.
- The offender demonstrates primarily non-distorted thinking.
- The offender has accepted and is actively and consistently working to address any diagnosed personality disorders.
- The offender has addressed in treatment and demonstrated the ability to practice ongoing self care regarding: 1) previous trauma, 2) social skills, 3) stress management, 4) anger management, and 5) independent living skills.
- The offender has consistently demonstrated realistic and healthy attitudes and behavior about sexuality and sex roles.
- The offender has addressed power and control issues in treatment and has consistently demonstrated an ability to engage with others without abusing power and control.
- The offender has willingly engaged in risk assessment and physiological monitoring and has an active plan to continue.
- The offender has developed a positive life purpose which is internally oriented, value driven and not outcome dependent.

E. Co-morbidity and Adjunctive Issues

Progress:

- The offender is addressing any domestic violence history with appropriate domestic violence treatment and has not engaged in domestic violence.
- The offender is addressing drug and alcohol problems in treatment and is maintaining abstinence of recommended.
- The offender is addressing any psychiatric conditions in treatment and is in compliance with all recommended medications.

Completion:

- The offender has not committed any new incidents of domestic violence, has addressed domestic violence in treatment and demonstrates a commitment to continue domestic violence treatment as needed.
- The offender demonstrates an ongoing commitment to participate in recommended substance abuse treatment and maintenance programs.
- The offender has addressed any psychiatric conditions in treatment and demonstrates an ongoing commitment to participate in recommended treatment, maintenance and medication programs.

Discussion: Sex offenders who are sadists or psychopaths may not have the ability to successfully complete treatment. These offenders should not be considered for release from lifetime supervision.

4.200
Criteria for Successful Progress in Treatment in Prison: Sex Offender Treatment and Management Program, Colorado Department of Corrections

4.210 Sex offender treatment in the prison setting is always preliminary to continued treatment and supervision in the community post release from prison. Since sex offenders who participate in treatment in the prison setting cannot complete treatment in prison, the Sex Offender Treatment and Management Program has developed three formats for sex offender participation in prison treatment based on differing minimum sentences and time to parole eligibility.

It should be understood that the availability of these specialized formats does not ensure sex offender cooperation with or success in treatment. The eligibility requirements for SOTMP apply for all of these formats.

Sex offenders must meet all of the criteria for their assigned format to receive a recommendation for release to parole from the Sex Offender Treatment and Monitoring Program staff.

A. Criteria for the Standard Format

Offenders with 6 years or more minimum sentence will be assigned to the Standard Format.

1. The offender must be actively participating in treatment and applying what he or she is learning.

2. The offender must have completed a non-deceptive polygraph assessment of his or her deviant sexual history. Any recent monitoring polygraph exams must also be non-deceptive.

3. The offender must have completed a comprehensive Personal Change contact (relapse prevention plan) which is approved by the SOTMP team.

4. The offender must have, at a minimum, one approved support person who has attended family/support education and has reviewed and received a copy of the Offender's Personal Change Contract.

5. The offender must be practicing relapse prevention with no institutional acting out behaviors within the past year.

6. The offender must be compliant with any DOC psychiatric recommendations for medication which may enhance his or her ability to benefit from treatment and or reduce his or her risk of re-offense.

7. The offender must be able to be supervised in the community without presenting an undue threat.

B. Criteria for the Modified Format

Offenders with 2 to 6 years minimum sentence will be assigned to the Modified Format.

1. The offender must be actively participating in treatment and applying what he or she is learning.

2. The offender must have completed a non-deceptive polygraph assessment of his or her deviant sexual history. Any recent monitoring polygraph exams must also be non-deceptive.

3. The offender must be practicing relapse prevention with no institutional acting out behaviors within the past year.

4. The offender must have defined and documented his or her sexual offense cycle.

5. The offender must have, at a minimum, one approved support person who has attended family/support education and has reviewed and received a copy of the Offender's Personal Change Contract.

6. The offender must be compliant with any DOC psychiatric recommendations for medication which may enhance his or her ability to benefit form treatment and or reduce his or her risk of re-offense.

7. The offender must be able to be supervised in the community without presenting an undue threat.

C. Criteria for the Foundation Format

Sex Offenders with less than 2 years minimum sentence will be assigned to the Foundation Format.

1. The offender must be actively participating in treatment and applying what he or she is learning.

2. The offender must have completed a non-deceptive polygraph assessment of his or her deviant sexual history. Any recent monitoring polygraph exams must also be non-deceptive.

3. The offender must participate in a comprehensive sex offense-specific evaluation and have a SOTMP approved individual treatment plan.

4. The offender must have no institutional acting out behaviors within the last year.

5. The offender must be compliant with any DOC psychiatric recommendations for medication which may enhance his or her ability to benefit form treatment and or reduce his or her risk of re-offense.

6. The offender must have a plan to establish at least one approved support person.

7. The offender must be able to be supervised in the community without presenting an undue threat.