

# Colorado Sex Offender Management Board

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



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# INTRODUCTION

In 1992, the Colorado General Assembly passed legislation ( Section 16-11.7-101 through Section 16-11.7-107 C.R.S.) which 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 (hereafter Board) in 1998 to more accurately reflect the duties assigned to the Board. The standards and guidelines (hereafter Standards) were originally drafted by the Board over a period of two years and were first published in January 1996. The Standards were revised in 1998 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 and guidelines are designed to establish a basis for systematic management and treatment of adult sex offenders. The legislative mandate of the Board 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 Board 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 Sex Offender Management Board, 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.

Sex offender management and treatment is a developing specialized field. The Board will remain current on the emerging literature and research and will modify the Standards periodically on the basis of new findings. The current revisions to 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 on-going 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 mental health 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:

- P Sex offenders should not be in the community without comprehensive treatment, supervision, and behavioral monitoring
- P Each discipline brings to the team specialized knowledge and expertise
- P Open professional communication confronts sex offenders' tendencies to exhibit secretive, manipulative and denying behaviors, and
- P 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.

- P 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.
- P 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.
- P 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); 2.070 (Psycho-sexual Evaluations); 3.120 (Standards for Treatment Providers); 3.210 (Confidentiality); 3.310 (Provider-Offender Contract); 5.710 (Offender-Victim Contact).



# DEFINITIONS

- Accountability:** Accountability means accurate attributions of responsibility, without distortion, minimization, or denial.
- 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 mental health 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.
- Board:** Board means the Colorado Sex Offender Management Board.
- 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.
- Clinical Polygraph:** Clinical polygraph examination means the employment of instrumentation used for the purpose of detecting deception or verifying truth of statements of a person under criminal justice supervision and/or treatment for the commission of sex offenses. A clinical polygraph examination is specifically intended to assist in the treatment and supervision of convicted sex offenders. Clinical polygraphs include specific-issue, disclosure and periodic or maintenance examinations. Clinical polygraphs may also be referred to as post-conviction polygraphs. (See also Sex Offender Polygraph.)
- 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 Appendix B, Levels and Types of Denial.)

**Department:** Department means the Colorado Department of Public Safety.

**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 "mental health 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 mental health sex offense-specific evaluations of sex offenders according to the guidelines and standards contained in this document, and according to professional standards.

**Guideline:** Guideline means a principle by which to make a judgement or determine a policy or course of action.

**Incidental Contact:** Any verbal or physical contact.

**Informed Assent:**<sup>1</sup> 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.

## Non-deceptive Polygraph

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<sup>1</sup> 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.



**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.

**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 Board, identifies the treatment providers, evaluators, plethysmograph examiners and polygraph examiners who meet the criteria set forth in these Standards and Guidelines. The determination that the providers meet the criteria is made by the Board 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.

**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 statute.<sup>2</sup> For purposes of this document a sex offender is:

- (1) Any (adult) person convicted of a sex offense (defined below) in Colorado after January 1, 1994;
- (2) Any (adult) person convicted of any criminal offense in Colorado after January 1, 1994 who has previously been convicted of a sex offense in Colorado;
- (3) Any (adult) person who has previously been convicted in any other jurisdiction of any offense which would constitute a sex offense in Colorado, or;

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<sup>2</sup> Section 16-11.7-101(2) C.R.S.

- (4) Any (adult) person who has a history of any sex offense.

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.<sup>3</sup> For purposes of this document, a sex offense is:

- (1) Sexual Assault in the first, second and third degree;
- (2) Sexual Assault on a child;
- (3) Sexual Assault on a child by one in a position of trust;
- (4) Sexual Assault on a client by a psychotherapist;
- (5) Enticement of a child;
- (6) Incest;
- (7) Aggravated Incest;
- (8) Trafficking in children;
- (9) Sexual Exploitation of children;
- (10) Procurement of a child for sexual exploitation;
- (11) Indecent Exposure;
- (12) Soliciting for child prostitution;
- (13) Pandering of a child;
- (14) Procurement of a child;
- (15) Keeping a place of child prostitution;
- (16) Pimping of a child;
- (17) Inducement of child prostitution;
- (18) Patronizing a prostituted child, or;

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<sup>3</sup> Section 16-11.7-101(3) C.R.S.

- (19) 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.

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

**Standards and Guidelines:** “Standards and Guidelines” means the standards 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 Board. (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** Each sex offender should be the subject of a pre-sentence investigation, including a mental health sex offense-specific evaluation, prior to sentencing, even when by statute it is otherwise acceptable to waive the pre-sentence investigation.

*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 mental health 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 mental health 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 of conviction, including plea agreements, deferred judgements and sentences for a non-sexual crime, if the current offense has a factual basis of unlawful sexual behavior, the offender's case should be assigned to a pre-sentence investigator specially trained to assess sex offenders.

*Discussion: While it is preferable that sexual crimes not be plea bargained to non-sexual crimes, such plea bargains sometimes occur. However, this does not eliminate the need for the offender to be assessed based on the factual basis of the case.*

- 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:

- P Criminal history
- P Education/employment
- P Financial status
- P Assaultiveness
- P Residence
- P Leisure/recreation
- P Companions
- P Alcohol/drug problems
- P Victim impact
- P Emotional/personal problems
- P Attitude/orientation
- P Family, marital and relationship issues
- P Offense patterns and victim grooming behaviors
- P Mental health sex offense-specific evaluation report

**P** The potential impact of each sentencing option on the victim(s)

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 mental health sex offense-specific evaluation, pre-sentence investigators should send to the evaluator, as part of the referral packet:

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

**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 requirement the offender will have to meet should probation be granted.*

## 2.000 STANDARDS FOR MENTAL HEALTH SEX OFFENSE-SPECIFIC EVALUATIONS

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

*Discussion: Evaluations are conducted to identify individuals who are at low risk of re-offending as well as those who are highly likely to re-offend. Because of the importance of the information collected during an evaluation to subsequent sentencing, supervision, treatment, and behavioral monitoring, it is the Board's philosophy that each sexual offender should receive a thorough assessment and evaluation. In addition, it is important to recognize that assessment and evaluation are ongoing processes and should continue through each stage of supervision and treatment. Re-evaluation should occur on a regular basis to ensure recognition of changing levels of risk for many offenders.*

**2.020** The mental health sex offense-specific evaluation has the following purposes:

- P To document the treatment needs identified by the evaluation (even if resources are not available to address adequately the treatment needs of the sexually abusive offender);
- P To provide a written clinical evaluation of an offender's risk for re-offending and current amenability for treatment;
- P To guide and direct specific recommendations for the conditions of treatment and supervision of an offender;
- P To provide information that will help to identify the optimal setting, intensity of intervention, and level of supervision, and;
- P To provide information that will help to identify offenders who should not be referred for community-based treatment.

**2.030** The evaluator shall meet the same requirements, and have the same skills, and experience as sex offender treatment providers and shall demonstrate specific clinical experience with sex offense-specific mental health evaluation of convicted sex offenders. (Qualifications for evaluators and treatment providers are outlined in Section 4.000.) In addition, evaluators shall adhere to established ethical standards, practices and guidelines of their respective professions with regard to the administration of psychological tests.

**2.040** The evaluator shall obtain the informed assent of the offender for the evaluation, and shall inform an offender of the assessment and evaluation methods, how the information will be used, and to whom it will be given. The evaluator shall also inform the offender about the nature of the evaluator's relationship with the offender and with the court. The evaluator shall respect an offender's right to be fully informed about the evaluation procedures. Results of the evaluation should be shared with the offender and any questions clarified.

**2.050** The evaluator shall be sensitive to any cultural, ethnic, developmental, sexual orientation, gender, medical and/or educational issues that may arise during the evaluation.

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

- P Use of instruments that have specific relevance to evaluating sex offenders
- P Use of instruments with demonstrated reliability and validity
- P Integration of collateral information
- P Use of multiple assessment instruments and techniques
- P Use of structured<sup>4</sup> interviews
- P Use of interviewers who have been trained to collect data in a non-pejorative manner

*Discussion: The Board recognizes that the field of evaluation of sex offenders is in a formative stage. There is, however, a great deal of research currently being done to increase our ability to predict sex offenders' risk of re-offending. Undoubtedly, evaluation instruments and processes will be subject to change as more is learned in this area. Because measures of risk are uncertain 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 form a picture of a sex offender's dangerousness, likelihood of re-offending, and amenability to treatment. When the evaluator is in doubt, s/he should err on the side of protecting community safety.*

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

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

**2.080** 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. If this option is not used, other means for measuring deception must be part of the assessment. (See Sections 6.000 for standards on the use of the polygraph.)

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

- P Sexual evaluation, including sexual developmental history and evaluation for sexual arousal/interest, deviance and paraphilias
- P Character pathology
- P Level of deception and/or denial
- P Mental and/or organic disorders

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<sup>4</sup> The use of the term "structured" is not meant to imply that there is only one acceptable format for a clinical evaluation. Rather, the importance of structuring a clinical interview in such a way as to assure that all necessary areas of the mental health sex offense-specific systematic manner.



- P Drug/alcohol use
- P Stability of functioning
- P Self-esteem and ego-strength
- P Medical/neurological/pharmacological needs
- P Level of violence and coercion
- P Motivation and amenability for treatment
- P Escalation of high-risk behaviors
- P Risk of re-offense
- P Treatment and supervision needs
- P Impact on the victim, when possible

*Discussion: Outlined below are the required areas of a mental health sex offense-specific evaluation. The examples identify specific evaluation instruments/processes for each area. Use of any of these specific procedures is optional unless indicated as required in Section 2.070. However, it is minimally required that an evaluator do some type of offense-specific psychological testing. 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. Effective evaluations must include multiple risk factors. The evaluator should be cognizant that an offender's self-report is demonstrated by research to be the least reliable source of information during the evaluation, and shall take steps not to rely solely on self-report information.*

*Standardized psychological testing should be utilized based on the clinical judgment of the evaluator. Evaluators meeting these standards will not necessarily be qualified to directly evaluate medical, neurological, and/or pharmacological needs. Therefore it is imperative that the evaluator perform adequate screening for referral to medical doctors for assessment of these conditions. Un-interpreted raw data from any type of testing should never be included in evaluation reports. Care should be taken by the evaluator to guard against over interpretation of the data.*

*Any component which is not included as required in Section 2.070 shall be noted in the report. Any impact this may have on assessing risk shall be noted as well.*

*Before evaluating sex offenders, evaluators (and treatment providers) should also have a thorough understanding of counter-transference issues, and should have a broad sense of sexuality in the general population.*

## MENTAL HEALTH SEX OFFENSE-SPECIFIC EVALUATION

Evaluation Areas - Required	Possible Evaluation Procedures
<b>EVALUATE MENTAL AND/OR ORGANIC DISORDERS</b>	
<b>O IQ Functioning</b> ( <i>Mental Retardation, Learning Disability, and Literacy</i> )	<ul style="list-style-type: none"> <li>• History of Functioning and/or Standardized Tests. Examples:               <ul style="list-style-type: none"> <li>N WAIS-R or WAIS III</li> <li>N WRAT-R</li> <li>N Revised Beta</li> <li>N TONI (Test of Non-Verbal Intelligence)</li> <li>N Shipley Institute of Living Scale Revised</li> <li>N Kaufman IQ Test for Adults</li> <li>N Stanford Binet</li> </ul> </li> </ul>
<b>O Organic Brain Syndrome (OBS)</b>	<ul style="list-style-type: none"> <li>• History of Functioning and/or Standardized Tests. Examples:               <ul style="list-style-type: none"> <li>N WAIS-R</li> <li>N Weschler Memory Scale Revised</li> <li>N Limbic System Checklist</li> <li>N Structured Mental Status Exam</li> <li>N Jacobs Cognitive Screening Test</li> <li>N Quick Neurological Screening Test</li> <li>N Medical Tests Necessary for Diagnosis</li> </ul> </li> </ul>
<b>O Mental Illness</b>	<ul style="list-style-type: none"> <li>• History of Functioning and/or Structured Interview</li> <li>• MMPI or MMPI2</li> <li>• MCMII-II or III</li> <li>• Beck Depression Scale</li> </ul>
<b>EVALUATE DRUG/ALCOHOL USE*</b>	
<b>O Use/Abuse</b>	<ul style="list-style-type: none"> <li>• History of Functioning and/or Structured Interview; and/or Standardized Tests</li> <li>• MMPI</li> <li>• CAQ (Clinical Analysis Questionnaire)</li> <li>• PHQ (Personal History Questionnaire)</li> <li>• ADS</li> <li>• DAST-20</li> <li>• Adult Substance Use Survey</li> <li>• Substance Use History Matrix</li> <li>• Collateral Information</li> </ul>
<b>O Number of Relapses</b>	<ul style="list-style-type: none"> <li>• History of Functioning and/or Structured Interview</li> <li>• Treatment History</li> <li>• Collateral Information</li> </ul>

\* Coordination of testing with 1173 requirements is important.

<b>EVALUATE CHARACTER PATHOLOGY</b>	
<b>O Degree of Impairment</b>	<ul style="list-style-type: none"> <li>• Hare PSYCHOPATHY CHECKLIST REVISED (PCLR OR PCLSC)</li> <li>• Structured Interview</li> <li>• MCMI-II or III</li> <li>• History</li> <li>• Collateral Information</li> </ul>

<b>EVALUATE STABILITY OF FUNCTIONING</b>	
<b>O Marital/Family Stability</b> Q Past Q Current Q Familial Violence Q Familial Sexual Q Financial Q Housing	<ul style="list-style-type: none"> <li>• History of Functioning and/or Structured Interview</li> <li>• FES (Family Environment Scale)</li> <li>• DAS (Dyadic Adjustment Scale)</li> <li>• MSI (Marital Satisfaction Inventory)</li> <li>• Interview Attitudes</li> <li>• Collateral Information</li> </ul>
<b>O Employment/Education</b> Q Completion of Major Life Tasks	<ul style="list-style-type: none"> <li>• History of Functioning and/or Structured Interview</li> <li>• PHQ (Personal History Questionnaire)</li> </ul>
<b>O Social Skills</b> Q Ability to Form Relationships Q Ability to Maintain Relationships Q Courtship/Dating Skills Q Ability to Demonstrate Assertive Behavior	<ul style="list-style-type: none"> <li>• History of Functioning and/or Structured Interview</li> <li>• Collateral Information</li> <li>• IBS (Interpersonal Behavior Survey)</li> <li>• Social Avoidance and Distress Scale</li> <li>• Waring's Intimacy Scale</li> <li>• UCLA Loneliness Scale</li> <li>• Tesch's Intimacy Scale</li> <li>• Miller's Social Intimacy Scale</li> </ul>

<b>DEVELOPMENTAL HISTORY</b>	
Q Disruptions in parent/child relationship Q History of bed wetting, cruelty to animals Q History of behavior problems in elementary school Q History of special education services, learning disabilities, school achievement Q Indicators of disordered attachments	<ul style="list-style-type: none"> <li>• History of Functioning and/or Structured Interview</li> <li>• Collateral Information</li> </ul>

<b>EVALUATION OF SELF</b>
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<p>Q Self-image, Self Esteem Q Ego Strength</p>	<ul style="list-style-type: none"> <li>• History of Functioning and/or Structured Interview</li> <li>• MPD (Measures of Psychological Development)</li> <li>• CAQ (Clinical Analysis Questionnaire)</li> <li>• CPI (California Personality Inventory)</li> </ul>
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<b>MEDICAL SCREENING MEASURES</b>	
<p>Q Pharmacological Needs Q Medical Condition Impacting Offending Behavior Q History of Medication Use/Abuse</p>	<ul style="list-style-type: none"> <li>• History of Functioning and/or Structured Interview</li> <li>• Referral to Physician if indicated</li> <li>• Medical Tests</li> </ul>

<b>SEXUAL EVALUATION</b>	
<p><b>O Sexual History</b> (<i>Onset, Intensity, Duration, Pleasure Derived</i>)  Q Age of Onset of Expected Normal Behaviors  Q Quality of First Sexual Experience  Q Age of Onset of Deviant Behaviors  Q Witnessed or Experienced Victimization (Sexual or Physical)  Q Genesis of Sexual Information  Q Age/Degree of Use of Pornography, Phone Sex, Cable, Video, or Internet for Sexual Purposes  Q Current and Past Range of Sexual Behavior</p>	<ul style="list-style-type: none"> <li>• History of Functioning and/or Structured Interview</li> <li>• Collateral Information</li> <li>• PSCI (Personal Sentence Completion Inventory--Miccio-Fonseca)</li> <li>• Wilson Sexual Fantasy Questionnaire</li> <li>• SONE Sexual History Background Form</li> <li>• SORI (Sex Offender Risk Instrument - in research stage)</li> </ul>
<p><b>O Reinforcement Structure for Deviant Behavior</b>  Q Culture  Q Environment  Q Cults</p>	<ul style="list-style-type: none"> <li>• Structured Interview</li> </ul>
<p><b>O Arousal Pattern</b>  Q Sexual Arousal  Q Sexual Interest</p>	<ul style="list-style-type: none"> <li>• Plethysmograph</li> <li>• Abel Screen</li> </ul>

<p><b>O Specifics of Sexual Crime(s)</b> (<i>Onset, Intensity, Duration, Pleasure Derived</i>)</p> <p>Q Detailed Description of Sexual Assault</p> <p>Q Seriousness, Harm to Victim</p> <p>Q Mood During Assault (Anger, Erotic, "Love")</p> <p>Q Progression of Sexual Crimes</p> <p>Q Thoughts Preceding and Following Crimes</p> <p>Q Fantasies Preceding and Following Crimes</p>	<ul style="list-style-type: none"> <li>• Structured Interview</li> <li>• History of Crimes</li> <li>• Collateral Information</li> <li>• Review of Criminal Records</li> <li>• Review of Victim Impact Statement</li> <li>• Contact with Victim Therapist</li> <li>• Polygraph</li> </ul>
<p><b>O Sexual Deviance</b></p>	<ul style="list-style-type: none"> <li>• Structured Interview</li> <li>• MSI (Multiphasic Sex Inventory)</li> <li>• SONE</li> <li>• Clarke</li> </ul>
<p><b>O Dysfunction</b> (<i>Impotence, Priapism, Injuries, Medications Affecting Sexual Functioning, Etc.</i>)</p>	<ul style="list-style-type: none"> <li>• Structured Interview</li> <li>• MSI (Multiphasic Sex Inventory)</li> <li>• Sexual Autobiography</li> </ul>
<p><b>O Offender's Perception of Dysfunction</b></p>	<ul style="list-style-type: none"> <li>• Structured Interview</li> <li>• Sexual Autobiography</li> <li>• Bentler Heterosexual Inventory</li> <li>• Abel and Becker Card Sort</li> <li>• History</li> </ul>
<p><b>O Perception of Sexual Functioning</b></p>	<ul style="list-style-type: none"> <li>• Structured Interview</li> <li>• Sexual Autobiography</li> <li>• Plethysmograph</li> <li>• Bentler Sexual Behavior Inventory</li> </ul>
<p><b>O Preferences</b> (<i>Male/Female; Age; Masturbation; Use of Tools, Utensils, Food, Clothing; Current Sexual Practices; Deviant as well as Normal Behaviors</i>)</p>	<ul style="list-style-type: none"> <li>• Structured Interview</li> <li>• Sexual Autobiography</li> <li>• Plethysmograph</li> <li>• Able Screen</li> </ul>
<p><b>O Attitudes/Cognition</b></p> <p>Q Motivation to Change/Continue Behavior</p> <p>Q Attitudes Toward Women, Children,</p> <p>Q Sexuality in General</p> <p>Q Attitudes About Offense (i.e., Seriousness, Harm to Victim)</p> <p>Q Degree of Victim Empathy</p> <p>Q Presence/Degree of Minimalization</p> <p>Q Presence/Degree of Denial</p> <p>Q Ego-syntonic vs. Ego-dystonic Sense of Deviant Behavior</p>	<ul style="list-style-type: none"> <li>• Structured Interview</li> <li>• Burt Rape Myth Acceptance Scale</li> <li>• MSI (Multiphasic Sex Inventory)</li> <li>• Buss/Durkee Hostility Inventory</li> <li>• Abel and Becker Cognitions Scale</li> <li>• Attitudes Towards Women Scale</li> <li>• Socio-Sexual Knowledge and Attitudes Test (For use with sex offenders who have developmental disabilities)</li> </ul>

**EVALUATE LEVEL OF DENIAL AND/OR DECEPTION**

Q Level of Denial Q Level of Deception	<ul style="list-style-type: none"> <li>• Structured Interview *</li> <li>• Collateral Information (such as from victim, police, others)</li> <li>• Polygraph</li> </ul>
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<b>EVALUATE LEVEL OF VIOLENCE AND COERCION</b>	
Q Level of Violence Q Overall Pattern of Assaultiveness Q Victim Selection Q Pattern of escalation of violence	<ul style="list-style-type: none"> <li>• Structured Interview</li> <li>• History</li> <li>• Collateral Information</li> <li>• Review of Criminal Records</li> </ul>

\*The use of the structured interview may assist in evaluation of deception on the part of an offender. However, it is not adequate on its own as an indicator of denial or deception.

<b>EVALUATE RISK</b>	
<b>O Risk of Re-offense</b>	<ul style="list-style-type: none"> <li>• Criminal History</li> <li>• Colorado Division of Criminal Justice Sex Offender Risk Scale (Actuarial scale normed on Colorado offenders from probation, parole and prison)</li> <li>• SOMB Checklist (Normed on Colorado Offenders from probation, parole and community corrections)</li> <li>• Oregon Risk Assessment Scale (Normed on Oregon offenders)</li> <li>• Violence Risk Assessment Guide (Normed on a psychiatric hospital sample)</li> <li>• Rapid Risk Assessment for Sex Offender Re-Arrest (Sample excludes incest offenders)</li> <li>• MnSOST-R (Normed on Minnesota Offenders in the Department of Corrections, excludes incest offenders)</li> </ul>

**2.110** The evaluator shall recommend:

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

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

**2.120** The evaluator shall consider the following factors when making recommendations relating to an offender's risk to re-offend and amenability to treatment.<sup>5</sup>

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<sup>5</sup> The list of risk assessment factors is based on and modified from the Adult Sexual Offender Assessment Packet, published by T Brandon, VT. Additional detail on each factor is provided in Appendix A.

- P Admission of offenses
- P Accountability (internal and external factors which control behavior)
- P Cooperation
- P Offense history and victim choice
- P Escalating pattern of offenses, violence, and dangerous behaviors
- P Sexual deviancy, arousal patterns, and sexual interest
- P Social interest
- P Lifestyle characteristics
- P Psychopathology
- P Developmental markers
- P History of childhood or adolescent delinquency
- P Substance abuse
- P Criminal history
- P Social support systems
- P Overall control and intervention
- P Motivation for treatment and recovery
- P Self-structure
- P Disowning behaviors
- P Prior treatment
- P Impact on victim(s)
- P Access to potential victim pool

*Discussion: Risk to re-offend and amenability to treatment must be considered together. It is important for evaluators to be conversant with the research that suggests that the presence of a number of these factors may increase or decrease treatment amenability and/or re-offense risk. In addition, some factors weigh more heavily than others. For example, a history of sexual offenses is currently considered one of the strongest predictors of re-offense. These factors may also be used as a guide to a structured interview for the purpose of assessing risk. However, no matter how carefully done, assessments cannot absolutely predict whether a given individual will or will not re-offend.*







# 3.000 STANDARDS OF PRACTICE FOR TREATMENT PROVIDERS

## 3.100 P Sex Offense-specific Treatment

- 3.110** Sex Offense specific treatment must be provided by a treatment provider registered at the full operating level or the associate level under these standards.
- 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.)
- 3.130** A provider shall develop a written treatment plan based on the needs and risks identified in current and past assessments/evaluations of the offender.

The treatment plan shall:

- P Provide for the protection of victims and potential victims and not cause the victim(s) to have unsafe and/or unwanted contact with the offender
  - P Be individualized to meet the unique needs of the offender
  - P Identify the issues to be addressed, including multi-generational issues if indicated, the planned intervention strategies, and the goals of treatment
  - P Define expectations of the offender, his/her family (when possible), and support systems
  - P Address the issue of ongoing victim input
- 3.140** A provider shall employ treatment methods that are supported by current professional research and practice:
- A. Group therapy (with the group comprised only of sex offenders) is the preferred method of sex offense-specific treatment. At a minimum, any method of psychological treatment used must conform to the standards for content of treatment (see F., below) and must contribute to behavioral monitoring of sex offenders. The sole use of individual therapy is not recommended with sex offenders, and shall be avoided except when geographical--specifically rural--or disability limitations dictate its use.
  - B. The use of male and female co-therapists in group therapy is highly recommended and may be required by the supervising agency.  
  
*Discussion: Group therapy may need to be supplemented by treatment for drug/alcohol abuse, marital therapy, individual crisis intervention. However, group sex-offense specific treatment should remain the primary modality utilized with sex offenders.*
  - C. The ratio of therapists to sex offenders in a treatment group shall not exceed 1:8. Treatment group size shall not exceed 12 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 c. above. The test for compliance with this standard will be the regularity with which the ratio of therapists to sex offenders is congruent with c. above.*

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

- D. 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.
- E. The provider shall employ treatment methods that are based on a recognition of the need for long-term, comprehensive, offense-specific treatment for sex offenders. Self-help or time-limited treatments shall be used only as adjuncts to long-term, comprehensive treatment.
- F. The content of offense-specific treatment for sex offenders shall be designed to:
  - 1. Reduce offenders' denial and defensiveness;
  - 2. Decrease and/or manage offenders' deviant sexual urges and recurrent deviant fantasies;
  - 3. 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;
  - 4. Teach offenders self-management methods to avoid a sexual re-offense;
  - 5. Identify and treat the offenders' thoughts, emotions, and behaviors that facilitate sexual re-offenses or other victimizing or assaultive behaviors;
  - 6. Identify and correct offenders' cognitive distortions;
  - 7. Educate offenders about non-abusive, adaptive, legal, and pro-social sexual functioning;
  - 8. Educate offenders about the impact of sexual offending upon victims, their families, and the community;
  - 9. Provide offenders with an environment that encourages the development of empathic skills needed to achieve sensitivity and empathy for victims;
  - 10. 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 restitution for the victim(s);
  - 11. Identify and treat offenders' personality traits and deficits that are related to their potential for re-offending;

12. Identify and treat the effects of trauma and past victimizations on 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);
13. Identify and decrease offenders' deficits in social and relationship skills, where applicable;
14. Require offenders to develop a written relapse prevention plan for preventing a re-offense; the plan should identify antecedent thoughts, feelings, circumstances, and behaviors associated with sexual offenses;
15. Provide treatment referrals, as indicated, for offenders with co-existing medical, pharmacological, mental, substance abuse and/or domestic violence issues, or other disabilities;
16. Maintain communication with other significant persons in offenders' support systems when indicated, and to the extent possible, to assist in meeting treatment goals;
17. Evaluate cultural, language, developmental disabilities, sexual orientation and/or gender factors that may require special treatment arrangements;
18. Identify and address issues of gender role socialization, and;
19. Identify and treat issues of anger, power, and control.

*Discussion: The provision of educational and support services to the families of sex offenders enhances the possibility of meeting treatment, supervision and community safety goals.*

- 3.150** Providers shall maintain clients' files in accordance with the professional standards of their individual disciplines and with Colorado state law on health care records. Client files shall:
- A. Document the goals of treatment, the methods used, the client's observed progress, or lack thereof, toward reaching the goals in the treatment records. Specific achievements, failed assignments, rule violations and consequences given should be recorded.
  - B. Accurately reflect the client's treatment progress, sessions attended, and changes in treatment.



## 3.200 P Confidentiality

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

*Discussion: Waivers of confidentiality will be required of the sex offender by the (1) conditions of probation, parole, and/or community corrections, or the prison treatment program, and 2) the treatment provider-client contract.*

*Notwithstanding such waivers of confidentiality, treatment providers shall safeguard the confidentiality of client information from those for whom waivers of confidentiality have not been obtained.*

*Waivers of confidentiality should also extend to the victim, or custodial parent or guardian ad litem of a child victim particularly with regard to (1) the offender's compliance with treatment and (2) information about risk, threats, and/or possible escalation of violence.*

- 3.220** A provider shall notify all clients of the limits of confidentiality imposed on therapists by the mandatory reporting law, Section 19-3-304 C.R.S.
- 3.230** 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.
- 3.240** When indicated and consistent with the informed assent of an offender, a provider shall obtain a waiver of confidentiality in order to communicate with the victim's therapist, guardian ad litem, custodial parent, guardian, caseworker or other professional involved in making decisions regarding reunification of the family or an offender's contact with past or potential child victim(s).
- 3.250** A provider shall obtain specific releases which waive confidentiality for communications with other parties in addition to those described in this standard.





## 3.300 P Treatment Provider-client Contract

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

- A. The contract shall explain the responsibility of a provider to:
1. Define and provide timely statements of the costs of assessment, evaluation, and treatment, including all medical and psychological tests, physiological tests, and consultations;
  2. Describe the waivers of confidentiality which will be required for a provider to treat the client for his/her sexual offending behavior; describe the various parties with whom treatment information will be shared during the treatment; describe the time limits on the waivers of confidentiality; and describe the procedures necessary for the client to revoke the waiver;
  3. Describe the right of the client to refuse treatment and/or to refuse to waive confidentiality, and describe the risks and potential outcomes of that decision;
  4. Describe the type, frequency, and requirements of the treatment and outline how the duration of treatment will be determined, and;
  5. Describe the limits of confidentiality imposed on therapists by the mandatory reporting law, Section 19-3-304 C.R.S.
- B. The contract shall explain any responsibilities of a client (as applicable) to:
1. Pay for the cost of assessment and treatment for him or herself, and his or her family, if applicable;
  2. Pay for the cost of assessment and treatment for the victim(s) and their family(ies), when ordered by the court, including all medical and psychological tests, physiological testing, and consultation;
  3. Inform the client's family and support system of details of past offenses which are relevant to ensuring help and protection for past victims and/or relevant to the relapse prevention plan. Clinical judgement should be exercised in determining what information is provided to children;
  4. Actively involve relevant family and support system, as indicated in the relapse prevention plan.
  5. Notify the treatment provider of any changes or events in the lives of the client and members of the client's family or support system;
  6. Participate in polygraph testing as required in the Standards and Guidelines and, if indicated, plethysmographic testing as adjuncts to treatment;

7. Assent to be tested for sexually transmitted diseases and HIV, and assent for the results of such testing to be released to the victim by the appropriate person, and;<sup>6</sup>
8. Comply with the limitations and restrictions placed on the behavior of the client, as described in the terms and conditions of probation, parole, or community corrections and/or in the contract between the provider and the client.

C. The contract shall also, (as applicable):

1. Provide instructions and describe limitations regarding the client's contact with victims, secondary victims, and children;
2. Describe limitations or prohibitions on the use or viewing of sexually explicit or violent material;
3. Describe the responsibility of the client to protect community safety by avoiding risky, aggressive, or re-offending behavior, by avoiding high risk situations, and by reporting any such forbidden behavior to the provider and the supervising officer as soon as possible;
4. Describe limitations or prohibitions on the use of alcohol or drugs not specifically prescribed by medical staff, and;
5. Describe limitations or prohibitions on employment or recreation.

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<sup>6</sup> Designation of an appropriate person to disclose the results of an HIV test is particularly important. Please see the *Protocol for Ct Testing of Sexual Assailants* prepared by the Colorado Coalition Against Sexual Assault and the Colorado Department of Health, in coo Colorado Association of District Attorneys, the Colorado Bureau of Investigation, the Denver Police Crime Lab, the Colorado Organizatio the Colorado Public Defenders Office.

## 3.400 P Completion of Court-ordered Treatment

**3.410** Completion of treatment should be understood as the cessation of court-ordered, offense-specific treatment, not the end of offenders' rehabilitative needs or the elimination of risk to the community. If risk increases, treatment may be reinstated. The sex offender community supervision team shall consult about the completion of treatment. This decision shall come after the evaluation and assessment, treatment plan, course of treatment sequence, and a minimum of a non-deceptive disclosure polygraph examination and two or more consecutive non-deceptive maintenance polygraph examinations, regarding compliance with court rules, compliance with supervision conditions, compliance with treatment contract provisions including complete abstinence from grooming of victims and full, voluntary compliance with all conditions required to prevent re-offending behavior. The two or more non-deceptive polygraph examinations must be those most recent prior to termination of treatment. (See definitions for non-deceptive polygraph examination results.) (A failed polygraph examination may not be used as the sole reason to deny successful completion of treatment.) The team should carefully consider termination of treatment based on maintaining community safety. Those offenders who pose an ongoing threat to the community, even while demonstrating progress in treatment, may require ongoing supervision and/or treatment to manage their risk. Any exception made to any of the requirements for treatment completion must be made by a consensus of the case management team. In this case, the team must document the reasons for the determination that treatment completion is appropriate without meeting all of the standard requirements and note the potential risk to the community.

- A. To determine the recommendation for the discontinuation of treatment, the provider shall:
1. Assess actual changes in a client's potential to re-offend prior to recommending treatment termination;
  2. Attempt to repeat, where indicated, those assessments that might show changes in a client;
  3. Assess and document how the goals of the treatment plan have been met, what actual changes in a client's re-offense potential have been accomplished, and what risk factors remain, particularly those affecting the emotional and physical safety of the victim(s);
  4. Seek input from others who are aware of a client's progress as part of the decision about whether to terminate treatment;
  5. Report to the supervising officer regarding a client's compliance with treatment and recommend any modifications in conditions of community supervision and/or termination of treatment;
  6. At the end of this reassessment process, inform the client regarding the recommendation to end court-ordered treatment.

**3.420** Prior to discontinuing offense-specific treatment, a provider shall, in cooperation with the case management team, develop an aftercare plan that includes ongoing behavioral monitoring, such as periodic polygraph examinations. Such monitoring is intended to motivate the offender to avoid high-risk behaviors that might be related to increased risk of re-offense.



## 3.500 P Treatment of Sex Offenders in Prison

**3.510** An offender who has been sentenced to the Department of Corrections (DOC), and who is being paroled or being released to community corrections, and who did not receive a mental health sex offense-specific evaluation at the time of the pre-sentence investigation should receive an evaluation comparable to the mental health sex offense-specific evaluation outlined in this document (See Section 2.000). The evaluation may occur prior to or during the course of sex offense-specific treatment in the prison or prior to release to community corrections or parole if the offender has not been in treatment.

**3.520** At the discretion of the treatment provider at DOC, offenders who received a mental health sex offense-specific evaluation many years prior to entering treatment at DOC, or offenders who in the opinion of DOC treatment providers received a partial or inadequate evaluation, or offenders whose circumstances have changed, may receive a mental health sex offense-specific evaluation comparable to that outlined in these standards.

*Discussion: The first priority for the use of resources is the assessment and treatment of those sex offenders who are motivated to participate in treatment and are eligible for release, and/or present an unusually high risk to the community.*

**3.530** Treatment for sex offenders in prison shall conform to the standards for offense-specific sex offender treatment described in Section 3.000 and shall be provided by therapists who meet the qualifications for treatment providers described in Section 4.000.

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

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

**3.560** The duration of time in treatment in prison (a minimum of two years) shall not offset the need for the offender's continued treatment upon his/her supervised release to the community.

**3.570** Prison treatment providers shall prepare a brief summary of offenders' participation in treatment and their institutional behavior. This summary, which is provided to the parole board prior to a hearing, should also be provided to the parole officer at the time of the pre-parole investigation.

**3.580** A pre-parole investigation/assessment should be completed prior to an offender's beginning parole supervision. The purpose of the pre-parole investigation is to:

- A. Assess the resources that will be available to an offender who will live and work in the community and;

B. Make recommendations for conditions of supervision, including the offender's treatment.

**3.590** A discharge summary should also be completed for sex offenders who will be released directly into the community without a period of parole or community corrections. The summary should provide information on the offender's institutional behavior, modus operandi, and risk of re-offending. Such discharge data shall be forwarded to the Division of Parole for potential dissemination to law enforcement agencies.

**3.511** In addition to general conditions imposed on all offenders, the following special conditions should be imposed on sex offenders who are incarcerated:

- A. Sex offenders should have no contact with their victims(s), including correspondence, telephone contact, or communication through third parties except under circumstances approved in advance and in writing by the prison treatment provider;
- B. Sex offenders should have no contact with children, including their own children, unless approved in advance and in writing by the prison treatment provider;
- C. Sex offenders shall not date or befriend anyone who has children under the age of 18 unless approved in advance and in writing by the prison treatment provider;
- D. Sex offenders shall not access or loiter near children in the visiting room or participate in any volunteer activity that involves contact with children except under circumstances approved in advance and in writing by the prison treatment provider;
- E. Sex offenders should not possess any pornographic, sexually oriented or sexually stimulating materials, including visual, auditory, telephonic, or electronic media, and computer programs or services that are relevant to the offender's deviant behavior/pattern. Sex offenders shall not patronize any place where such material or entertainment is available. Sex offenders shall not utilize "900" or adult telephone numbers or any other sex-related telephone numbers;
- F. Sex offenders will be required to undergo blood, saliva, and DNA testing as required by statute;
- G. Other special conditions that restrict sex offenders from high-risk situations and limit access to potential victims may be imposed by the prison treatment provider, and;
- H. Sex offenders in treatment shall sign information releases to allow all professionals involved in assessing, treating, and behavioral monitoring of the sex offender to communicate with each other.

## 3.600 P Community Placement and Treatment of Sex Offenders in Denial <sup>7</sup>

- 3.610** Sex offenders who continue to deny the conviction offense or continue to be highly defensive should not be placed on community supervision.

*Discussion: Secrecy, denial, and defensiveness are part of the sex offenders' disorder. Almost all offenders fluctuate in their level of accountability or "denial" of the offense. Although most are able to admit responsibility for the act relatively soon after conviction, some offenders do not. An offender's continued denial of the act after plea bargaining or conviction threatens community safety and is highly distressing and emotionally damaging to the victim.*

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

*Discussion: In assessing an offender's risk and amenability to treatment during the mental health sex offense-specific evaluation, it is important to take into account the offender's continued denial and defensiveness. In some cases, denial alone may be regarded as a sufficient factor to eliminate an offender from a recommendation for community-based treatment. Continued strong or severe denial of the instant offense (as opposed to fluctuating or moderate denial), and/or continued strong defensiveness in general (as opposed to fluctuating or moderate defensiveness), suggest a level of risk that should rule out an offender's eligibility for community-based treatment.*

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

*Discussion: Although all offense-specific treatment programs usually begin by addressing denial and defensiveness, treatment for strong or severe deniers typically occurs separately from regular group therapy that is provided for offenders who have, at a minimum, admitted the crime of conviction. Treatment for such denial may include a variety of modalities specifically designed to reduce denial and resistance to treatment.*

- 3.640** Supervision and behavioral monitoring of sex offenders in strong or severe denial should be maximized during this initial treatment phase. Home detention, electronic monitoring, field supervision, and/or stringent restrictions on offenders' time are examples of additional conditions that may be indicated during treatment for denial.

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

*Discussion: It is important that judges support community safety by proceeding with revocations for those sex offenders whose continued denial and/or resistance make treatment impossible.*

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<sup>7</sup> An outline of levels and types of denial is provided in Appendix B (Brake et. al., 1995).

**3.660** Treatment for denial may be provided only by treatment providers who also meet the requirements to provide sex offense-specific treatment, as defined in this document.

**3.670** Progress in treatment of denial is reflected by the offender's decreased resistance to treatment, decreased defensiveness and denial, and increased accountability for behavior. This progress should be documented by:

- P The offender's compliance with the conditions of offense-specific denial treatment
- P The offender's verbal disclosures during treatment that document changes in denial
- P Changes in the offender's responses on standardized tests
- P The timely and competent completion of homework and in-session assignments
- P The offender's willingness to schedule and undergo polygraph testing

**3.680** Treatment providers and case management 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 the next phase of offense-specific treatment at the end of six months. It is especially important to document measures of offenders' acceptance of responsibility for their offenses.

*Discussion: In the event that an offender fails to make sufficient progress in the attainment of those goals and is therefore terminated from treatment, documentation is imperative for future revocation proceedings.*

**3.690** Use of the polygraph is important in reducing an offender's denial, but the timing of its use should be flexible. In cases with highly resistant offenders, use of the polygraph before adequate preparation might increase the resistance. In some cases, the polygraph can be used as a "last resort" to lessen denial.



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

**3.710** A treatment provider *may* employ treatment methods that integrate the results of plethysmography, the Abel screen or other physiological testing, as indicated. If plethysmography is used, the examiner must meet the standards for plethysmography as defined in the ATSA Practitioner's Handbook<sup>8</sup> and described in Section 7.000. If the Abel screen is used, the treatment provider or evaluator must be trained and licensed as a site to utilize the instrument.

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

*Discussion: Physiological data can be useful in assessing a client's progress in therapy. However, physiological assessment data of this type cannot be used as the sole basis for determining an offender's risk nor for determining whether an individual has committed or is going to commit a specific deviant sexual act. Providers who utilize this data shall be aware of the limitations of plethysmography and the Abel screen and shall recognize that this physiological data is only meaningful within the context of a comprehensive evaluation and/or treatment process.*

**3.730** In cooperation with the supervising officer, the provider shall employ treatment methods that incorporate the results of polygraph examinations, including specific issue polygraphs, disclosure polygraphs, and maintenance polygraphs. Exceptions to the requirement for use of the polygraph may be made only by the case management team or by a prison treatment provider.

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

*Discussion: Because of the epidemic nature of sexual assault, there is a need for more and better methods to accurately assess, treat, and monitor sex offenders. Polygraph testing is an effective tool for informing the case management team about the type and severity of abusive behavior patterns, and compliance with treatment and supervision conditions, and can assist in suggesting necessary levels of supervision and treatment. In addition, polygraph testing can improve treatment outcomes by shortening the denial phase. It is recommended that polygraph exams occur at least every six months, and more frequently as necessary.*

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<sup>8</sup> "Guidelines for the Use of the Penile Plethysmograph," from *The ATSA Practitioner's Handbook*, published by the Association for of Sexual Abusers (1993) are listed in Appendix C.



# 4.000 QUALIFICATIONS OF TREATMENT PROVIDERS/ EVALUATORS

**4.010 TREATMENT PROVIDER - Full Operating Level:** A treatment provider at the full operating level may treat sex offenders without supervision and may supervise a treatment provider operating at the associate level. To qualify to provide sex offender treatment at the full operating level under Section 16-11.7-106 C.R.S., an individual must meet all the following criteria:

- A. The individual shall have attained the underlying credential of licensure or certification and be in good standing as a physician, psychologist, clinical social worker, professional counselor, marriage and family therapist, or clinical psychiatric nurse specialist;
- B. The individual shall have completed within the past five (5) years a minimum of one thousand (1000) hours of clinical experience specifically in the areas of evaluation and treatment of sex offenders, at least half of which shall have been face-to-face therapy with adult convicted sex offenders (See definition of clinical experience of page 6.). Such clinical experience may have been obtained while seeking licensure or after obtaining licensure; however, if it was obtained in part or in full after licensure, it is subject to the same requirements for supervision as required for treatment providers under these Standards;
- C. The individual shall have had at least eighty (80) hours of documented training specifically related to evaluation and treatment methods described in Sections 2.000 and 3.100 of these standards, and including training in the area of victimology, within the last five years. The individual must demonstrate a balanced training history, having covered a wide or varied range of training topics. This training must directly relate to sex offender assessment/ treatment/ management and may include but is not limited to:
  - P Statistics on offense/victimization rates
  - P Typologies
  - P Sex offender assessment
  - P Sex offender evaluation
  - P Sex offender treatment techniques including:
    - R Evaluating and reducing denial
    - R Behavioral treatment techniques
    - R Cognitive behavioral techniques
    - R Relapse prevention
    - R Empathy training
  - P Offender/offense characteristics
  - P Sex offender risk
  - P Physiological techniques including:
    - R Polygraph
    - R Plethysmograph
    - R Abel Screen
  - P Victim Issues
  - P Family reunification/visitation
  - P Legal issues regarding sex offenders
  - P Special sex offender populations including:

- R Sadists
- R Developmentally disabled
- R Compulsive
- R Juvenile
- R Female
- P Pharmacotherapy with sex offenders
- P Impact of sex offenses
- P Assessing Treatment Progress
- P Secondary and vicarious trauma
- P Anger management
- P Sex education
- P Supervision techniques with sex offenders
- P Philosophy and principles of the Sex Offender Management Board
- P Group therapy dynamics

To receive credit for training not identified on this list, it is incumbent on the trainee to write a justification demonstrating relevance to sex offender assessment/treatment/management as described in these standards;

- D. In concert with the generally accepted standards of practice of the individual's mental health profession, the individual shall adhere to the Code of Ethics published by the Association for the Treatment of Sexual Abusers (ATSA), which is contained in Appendix D, and shall demonstrate competency according to the individual's respective professional standards and conduct all treatment in a manner that is consistent with the reasonably accepted standard of practice in the sex offender treatment community.

**4.020 Continued Placement on the Provider List:** Treatment providers must apply for continued placement on the List every 3 years by the date provided by the Board. Requirements are as follows:

- A. The treatment provider must demonstrate continued compliance with the Standards and Guidelines;
- B. The individual shall accumulate a minimum of 600 hours of clinical experience every three years, 300 hours of which shall be face-to-face therapy with adult convicted sex offenders (See definition of clinical experience on page 6.);
- C. Treatment providers shall complete a minimum of forty (40) hours of continuing education every three 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. Up to 10 hours of this training may be indirectly related to sex offender assessment/treatment/management. In order to receive credit for training that is indirectly related, it is incumbent on the trainee to write a justification demonstrating relevance to sex offender assessment/treatment/management as described in these standards. The remaining 30 hours must be directly related to sex offender assessment/treatment/management (See Standard 4.010 C.);
- D. Provide satisfactory references as requested by the Sex Offender Management Board. The Sex Offender Management Board may also solicit such additional references as necessary to determine compliance with the Standards and Guidelines. The references shall include other members of the case management team;

- E. Submit to a current background check;
- F. Report any practice that is in significant conflict with the Standards;
- G. Comply with all other requirements outlined in the Sex Offender Management Board administrative policies (See Appendix E).

**4.030 EVALUATOR - Full Operating Level:** An evaluator at the full operating level may evaluate 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 individual must meet all the following criteria:

- A. The individual shall have attained the underlying credential of licensure or certification and be in good standing as a physician, psychologist, clinical social worker, professional counselor, marriage and family therapist, or clinical psychiatric nurse specialist;
- B. The individual must be registered as a treatment provider at the full operating level;
- C. An evaluator shall have completed a minimum of 40 mental health sex-offense specific evaluations as defined in section 2.000 of these Standards within the last five years;
- D. The individual shall have had at least eighty (80) hours of documented training specifically related to evaluation and treatment methods described in Sections 2.000 and 3.100 of these standards, and including training in the area of victimology, within the last five years. The individual must demonstrate a balanced training history, having covered a wide or varied range of training topics. This training will be identified as directly related to sex offender assessment/treatment/management and may include but is not limited to:

- P Statistics on offense/victimization rates
- P Typologies
- P Sex offender assessment
- P Sex offender evaluation
- P Sex offender treatment techniques including:
  - R Evaluating and reducing denial
  - R Behavioral treatment techniques
  - R Cognitive behavioral techniques
  - R Relapse prevention
  - R Empathy training
- P Offender/offense characteristics
- P Sex offender risk
- P Physiological techniques including:
  - R Polygraph
  - R Plethysmograph
  - R Abel Screen
- P Victim Issues
- P Family reunification/visitation
- P Legal issues regarding sex offenders
- P Special sex offender populations including:
  - R Sadists
  - R Developmentally disabled
  - R Compulsive

- R Juvenile
- R Female
- P Pharmacotherapy with sex offenders
- P Impact of sex offenses
- P Assessing Treatment Progress
- P Secondary and vicarious trauma
- P Anger management
- P Sex education
- P Supervision techniques with sex offenders
- P Philosophy and principles of the Sex Offender Management Board
- P Group therapy dynamics

To receive credit for training not identified on this list, it is incumbent on the trainee to write a justification demonstrating relevance to sex offender assessment/ treatment/ management as described in these standards;

- E. In concert with the generally accepted standards of practice of the individual's mental health profession, the individual shall adhere to the Code of Ethics published by the Association for the Treatment of Sexual Abusers (ATSA) , which is contained in Appendix D and shall demonstrate competency according to the individual's respective professional standards and conduct all evaluations in a manner that is consistent with the reasonably accepted standard of practice in the sex offender evaluation community.

**4.040 Continued Placement on the Provider List :** Evaluators must apply for continued placement on the List every 3 years by the date provided by the Board. Requirements are as follows:

- A. The evaluator must demonstrate continued compliance with the Standards and Guidelines;
- B. The individual may maintain registration as a treatment provider and evaluator at the full operating level. In this case, the individual shall accumulate a minimum of 600 hours of clinical experience every three years, 300 hours or which shall be face-to-face consultation or therapy with sex offenders. (See definition of clinical experience on page 6.) This evaluator shall complete a minimum of 20 mental health sex-offense specific evaluations in the three (3) year period;

Or

The evaluator may discontinue their listing as a treatment provider at the full operating level and be placed on the Provider List as an evaluator only. Evaluators re-registering as evaluators only shall complete a minimum of forty 40 mental health sex offense-specific evaluations in the three (3) year period;

- C. Evaluators shall complete a minimum of forty (40) hours of continuing education every three years in order to maintain proficiency in the field of sex offender evaluation and to remain current on any developments in the assessment, treatment, and monitoring of sexual offenders. Up to ten (10) hours of this training may be indirectly related to sex offender assessment/treatment/management. In order to receive credit for training that is indirectly related, it is incumbent on the trainee to write a justification demonstrating relevance to sex offender assessment/treatment/management as described in these standards. The remaining thirty (30) hours must be directly related to sex offender assessment/treatment/management. (See Standard 4.030 D.);

- D. Provide satisfactory references as requested by the Sex Offender Management Board. The Sex Offender Management Board may also solicit such additional references as necessary to determine compliance with the standards and guidelines. These references shall include other members of the case management team;
- E. Submit to a current background check;
- F. Report any practice that is in conflict with the standards;
- G. Comply with all other requirements outlined in the Sex Offender Management Board administrative policies (See Appendix E).

**4.050 TREATMENT PROVIDER - Associate Level:** A treatment provider at the associate level may treat sex offenders under the supervision of a treatment provider approved at the full operating level under these Standards. To qualify to provide sex offender treatment at the associate level under Section 16-11.7-106 C.R.S. an individual must meet all the following criteria:

- A. The individual shall have a baccalaureate degree or above in a behavioral science;
- B. The individual shall have completed within the past five (5) years a minimum of five hundred (500) hours of supervised clinical experience specifically in the area of treatment of sex offenders. At least half (250) of these hours must be in face to face therapy with convicted adult sex offenders. In addition, at least one hundred sixty (160) of these face to face hours must have been in co-therapy, in the same room, with a treatment provider registered at the full operating level;
- C. The individual must have received at least fifty (50) hours of face-to-face clinical supervision by a treatment provider at the full operating level. The supervision must be reasonably distributed over the time in which the above clinical experience was being obtained (approximately 1 hour of supervision for each 10 hours of clinical experience);
- D. The individual shall have had at least forty (40) hours of documented training specifically related to evaluation and treatment methods described in Sections 2.000 and 3.100 of these standards, and including training in the area of victimology, within the last five years. The individual must demonstrate a balanced training history, having covered a wide or varied range of training topics. This training will be identified as directly related to sex offender assessment/treatment/management and may include but is not limited to:

- P Statistics on offense/victimization rates
- P Typologies
- P Sex offender assessment
- P Sex offender evaluation
- P Sex offender treatment techniques including:
  - R Evaluating and reducing denial
  - R Behavioral treatment techniques
  - R Cognitive behavioral techniques
  - R Relapse prevention
  - R Empathy training
- P Offender/offense characteristics

- P Sex offender risk
- P Physiological techniques including:
  - R Polygraph
  - R Plethysmograph
  - R Abel Screen
- P Victim Issues
- P Family reunification/visitation
- P Legal issues regarding sex offenders
- P Special sex offender populations including:
  - R Sadists
  - R Developmentally disabled
  - R Compulsive
  - R Juvenile
  - R Female
- P Pharmacotherapy with sex offenders
- P Impact of sex offenses
- P Assessing Treatment Progress
- P Secondary and vicarious trauma
- P Anger management
- P Sex education
- P Supervision techniques with sex offenders
- P Philosophy and principles of the Sex Offender Management Board
- P Group therapy dynamics

To receive credit for training not identified on this list, it is incumbent on the trainee to write a justification demonstrating relevance to sex offender assessment/treatment/management as described in these standards;

- E. In concert with the generally accepted standards of practice of the individual's mental health profession, the individual shall adhere to the Code of Ethics published by the Association for the Treatment of Sexual Abusers (ATSA) , which is contained in Appendix D and shall demonstrate competency according to the individual's respective professional standards and conduct all treatment in a manner that is consistent with the reasonably accepted standard of practice in the sex offender treatment community.

**4.060 Movement to Full Operating Level:** Associate level treatment providers wishing to move to full operating level status must complete and submit documentation of a total of 1000 hours of supervised clinical experience, 100 hours of clinical supervision, at least half of which must be face to face, 80 hours of training and submit a letter from their supervisor indicating their readiness to become a full operating level provider.

**4.070 Continued Placement:** Associate level treatment providers must apply for continued placement on the list every 3 years by the date provided by the Board. Requirements are as follows:

- A. The associate level treatment provider must demonstrate continued compliance with the Standards and Guidelines;
- B. The individual shall accumulate a minimum of 600 hours of clinical experience every three years, 300 hours of which shall be face-to-face therapy with adult convicted sex offenders (See definition of clinical experience on page 6.);



- C. The individual shall obtain a minimum of one hour of face-to-face supervision, from an individual registered at the full operating level under these Standards, for every 30 hours of clinical contact with sex offenders. This standard pertains both to those seeking licensure who have not yet met the licensing requirements of the state and to those who intend to provide treatment at the associate level for an indefinite amount of time;
- D. Associate level treatment providers shall complete a minimum of forty (40) hours of continuing education every three 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. Up to 10 hours of this training may be indirectly related to sex offender assessment/treatment/management. In order to receive credit for training that is indirectly related, it is incumbent on the trainee to write a justification demonstrating relevance to sex offender assessment/treatment/management as described in these standards. The remaining 30 hours must be directly related to sex offender assessment/treatment/management (See Standard 4.010 C);
- E. Provide satisfactory references as requested by the Sex Offender Management Board. The Sex Offender Management Board may also solicit such additional references as necessary to determine compliance with the standards and guidelines. The references shall include other members of the case management team;
- F. Submit to a current background check;
- G. Report any practice that is in significant conflict with the standards;
- H. Comply with all other requirements outlined in the Sex Offender Management Board administrative policies (see Appendix E).

**4.080 EVALUATOR - Associate Level:** An evaluator at the associate level may evaluate sex offenders under the supervision of an evaluator approved at the full operating level. An evaluator at the associate level is an individual who has completed fewer than 40 mental health sex-offense specific evaluations in the last five years. To qualify to provide sex offender evaluation at the associate level under Section 16-11.7-106 C.R.S. an individual must meet all the following criteria:

- A. The applicant must be listed as a treatment provider at the associate level or the full operating level;
- B. The individual must have received at least fifty (50) hours of face-to-face clinical supervision by a treatment provider at the full operating level. The supervision must be reasonably distributed over the time in which the above clinical experience was being obtained (Approximately 1 hour of supervision for every 10 hours of clinical experience.);
- C. The associate level evaluator must have a clinical supervisor at the full operating evaluator level sign off on each evaluation they conduct at the associate level;
- D. The individual shall have had at least forty (40) hours of documented training specifically related to evaluation and treatment methods described in Sections 2.000 and 3.100 of these standards, and including training in the area of victimology, within the last five years. The individual must demonstrate a balanced training history, having covered a wide or varied range

of training topics. This training will be identified as directly related to sex offender assessment/treatment/management and may include but is not limited to:

- P Statistics on offense/victimization rates
- P Typologies
- P Sex offender assessment
- P Sex offender evaluation
- P Sex offender treatment techniques including:
  - R Evaluating and reducing denial
  - R Behavioral treatment techniques
  - R Cognitive behavioral techniques
  - R Relapse prevention
  - R Empathy training
- P Offender/offense characteristics
- P Sex offender risk
- P Physiological techniques including:
  - R Polygraph
  - R Plethysmograph
  - R Abel Screen
- P Victim Issues
- P Family reunification/visitation
- P Legal issues regarding sex offenders
- P Special sex offender populations including:
  - R Sadists
  - R Developmentally disabled
  - R Compulsive
  - R Juvenile
  - R Female
- P Pharmacotherapy with sex offenders
- P Impact of sex offenses
- P Assessing Treatment Progress
- P Secondary and vicarious trauma
- P Anger management
- P Sex education
- P Supervision techniques with sex offenders
- P Philosophy and principles of the Sex Offender Management Board
- P Group therapy dynamics

To receive credit for training not identified on this list, it is incumbent on the trainee to write a justification demonstrating relevance to sex offender assessment/ treatment/ management as described in these standards;

- E. In concert with the generally accepted standards of practice of the individual's mental health profession, the individual shall adhere to the Code of Ethics published by the Association for the Treatment of Sexual Abusers (ATSA) , which is contained in Appendix D—and shall demonstrate competency according to the individual's respective professional standards and conduct all treatment in a manner that is consistent with the reasonably accepted standard of practice in the sex offender treatment community.

**4.090 Continued Placement:** Associate level evaluators must apply for continued placement on the list every 3 years by the date provided by the board. Requirements are as follows:

- A. The evaluator must demonstrate continued compliance with the Standards and Guidelines;
- B. The evaluator at the associate level shall maintain registration as a treatment provider at the associate level or the full operating level and shall complete a minimum of 20 mental health sex-offense specific evaluations in the three (3) year period;
- C. Evaluators shall complete a minimum of forty (40) hours of continuing education every three years in order to maintain proficiency in the field of sex offender evaluation and to remain current on any developments in the assessment, treatment, and monitoring of sexual offenders. Up to ten (10) hours of this training may be indirectly related to sex offender assessment/treatment/management. In order to receive credit for training that is indirectly related, it is incumbent on the trainee to write a justification demonstrating relevance to sex offender assessment/treatment/management as described in these standards. The remaining thirty (30) hours must be directly related to sex offender assessment/treatment/management. (See Standard 4.030 D.);
- D. Provide satisfactory references as requested by the Sex Offender Management Board. The Sex Offender Management Board may also solicit such additional references as necessary to determine compliance with the standards and guidelines. These references shall include other members of the case management team;
- E. Submit to a current background check;
- F. Report any practice that is in significant conflict with the standards;
- G. Comply with all other requirements outlined in the Sex Offender Management Board administrative policies (see Appendix E).

**4.011 Period of Compliance:** Individuals currently listed on the Provider List as treatment providers and/or evaluators who do not meet one or more of the revisions to the Standards under qualifications have a period of compliance not to exceed one year from the effective date of these revised Standards to meet the revision. It is incumbent upon the provider to complete an affidavit of his/her intent to comply with the standards within the specified period.

Any new applicants must be in compliance when they apply.

**4.012** The original 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 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. The waiver process was not intended to be available at any time after December 31, 1996. There is currently no provision for a waiver of the Standards for treatment providers or evaluators for any reason.

# 5.000 STANDARDS AND GUIDELINES FOR MANAGEMENT OF SEX OFFENDERS ON PROBATION PAROLE AND COMMUNITY CORRECTION

## 5.100 P 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 mental health 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:

- P the supervising officer
- P the offender's treatment provider and
- P the polygraph examiner<sup>9</sup>

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.*

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<sup>9</sup> Please see Standard 5.420 regarding the attendance of polygraph examiners at team meetings.

- 5.130** The team is coordinated by the supervising officer, who determines:
- A. The members of the team, beyond the required membership, who 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 P Responsibilities of the Supervising Officer for Team Management

- 5.210** 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 Sex Offender Management Board's Provider List and that the treatment program is consistent with Sex Offender Management Board 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.*

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

- P Releases of information to treatment providers, including information from any treatment program in which the offender participated at the Department of Corrections;
- P 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;
- P 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.

- 5.230** The supervising officer, in cooperation with the treatment provider and polygraph examiner, should utilize the results of periodic polygraph examinations for treatment and behavioral monitoring. Team members should provide input and information to the polygraph examiner regarding examination questions. 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 Sex Offender Management Board's Provider List and that the examinations are consistent with Sex Offender Management Board 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.*

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

- 5.250** The supervising officer should require sex offenders to obtain the officer's written permission to change treatment programs.
- 5.260** 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.
- 5.270** The supervising officer should require treatment providers to keep monthly written updates on sex offenders' status and progress in treatment.
- 5.280** The supervising officer should discuss with the treatment provider, the victim's therapist, custodial parent or foster parent, and guardian ad litem specific plans for any and all contacts of an offender with a child victim and plans for family reunification.
- 5.290** 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.
- 5.211** 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.
- 5.212** The supervising officer should not request early termination of sex offenders from supervision.
- 5.213** 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.
- 5.214** If contact is allowed, the supervising officer should limit and control the offenders' authority to make decisions for minors or to discipline them.
- 5.215** If necessary and possible, the supervising officer should request an extension of supervision to allow an offender to complete treatment.
- 5.216** The supervising officer should notify sex offenders that they must register with local law enforcement, in compliance with Section 18-3-412.5 C.R.S.
- 5.217** The supervising officer should discuss treatment issues and progress with offenders during office visits and other contacts.

- 5.218** 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.
- 5.219** 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.
- 5.221** 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.*

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

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

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

- 5.223** On an annual basis, supervising officers should obtain continuing education/training specific to sex offenders.
- 5.224** 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 P Responsibilities of the Treatment Provider within the Team

- 5.310** A treatment provider shall establish a cooperative professional relationship with the supervising officer of each offender and with other relevant supervising agencies. 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 P 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 P Conditions of Community Supervision

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

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

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

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 P Sex Offenders' Contact with Victims and Potential Victims

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

- A. Whenever possible, collaborate with an adult victim's therapist or advocate, or a child victim's therapist, guardian, custodial parent, foster parent, and/or guardian ad litem, in making decisions regarding communication, visits, and reunification;
- B. Support the victim's wishes when the victim does not wish to have contact with the offender;
- C. Arrange contact in a manner that places child and/or victim safety first. When assessing safety, both psychological and physical well-being shall be considered;
- D. Ensure consultation with custodial parents or guardians of a child victim and the child's guardian ad litem and treatment provider prior to authorizing contact and that contact is in accordance with court directives;
- E. Before recommending contact with a child victim or any potential victims, assess the offender's readiness and ability to refrain from re-victimizing, i.e. to avoid coercive and grooming statements and behaviors, to respect the child's personal space, and to recognize and respect the child's indication of comfort or discomfort. In addition, the following criteria must 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.
- F. 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 care giver should be available. The potential supervisor must complete training addressing sexual offending and safe and effective visitation supervision.

**5.720 Family Reunification.** The goal of family reunification shall never take precedence over the safety of any former or potential victim. If reunification is indicated, after careful consideration of all the potential risks, supervising officers and providers shall closely supervise and monitor the process. Even when indicated, family reunification is a process that is potentially dangerous and should be approached with great consideration and over an extended period of time.

Any move toward family reunification should be avoided until after disposition of the criminal case. Child sexual abusers who are convicted will not be allowed to live in the home with the victim (or any other home where children reside) without approval in advance, in writing, from the community supervision team. When a child protective agency is involved in a case in which the offender is on probation or parole, family reunification, if any, should be carefully coordinated with the community supervision team described in these standards. Sex offense-specific treatment providers and community supervision teams are in the best position to assess offender's risk when reunification is being considered. Agencies or providers who fail to consider the recommendations of the community supervision team members are at increased risk of liability if the safety of any victim or potential victim is jeopardized by a reunification effort.



# 6.000 STANDARDS FOR POLYGRAPHY

## 6.100 P Standards of Practice for Sex Offender Clinical Polygraph Examiners

- 6.110** Examiners shall use a computerized polygraph system or a late model (1980's to present) state-of-the-art, four or five channel polygraph instrument that will simultaneously record the physiological phenomena of abdominal and thoracic respiration, galvanic skin response, and the cardiovascular system.
- 6.120** The examiner must employ a computerized polygraph system, and a recognized scoring software must be used (e.g., the Johns Hopkins Applied Physics Laboratory scoring algorithm). Computerized charts must also be independently hand scored by the examiner.
- 6.130** The duration of each examination (including the pre-test, in-test, and post-test phases) shall be a minimum of 90 minutes. Time begins when the examinee enters the examination room with the examiner and ends when the examinee departs after the conclusion of the polygraph examination.
- 6.140** Examiners shall use a recognized Control Question Technique (CQT), plus a Peak of Tension test when necessary.
- 6.150** Examiners shall adhere to the established ethics, standards, and practices of the American Polygraph Association (APA). In addition, clinical polygraph examiners shall demonstrate competency according to professional standards and conduct all polygraph examinations in a manner that is consistent with the reasonably accepted standard of practice in the clinical polygraph examination community.
- 6.160** Examiners shall use the following specific procedures during the administration of each examination:
- A. The examinee shall agree in writing or on video tape to a standard waiver/release statement. The language of the statement should be agreed upon prior to the polygraph examination with the therapist, probation/parole officer, community corrections case manager, or prison treatment provider;
  - B. The examiner shall elicit relevant biographical and medical history information from the examinee prior to administering the actual polygraph examination;
  - C. The testing process shall be completely explained to the examinee, including an explanation of the instrumentation used and causes of general nervous tension;
  - D. Examiners shall conduct a thorough pre-test phase, including a detailed discussion of each relevant issue. There shall be an open dialogue with the examinee to confirm his/her version of the issues;

- E. Examiners shall review and explain all test questions to the examinee. Examinees must demonstrate that they comprehend the meaning of each question;
- F. Surprise or trick questions are forbidden during the administration of primary test charts;
- G. All test questions must be formulated to allow only Yes or No answers;
- H. An optional acquaintance/practice test may be run;
- I. A minimum of three primary test charts shall be administered on the primary issue(s);
- J. Test results shall be reviewed with the examinee;
- K. The examiner must have received all pertinent and available case facts within a time frame sufficient to prepare for the examination.

**6.170** Videotaping of polygraph examinations is required. Video tapes of the entire examination shall be maintained for a minimum of three years from the date of the examination.

*Discussion: Although videotaping of the polygraph examination has only recently been integrated into clinical sex offender examinations, videotaping has such powerful results that it merits becoming a standard of practice in the examination of this offender population. Videotaping greatly enhances the validity of the polygraph record, is an effective tool for confronting sex offender denial, and creates a useful record to be used in disagreements about the content or report of the polygraph.*

**6.180** Examiners shall use an effective quality control process that allows for periodic independent review of all documentation, polygraph charts, and reports.

*Discussion: Quality control requires the periodic review of clinical polygraph examinations by other active examiners. The review should cover numerical chart analysis, technique and question formulation, and the inspection of instrumentation used in the examination as well as reports submitted to referral sources.*

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

- P Date of test or evaluation
- P Name of person requesting exam
- P Name of examinee
- P Location of examinee in the criminal justice system (Probation, parole, etc)
- P Reason for examination
- P Date of last clinical examination
- P Examination questions and answers
- P Any additional information deemed relevant by the Polygraph examiner, eg: examinees' demeanor
- P Reasons for inability to complete exam, information from examinee outside the exam, etc.

P Results of pre-test and post-test examination, including answers or other relevant information provided by the examinee.

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

P Be simple, direct and as short as possible

P Not include legal terminology that allows for examinee rationalization and utilization of other defense mechanisms

P Not include mental state or motivation terminology

P The meaning of each question must be clear and not allow for multiple interpretations

P Each question shall contain reference to only one issue under investigation

P Never presuppose knowledge on the part of the examiner

P Use language easily understood by the examinee and all terms used by the examiner should be fully explained to the examinee

P Be easily answered yes or no

P Avoid the use of any emotionally laden terminology (such as rape, molest, murder, etcetera) and use language that is behaviorally descriptive



## 6.200 P Qualifications of Polygraph Examiners

### 6.210 POLYGRAPH EXAMINER - Full Operating Level:

- A. The individual shall have graduated from an accredited American Polygraph Association (APA) school and shall have a baccalaureate degree from a four year college or university;
- B. The individual shall have conducted at least one hundred fifty (150) criminal specific-issue examinations. In addition, the examiner shall have conducted a minimum of 50 clinical polygraph examinations of which 20 must be disclosure polygraph examinations and 20 more must be either maintenance or disclosure polygraph examinations within a twelve month period (see definitions: Clinical Polygraph Examination);
- C. The individual shall have completed 40 hours of specialized clinical sex offender polygraph examiner training;

This training shall focus on polygraph examination of convicted sex offenders and on sex offender assessment, evaluation, treatment and behavioral monitoring, as follows:

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

Sixteen (16) Of these hours must be of specialized training in any of the following areas:

- P Behavior and motivation of sex offenders
- P Trauma factors associated with victims/survivors of sexual assault
- P Overview of assessment and treatment modalities for sex offenders
- P Sex offender denial.

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

- D. Provide satisfactory references as requested by the Sex Offender Management Board. The Sex Offender Management Board may also solicit such additional references as necessary to determine compliance with the standards and guidelines. These references shall include, but not be limited to, other members of the community supervision team.
- E. In concert with the generally accepted standards of practice of the polygraph profession, the individual shall adhere to the code of ethics published by the association for the treatment of



sexual abusers (ATSA) , which is contained in Appendix D, and 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.

**6.230 Continued Placement on the Provider List:** Clinical polygraph examiners at the full operating level must apply for continued placement on the Provider List every 3 years by the date provided by the board. Requirements are as follows:

- A. The polygraph examiner must demonstrate continued compliance with the Standards and Guidelines.
- B. Clinical polygraph examiners shall complete a minimum of forty (40) hours of continuing education every three 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 sexual offenders. Up to 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 30 hours must be directly related to sex offender assessment/treatment/management (See Standard 6.220 C.).
- C. Conduct a minimum of 75 clinical polygraph examinations for sex offenders in the 3 year registration period.
- D. Provide satisfactory references as requested by the Sex Offender Management Board. The Sex Offender Management Board may also solicit such additional references as necessary to determine compliance with the standards and guidelines, including, but not limited to other members of the community supervision team.
- E. Submit to a current background check.
- F. Submit documentation that the examiner has engaged in periodic peer review by other clinical polygraph examiners registered at the full operating level operating separately from the examiner's agency. Peer review must be conducted biannually at a minimum.
- G. Report any practice that is in significant conflict with the standards.
- H. Comply with all other requirements outlined in the Sex Offender Management Board administrative policies.

**6.220 POLYGRAPH EXAMINER - Associate Level:** A clinical polygraph examiner at the associate level is an individual who otherwise meets the standards for full operating level but who does not have a baccalaureate degree from a four year college or university and/or who has not yet completed 50 clinical polygraph examinations within a 12 month period as specified in standard 6.210 B. (see definitions, Clinical Polygraph Examination). The examiner shall obtain supervision from a clinical polygraph examiner at the full operating level under these standards for each remaining clinical polygraph examination up to the completion of 50 clinical polygraph exams as specified in standard 6.220 A. The supervision agreement must be in writing. Supervision must continue for the entire time an examiner remains at the associate level.

The supervisor of a clinical polygraph examiner shall review samples of the videotapes of clinical polygraphs and/or otherwise observe the examiner; and provide supervision and consultation on question formulation for clinical polygraph exams, report writing, and other issues related to the provision of clinical polygraph exams. Supervisors must review and sign off on each polygraph examination report completed by an associate level polygraph examiner under their supervision.

If the associate level polygraph examiner has met all the requirements for full operating level status except for obtaining a bachelor's degree, the supervision requirement that supervisors sign off on each exam may be waived by the registration committee if the following conditions are met:

The associate level polygraph examiner submits:

- P Documentation that all other criteria for full operating level status have been met
  - P Evidence of continuing work toward obtaining a B.A. degree
  - P Evidence that the examiner is continuing to conduct clinical polygraph exams
  - P A letter from the examiner's supervisor indicating their proficiency and their willingness to lower the intensity of supervision to one hour per month.
- A. The individual shall have completed 40 hours of specialized clinical sex offender polygraph examiner training.

This training shall focus on polygraph examination of convicted sex offenders, and on sex offender assessment, evaluation, treatment and behavioral monitoring, as follows:

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

Sixteen (16) of these hours must be of specialized training in any of the following areas:

- P Behavior and motivation of sex offenders
- P Trauma factors associated with victims/survivors of sexual assault
- P Overview of assessment and treatment modalities for sex offenders
- P Sex offender denial

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.

- B. Provide satisfactory references as requested by the Sex Offender Management Board. The Sex Offender Management Board may also solicit such additional references as necessary to

determine compliance with the standards and guidelines. These references shall include, but not be limited to other members of the community supervision team.

- C. In concert with the generally accepted standards of practice of the polygraph profession, the individual shall adhere to the code of ethics published by the association for the treatment of sexual abusers (ATSA), which is contained in Appendix D, and 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.
- D. Provide satisfactory references as requested by the Sex Offender Management Board. The Sex Offender Management Board may also solicit such additional references as necessary to determine compliance with the standards and guidelines, including, but not limited to other members of the community supervision team.
- E. Submit to a current background check.
- F. Submit documentation that the examiner has engaged in periodic peer review by other clinical polygraph examiners registered at the full operating level operating separately from the examiner's agency. Peer review must be conducted biannually at a minimum.
- G. Report any practice that is in significant conflict with the standards.
- H. Comply with all other requirements outlined in the Sex Offender Management Board administrative policies.

**6.230 Movement to Full Operating Level:** Associate level clinical polygraph examiners wishing to move to full operating level status must complete and submit documentation of obtaining a baccalaureate degree, conducting 150 criminal specific issue examinations, 50 clinical polygraph examinations of which 20 must be disclosure polygraph examinations and 20 more must be either maintenance or disclosure polygraph examinations within a twelve month period, and submit a letter from their supervisor indicating their readiness to become a full operating level provider.

**Continued Placement on the Provider List:** Clinical polygraph examiners at the associate level must apply for continued placement on the Provider List every 3 years by the date provided by the board. Requirements are as follows:

- A. The polygraph examiner must demonstrate continued compliance with the standards and guidelines.
- B. Clinical polygraph examiners shall complete a minimum of forty (40) hours of continuing education every three 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 sexual offenders. Up to 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. The remaining 30 hours must be directly related to sex offender assessment/treatment/management. (See Standard 6.220 C.)
- C. Conduct a minimum of 75 clinical polygraph examinations in the 3 year registration period.

- D. Provide satisfactory references as requested by the Sex Offender Management Board. The Sex Offender Management Board may also solicit such additional references as necessary to determine compliance with the standards and guidelines, including, but not limited to other members of the community supervision team.
- E. Submit to a current background check.
- F. Submit documentation that the examiner has engaged in periodic peer review by other clinical polygraph examiners registered at the full operating level operating separately from the examiner's agency. Peer review must be conducted biannually at a minimum.
- G. Report any practice that is in significant conflict with the standards.
- H. Comply with all other requirements outlined in the Sex Offender Management Board administrative policies.

**6.240 Period of Compliance:** Individuals who have been listed on the Provider List as clinical polygraph examiners and who do not meet one or more of the revised standards for qualifications for clinical polygraph examiner may request a period of compliance not to exceed one year from the effective date of these standards.

Any new applicants must be in compliance when they apply.



## 7.000

# STANDARDS FOR PLETHYSMOGRAPHY

## 7.100 P Standards of Practice for Plethysmograph Examiners

- 7.110** A plethysmograph examiner shall adhere to the "Guidelines for the Use of the Penile Plethysmograph,"<sup>10</sup> 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.

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<sup>10</sup> Plethysmographic testing measuring physiological changes associated with sexual arousal is also available for female sex offe

## **7.200 P Qualifications of Plethysmograph Examiners and Abel Screen Providers**

- 7.210** A plethysmograph examiner shall be listed as a treatment provider under these standards, have a baccalaureate degree from a four year college or university and demonstrate that s/he has received credible training in the use of the plethysmograph.

*Discussion: At this time there is no certification or accreditation process for plethysmograph examiners. Those wishing to conduct exams should seek credible training from experienced examiners. Should a certification process be developed, these standards will be revised to accommodate such a process.*

- 7.220** A plethysmograph examiner shall be proficient in the use of stimulus materials:

- A. Determination of type of stimuli to be utilized for each assessment;
- B. Use of specialized stimuli;
- C. Familiarity with state and federal codes regulating possession, storage, use and transportation of pornographic materials.

- 7.230** Interpretation of data shall consider the following:

- A. Differential responses to various stimuli categories;
- B. Required minimum response levels;
- C. Maximum response; latency; area under the curve;
- D. Base rates for responses;
- E. Client's self-estimates of response;
- F. Detecting faking/suppression attempts;
- G. Data validity/reliability.

- 7.240** A plethysmograph examiner shall have received manufacturer's and/or other supervised training on equipment operation and shall be trained in:

- A. Types and selection of available gauges;
- B. Gauge size determination for each client.

**7.250** A plethysmograph examiner shall be knowledgeable about and familiar with the uses of plethysmograph data for:

A. Assessment/evaluation:

- P Assessing cross-over of deviant interests;
- P Assessing reliability of self-report;
- P Determining existence of deviant arousal;
- P Determining baseline data for treatment of deviant arousal reduction/control.

B. Treatment:

- P Providing objective measure of treatment progress in terms of deviant arousal;
- P Providing recommendations based on knowledge of treatment methodologies.

C. Offenders in denial:

- P Understanding limitations;
- P Understanding proper/improper uses.

D. Validity/Reliability:

- P Familiarity with current and historical research;
- P Client's ability/potential to control arousal response during assessment;
- P As a variable for recidivism prediction;
- P Habituation as a potential contaminating factor.

**7.260 Continued Placement on the Provider List:** Plethysmograph examiners must apply for continued placement on the Provider List every 3 years by the date provided by the board. The application will be considered as a part of the application to continue placement on the List as a treatment provider, since placement on the List as a treatment provider is a requirement of all plethysmograph examiners.

Documentation of continued administration of plethysmograph examinations will be required. Additionally, the Board may request a review of reports or program materials specific to plethysmography or evidence of a portion of the continuing education hours addressing plethysmograph examinations.

**7.270** An Abel Screen provider shall be listed as a treatment provider under these Standards, have a baccalaureate degree from a four year college or university and demonstrate that he or she had been trained and licensed as a site to utilize the instrument.

**7.280 Continued Placement on the Provider List:** Abel Screen Providers must apply for placement on the Provider List every 3 years by the date provided by the Board. The application will be considered as a part of the application to continue placement on the List as a treatment provider, since placement on the List as a treatment provider is a requirement of all Abel Screen Providers.

Documentation of continued administration of the Abel Screen will be required. Additionally, the Board may request a review of reports or program materials specific to Abel Screen administration or evidence of a portion of the continuing education hours addressing use of the Abel Screen.







## 8.000

# DENIAL OF PLACEMENT ON PROVIDER LIST

**8.010** The Board 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 Board determines that the applicant does not demonstrate the qualifications required by these standards;
- B. The Board determines that the applicant is not in compliance with the standards of practice outlined in these standards;
- C. The applicant fails to provide the necessary materials for application as outlined in the application materials and the administrative policies and procedures;
- D. The applicant has been convicted or received a deferred judgement 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 Board 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, mental health 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 should be forwarded to the DOC's Denver Reception Diagnostic Center.

**9.020** When an offender is placed in the custody of the 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:

- P Describe the offender's level of cooperation and institutional behavior
- P Describe the offender's participation in treatment
- P Suggest specific conditions of parole
- P 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 mental health 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:

- P Treatment progress
- P Successful or unsuccessful completion of treatment
- P Auxiliary treatment
- P Community stability
- P Residence
- P Compliance with supervision plan and conditions of probation/parole/community corrections
- P 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:

- P Involvement in sex offender treatment
- P Successful or unsuccessful completion of treatment
- P Auxiliary treatment
- P Relapse prevention plan, if available
- P 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 Board 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:

- P Providing immediate medical referral
- P Minimizing the number of interviews of children
- P 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
- P Removing the alleged perpetrator, rather than the child alleged to be a victim of sexual abuse from the home
- P Using forensic medical examinations that meet the standards set by the Colorado Coalition Against Sexual Assault<sup>11</sup>
- P Providing emotional support (and victim advocacy services) to the alleged victim
- P Using community-based protocols for the response to alleged victims of sexual abuse<sup>12</sup>

## 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.

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<sup>11</sup> 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.

<sup>12</sup> 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 276-2880.

Investigative reports should include information that describes:

- P The dynamics of the alleged abuse
- P Alleged offender patterns of grooming (preparing) the victim
- P The ways in which the alleged offender discouraged disclosure
- P Presence of child pornography
- P Amount of violence and/or coercion
- P Any direct or indirect corroboration of the offense
- P 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 mental health 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 care giver should be available. The potential supervisor must complete training addressing sexual offending and safe and effective visitation supervision;

7. **Referrals for mental health 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 mental health 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 *r e l e a s e o f* information by the offender, with copies of the intake report and the mental health 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:<sup>13</sup>

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 aftereffects 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

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<sup>13</sup> This list of risk assessment factors is adapted from the "adult sexual offender assessment packet", published by the safer society  
\* Any modifications to the original are noted by an asterisk.

1. Frequency of deviant fantasies
  2. Frequency of masturbation to deviant fantasies
  3. Assessment of response to fantasy content and level of deviance
  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 schizoid 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. Overconcern 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

## LEVELS AND TYPES OF DENIAL

The offender's denial and resistance to treatment may be weak or strong. The offender may move from a weaker level of denial to a stronger one, or from a stronger level to a weaker one, depending upon a variety of internal or external events. The denial presented by the offender may be a mixture of varying degrees of conscious lying and subconscious ego-defensive maneuver. Because it is often difficult to discriminate between them, we note only that both may contribute to the offender's presentation. Following is a description of different levels of denial and different types of denial at each level.<sup>14</sup> Level 1 types of denial are weak and least resistant to change; Level 4 types of denial are severe and most resistant to change; Levels 2 and 3 types of denial are in between. This classification is similar to those proposed by Salter (1988) and Laflen and Sturm (1993) and, to a lesser extent, Winn (1993).

**LEVEL 1: Weak Avoidance.** This level consists of three separate types of denial which we view as statements of resistance which reflect only weak 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."

- Type 1: Minimal Denial. The offender admits committing the sexual offense with little minimization or justification.
- Type 2: Denial of Future Behavior. The offender admits committing the current sexual offense but denies the possibility of committing a similar offense in the future.
- Type 3: History-Specific Denial. The offender admits committing the current offense but denies committing any other offense at any other time even though collateral information indicates otherwise.

**LEVEL 2: Projections/Moderate Avoidance.** This level consists of three types of moderate avoidance indicative of defense maneuvers such as "projection" or "projective identification," "idealization," "reaction formation," or "minimization". Offenders at this level admit to some of the behavior involved in the offense, but justify its occurrence or minimize its importance. In most cases, offenders presenting with Level 2 denial are considered "admitters of fact."

- Type 4: Partial Denial - Justification. The offender admits committing the offense but justifies his behavior. For example, he might say "sex was by mutual consent," or "I was provoked," or "the behavior was simply part of her hygiene," or "I would not have committed the offense if I had not been drunk."
- Type 5: Partial Denial - Minimizations. The offender admits committing the offense, but minimizes its harm. For example, the client might state that the victim didn't behave as if any harm was done or that they were "just playing."
- Type 6: Denial of Arousal. The offender admits committing the current offense, but denies that he was sexually aroused during the offense.

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<sup>14</sup> Reprinted (in part) with permission from *Pre-Treatment of Offenders in Denial*, Stephen C. Brake, Ph.D. and Diann Shannon, P

**Level 3: Projections/Strong Avoidance.** This level consists of two types of stronger avoidance indicative of developmentally immature defenses such as "splitting." Offenders at this level do not admit committing the current sexual offense, but may admit to engaging in "less harmful" behaviors, or they may simply say they cannot recall the behavior in question.

Type 7: Denial "Screen." The offender denies committing the current sexual offense, but admits that other aspects of his behavior (usually more "acceptable" aspects) were somehow harmful to the victim. For example, "I hit her, but I did not rape her."

Type 8: False Dissociation. The offender claims that he does not remember the offense and therefore cannot admit to committing it. For example, he might state that he was drunk at the time.

**Level 4: Primitive Denial/Severe Avoidance.** This level consists of four types of denial which reflect severe statement of avoidance indicative of primitive defenses such as very strong "splitting," full "denial," and, possibly, "dissociation." Offenders at this level deny committing the current sexual offense and may refuse to acknowledge responsibility for even remotely similar behaviors. These types of denial are most resistant to change.

Type 9: Current-Incident-Specific Denial. The offender admits committing past sexual offenses, but not the current offense.

Type 10: "Plausible" Denial. The offender denies committing the current offense but is able and willing to accurately describe the harm resulting to a victim of such an offense.

Type 11: Full Denial. The offender denies committing any offense and does not seem willing to acknowledge the harm of such offenses.

Type 12: Pathological Denial. Client denies committing any offense and is excessively hostile, delusional, or defensive.



# Appendix C-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 of 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.

2. 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 C-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 arm chair or lounge chair with cleanable surface must be provided. A reclining lounge chair is preferable.
- # A disposable cover on the chair seat and on the arms of chair is required for each client.
- # Mercury-in-rubber, Indium-gallium, or Barlow gauges may be used and each gauge must be tested and calibrated before each use. Documentation of gauge calibrations should be provided.
- # A calibration device or cone is required in ½ cm increments with a minimal range of 6 cm.
- # Security devices must ensure client's privacy, but must also include emergency entrance and exit with the safety of the client in mind.
- # Slide projector for visual material should be capable of projecting images spanning a 35 degree visual angle.
- # An intercom system should be used to provide communication between client and examiner.
- # Clinician must have a protocol for fitting gauges, trouble-shooting equipment, breakdowns, and malfunctions.
- # Plethysmograph equipment should be used as designed, according to the user documents.
- # The penile plethysmograph should be isolated from AC with a DC converter.

## 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.
- 10. Any confounding physical or emotional inhibitors to sexual arousal.

## 13. **DISINFECTANT PROCEDURES**

- # Gauges will be disinfected prior to use, utilizing an accepted liquid emersable or other accepted laboratory disinfection procedures.
- # A disposable covering will be used for protection over the chair seat and arms of the chair.
- # Client will place gauge in receptacle after use of the gauge and before leaving the testing room. Client will also dispose of protective coverings before leaving testing room.
- # Clinician should use disposable gloves and anti-bacterial soap after contact with gauges. Any items or articles that have been in contact with the client should also be disinfected.





# Appendix C-3

## POLYGRAPH EXAMINATION

*From the Ethical Standards and Principles for the Management of Sexual Abusers, the Association for the Treatment of Sexual Abusers*

The polygraph's utility lies in its ability to elicit information not available through traditional interviewing techniques. When utilizing polygraph examinations with sexual abusers, therapists should work in conjunction with polygraphers in developing protocols for pre-examination interviewing, question formulation, reporting and use of results. Specific decisions relative to instrumentation, interpretation of data and question formulation should be made by trained polygraph examiners.

### 1. Types of Polygraph Examinations

#### A. Sexual History Examination

- C The sexual history examination is a thorough examination of an abuser's lifetime sexual history. This examination is usually included as part of a comprehensive psychosexual evaluation or completed within the first 90 days of treatment.
- C Due to the diverse response from various jurisdictions of the criminal justice system, clinicians should be aware of the general implications and local judicial policies regarding newly reported crimes and self incrimination when requiring clients to undergo sexual history polygraph examinations.

#### B. Specific Issue Examination

- C The specific issue examination is an examination regarding a specific behavior, allegation or event. This examination is generally implemented at the onset of or during the treatment process.

#### C. Maintenance/Monitoring Examination

- C The maintenance examination is a periodic examination of an abuser's compliance with treatment and/or probation/parole restrictions. This examination serves to identify and deter high risk behaviors. Monitoring or maintenance polygraph examinations are usually implemented every four to six months, but can be done more frequently on those abusers who present as high risk.
- C The examinations further assist the service providers in tailoring more effective intervention strategies.

### 2. Polygraph Examination Recording Guidelines

- C All polygraph examinations will be appropriately recorded for diagnostic and documentation purposes.
- C Recording channels/components required for polygraph examinations have been outlined by the American Polygraph Association which requires that:
  - a) Respiration patterns made by pneumograph component(s)--at least one respiration component will record the thoracic (upper chest) respiration and/or abdominal (lower stomach) respiration pattern.

2. One of the chart tracings will record the Skin Conductance Response (SCR) also commonly referred to as Galvanic Skin Response (GSR), which reflects relative changes in the conductivity/resistance of very small amounts of current by the epidermal tissue.
  3. A cardiograph tracing will be utilized to record changes in the pulse rate, pulse amplitude, and changes in the relative blood pressure.
- C To effectively evaluate the polygraph tracings collected during any polygraph examination, it is necessary that easily readable trace recordings be obtained. Tracings that are either too large or too small or that have extraneous responses to outside stimuli are difficult to evaluate.
- C Chart tracings consistently less than one-half inch in amplitude in the pneumograph and/or cardiograph tracings, without sufficient documented explanation of physiological cause, may be considered insufficient for analysis purposes.

### **3. Polygraph Instrument Calibration**

- C Standardized Chart Markings recognized and used within the polygraph profession will be employed to annotate all calibration and examination charts.
- C Each polygraph instrument will be calibrated on a regular basis to ensure the instrument is functioning properly. The examiner shall maintain true and accurate records of such calibration. The records of these calibrations shall be maintained by the examiner for no less than two years.
- C If the instrument remains stationary, all analog polygraph instruments will be calibrated at least once each week.
- C If the instrument was moved subsequent to its last calibration procedure, each analog instrument will be calibrated prior to being used.
- C Digital polygraph instruments will be calibrated according to factory specifications and the manufacturer's recommendations.

### **4. Recommended Frequency of Polygraph Examinations**

The following guidelines for polygraph examination frequency are recommended to maximize validity and reliability of examination rules:

- C To safeguard against the possibility of client habituation and familiarization between the examiner and the subject, it is recommended that the polygraph examiner not conduct more than three separate examinations per year on the same client.
- C A re-examination to resolve a previously failed examination, or where no clear opinion was formed as to the subject's truthfulness, would not be considered a separate examination.
- C In order to allow sufficient time for the pre-test, in-test, and post-test phases of the examination, most tests will require at least 60 minutes. In many cases, it should be anticipated that the examination session will take longer to complete.

## **5. Polygraph Testing Techniques and Procedures**

Polygraph examination techniques will be limited to those techniques that are recognized by the industry as standardized and validated examination procedures.

- C To be an approved examination format, the examination procedure must include appropriately designed relevant questions, appropriately designed control questions for diagnostic purposes, and appropriately designed irrelevant questions as applicable to that defined and standardized procedure.
- C A standardized examination technique or procedure is defined as:
  - a) A technique or procedure which has achieved a published, scientific database sufficient to support and demonstrate validity and reliability from the application and use of that specific polygraph technique.
  - b) A technique or procedure that is evaluated according to the published methods for that specific procedure and provides for numerical scoring and quantification of the chart data.
  - c) A technique or procedure that has not been modified without the support of published validity and reliability studies for that particular modification.
  - 4. A technique or procedure that has been taught as part of the formal course work at a basic polygraph school accredited by the American Polygraph Association.
- C Recommended procedures include:
  - a) Standardized and published Zone Comparison Techniques (ZCT)
  - b) Standardized and published Control Question Techniques (CQT)
  - c) And other standardized and published procedures that meet the guidelines and requirements described above.
- C Utilizing these procedures ensures maximum validity and reliability of diagnostic opinions and ensures that opinions rendered are defensible in court.

## **6. Stimulation/Acquaintance Test**

- C The Stimulation/Acquaintance Test is used to demonstrate that the psychological set of the client and the client's reaction capabilities are established for diagnostic purposes.
- C This test is a recognized procedure utilized in conjunction with professional examination formats and may be a part of the polygraph examination.

## **7. Number of Relevant Questions**

- C All standardized and recognized published examination formats and procedures define the number of relevant questions that may be used. Those applications should not be modified or altered.

- C No recognized examination procedure allows for more than five relevant questions to be asked during any given examination.

### **8. Single-Issue and Mixed Issue Examinations**

- C Available scientific research has indicated that mixing issues during an examination can significantly reduce the ability to form valid and reliable opinions.
- C The importance of psychological set, satiation, adrenaline exhaustion and other principles forming the foundation of the polygraph science must be maintained.

### **9. Relevant Question Construction**

In order to design an effective polygraph examination and to adhere to standardized and recognized procedures, the relevant questions should be constructed with the following considerations:

- a) To be as simple, direct and short as possible.
- b) To not include legal terminology (i.e., sexual assault, homicide, incest, etc.) as this terminology allows for client rationalization and utilization of other defense mechanisms.
- c) To ensure the meaning of each question is clear, not allow for multiple interpretations and not be accusatory in nature.
- d) To never presuppose knowledge.
- e) To contain reference to only one element of the issue under investigation.
- f) To use language easily understood by the client.
- g) To be easily answerable yes or no.
- h) To avoid the use of any emotionally laden terminology (i.e., rape, molest, murder, etc.)

# Appendix C-4

## POST CONVICTION POLYGRAPH STANDARDS FOR SEX OFFENDER TESTING

*From the American Polygraph Association*

**Standard 1.** A minimum of 40 hours of post conviction specialized instruction, beyond the basic polygraph examiner training course requirements, shall be requisite of those who practice sexual offender testing.

**Standard 2.** A final written examination approved by the American Polygraph Association (APA) or its designated representative will be given in which the student must pass in order to get a diploma.

**Standard 3.** The written examinations shall be controlled and protected. The instructors will be required to know the topic areas along with a pool of possible test questions that will be asked; however, the exact test questions will not be disclosed to the instructor.

**Standard 4.** All polygraph examinations of sexual offenders submitted for quality control shall be recorded in their entirety. Though video recording is the preferred medium, audio recording is sufficient to meet this standard.

**Standard 5.** At a minimum, testing facilities will:

- a. Afford privacy and freedom from interruptions.
- b. Be free from visual distractions and noise problems.
- c. Have comfortable temperature and adequate ventilation.
- d. Have an area sufficient for testing.
- e. Support recording equipment (audio/video).

**Standard 6.** The minimum pretest interview specifications are:

- a. Examinees must be advised of the purpose of the examination.
- b. Examinees must be advised that the examination is voluntary.
- c. Examinees must be advised that the examination can be terminated upon request.
- d. Examination must be conducted in a professional manner, and the examinee treated with respect and dignity.
- e. The pretest interview must be conducted in a non-accusatory manner.
- f. The examination must be conducted in compliance with governing local, state and federal regulations and laws, as well as APA standard and principles of practice.
- g. Examiner must properly prepare for the pre-test interview. Preparation should include, at a minimum, a thorough review of the case facts and the information known about the examinee, and the goal of the examination.
- h. The examinee must agree upon the relevant test issues in advance of testing.
- i. Examiners must not display any type of bias, preconceptions or prejudgment of any examinee's innocence or guilt.
- j. Examiners must convey to examinees that test results will be based solely on the polygraph charts, and that a thorough analysis will not be conducted until all data has been collected.
- k. Examiners must provide examinees with a sufficient explanation of the polygraph, including the physiological activity to be recorded.

- l. Examiners must provide examinees with a complete review of the testing procedures.
- m. Examiners must allow sufficient time for a thorough discussion of the test issues, and for the examinee to fully explain his/her position.
- n. Examiners must review all test questions with examinees prior to testing.
- o. Examiners must verify that examinees understand each question.
- p. Examiners must inform examinees of the need to cooperate during the examination.
- q. Examiners must satisfy the following administrative requirements:
  - # Documenting that examinees were advised that the test is voluntary.
  - # Verifying the identity of the examinee.
  - # Obtaining information from the examinees about existing medical and physical conditions in order to assess fitness for testing.

**Standard 7.** The minimum in-test specifications are:

- C Collection of test data must include, a permanent recording of the examinee's respiratory, electrodermal, and cardiovascular activity.
- C Physiological data will be continuously collected during each chart.
- C All physiological data collected will be preserved as a part of the examination file as long as is required by regulation or law, but for a minimum of one year.
- C Each single issue examination shall employ a technique and format that has been validated through research.
- C Reasonable deviations from formats validated by research will be permitted, to the extent that an independent examiner/reviewer would concur that the research and field formats were not significantly dissimilar. Any deviations shall be fully explained and justified by the examiner in writing where this test is subjected to an independent quality control.
- C Test question pacing shall allow reasonable time for physiological recovery following response and/or distortion.
- C Examiners shall conduct a sufficient number of charts, appropriate for testing technique. Examiners shall ensure that the physiological data collected are suitable for evaluation, and that each relevant question is asked on each of at least two separate charts.

**Standard 8.** If an examinee appears deceptive to one or more of the relevant issues, further testing, at a later date, may be required, depending on what new information is provided by the examinee explaining why he did not pass the question(s). If a follow-up examination is done to resolve issues, that test will focus on a single issue or specific issue and will be in the format of a ZCT or validated comparison question technique.

**Standard 9.** All polygraph files will be maintained for a minimum period of one calendar year. Every file must include at a minimum the following information: name, date, location of examination, copy of consent forms and pre-test work sheet, copy of test questions, all case briefing materials, copy of charts or disk which contains charts, an examiner hand score sheet, and the examiner's decision.

**Standard 10.** All examination documentation shall list the amount of time that it took to conduct that examination. At a minimum all post conviction sexual offender examinations will be scheduled for a minimum of 90 minutes in duration.

# Appendix D

## ATSA CODE OF ETHICS

*From the Ethical Standards and Principles for the Management of Sexual Abusers, the Association for the Treatment of Sexual Abusers*

### ETHICAL STANDARDS

Members of this voluntary association of professionals are trained to provide assessment and treatment of sexual abusers. These service providers are committed to the goal of reducing sexual abuse and, in that context, establishing and maintaining professional standards related to the assessment and treatment of sexual abusers. As such, they are conscious of their special skills and aware of their professional limitations and boundaries.

Members perform their professional duties with the highest level of integrity and appropriate confidentiality, with the scope of their statutory responsibilities. They do not hesitate to seek assistance from other professional disciplines when circumstances dictate. They are committed to protect the public against unethical or incompetent practices. In order to maintain the highest standards of service and consumer protection, they commit themselves to the following standards designed to promote the greatest level of public confidence.

### PROFESSIONAL CONDUCT

- A. Members will not allow personal feelings related to a client's crimes or behavior to interfere with professional judgment and objectivity. When a therapist cannot offer service to a client for any reason, he or she will make a proper referral.
- B. Members shall not engage in discrimination based on age, gender, race, ethnicity, national origin, religion, sexual orientation, political affiliation, social or economic status, disability, or any basis prescribed by law.
- C. Members will not engage in sexual harassment. Sexual harassment is sexual solicitation, physical advances, verbal or nonverbal conduct that is sexual in nature and occurs in connections with the member's activities or role as a service provider. Sexual harassment can consist of a single intense or severe act or multiple persistent or pervasive acts. The conduct is further defined as that which:
  - 1. Is unwelcome, is offensive or creates a hostile workplace environment and the member knows or is told this.
  - 2. Is sufficiently severe or intense to be abusive to a reasonable person in the context.
- D. Members do not exploit persons over whom they have supervisory, evaluative or other authority such as students, supervisees, employees, research participants and clients.
- E. Members do not engage in sexual relationships with students, supervisees or other over whom the member has evaluative or direct authority, as such relationships are likely to impart judgement or be exploitative.
- F. Members have not been convicted of a felony or been involved in sexually deviant behavior.



- G. Other than customary fees, members will refrain from using professional relationships, related to the assessment or treatment of a client, to further personal, religious, political or economic interests.
- H. Bartering for services can result in a multiple relationship and therefore is considered unethical.
- I. Members have an obligation to engage in continuing education and professional growth activities on a regular basis to assure an awareness of advances in the field.
- J. Members will refrain from diagnosing, treating or advising about problem outside the recognized boundaries of his or her competence.

## **CLIENT RELATIONSHIPS**

- A. Members, while offering dignified and reasonable support to clients, are courteous in making prognoses and do not exaggerate the efficacy of his or her services.
- B. Members will recognize the importance of addressing the following financial matters with clients:
  - 1. Information concerning fees for services shall be provided to the client either prior to or at the time of the initial appointment.
  - 2. Arrangements for payments are to be settled at the beginning of an assessment or a therapeutic relationship.
  - 3. If there is a change in fee, or if a services is to be provided for which the fees have not been discussed, the client shall be informed of all fees in the manner outlined above.
- C. Informed consent is considered as essential component of the provision of any professional service. At the time of the initial appointment, each client and the parent or guardian of a juvenile, shall be informed verbally or in writing of:
  - 1. The types of services proposed.
  - 2. Reasonable expectation of outcome.
  - 3. Alternatives to the type of services proposed.
  - 4. Potential benefits and risks involved in the services.
  - 5. The limits of privilege and confidentiality.
- D. Members will avoid engaging in multiple relationships with a client.
  - 1. A multiple relationship occurs whenever a member and a client are involved with one another in a manner that conflicts with and/or compromises the primary professional relationship.
  - 2. Multiple relationships may impair professional judgment and pose a significant risk for client exploitation.

- E. Members shall engage in supervisory or peer-based consultation as a method of effectively maintaining appropriate clinical boundaries with clients.
- F. Sexual intimacy with clients or former clients is unethical. A member should not engage in a sexual relationship with any client who is receiving or has received professional services or consultation, regardless of whether payment for the services was involved.
- G. Members shall not withdraw services from a client in a precipitous manner. When considering termination of services, each member shall give careful consideration to all factors involved in the situation and take care to minimize possible adverse effects on the client.
- H. If a member anticipates the termination or disruption of services to a client, he or she shall notify the client promptly and, when possible, provide for transfer or referral to another service provider.
- I. Members who serve a client of a colleague during a temporary absence or emergency will serve that client with the same consideration afforded to their own clients.

## **CONFIDENTIALITY**

- A. In accordance with professional and legal requirements, members shall store all client records in such a way as to ensure their safety and confidentiality.
- B. Members are responsible for informing clients of the limits of confidentiality.
- C. A client should be informed of any circumstances which may cause an exception to the agreed upon confidentiality.
- D. Unless reporting is mandated, written permission shall be required before any data may be divulged to other parties. The client shall be informed of the reason for the release of information.
- E. Client information is not communicated to others without the written consent of the client, unless the following circumstances apply:
  - 1. The client presents a clear and immediate danger to a person(s).
  - 2. The client is in clear and immediate danger.
  - 3. There is an obligation to comply with specific statutes requiring reporting of suspected abuse to authorities.
- F. Members in criminal justice settings should inform all parties (including the client) of the level of confidentiality which applies.
- G. Each member is responsible for becoming fully aware of all statutes which pertain to the conduct of his or her professional practice.

## **PROFESSIONAL RELATIONSHIPS**

- A. Members will refrain from knowingly offering services to a client who is in treatment with another professional without consultation between all parties involved.

- B. At the time of the initial appointment, a client should be asked to provide information about treatment involvement with other service providers and a release of information should be required in order to consult with that service provider. If the client refuses to comply, serious consideration should be given to discontinuing the therapeutic relationship.
- C. If, after involving a client in therapy, a member discovers that the client was in treatment with another service provider, the release of information should be signed immediately and consultation with the other service provider should occur in a timely fashion.
- D. Members are encouraged to affiliate with professional groups, clinics or agencies engaged in the assessment and treatment of sexual abusers. Interdisciplinary contact and cooperation are encouraged.
- E. Members will neither offer nor accept payments for referrals.

## **RESEARCH AND PUBLICATIONS**

- A. Members should plan and conduct research in a manner consistent with federal, state and provincial laws and regulations, as well as professional standards governing the conduct of research. This includes compliance with the U.S. Department of Health and Human Services' regulations for the protection of human subjects.
- B. Members will carefully evaluate the ethical implications of possible research and should accept full responsibility to ensure that ethical practices are enforced in conducting such research.
- C. The practice of informed consent applies to all research projects.
- D. The research participant shall have full freedom to decline to participate in or withdraw from research at any time without any prejudicial consequences.
- E. The research subject shall be protected from physical and mental discomfort to the greatest degree possible.
- F. Publication credit is assigned to those who have contributed to a publication proportion to their contribution and in accordance with customary publication practices.

## **PUBLIC INFORMATION AND ADVERTISING**

- A. All professional presentations to the public will be governed by the following standards on public information and advertising:
  - 1. Assessment and treatment of the sexual abuser exist for the public welfare.
  - 2. Members have a responsibility to the public to avoid misrepresentation or misleading statements.
- B. Information that appears in advertising or public information documents should include:
  - 1. Office or agency identifies (name, group name, names of professional associates, address, telephone number, second languages, office hours).

2. Professional degrees, state licensure and/or professional certification.
  3. Specific experience and training in their specialization and services offered.
  4. Fee information, including methods of payment accepted.
- C. Public communications that produce unrealistic expectations, bring about a lack of confidence in the profession or are harmful to the community are unprofessional and unethical.
  - D. Use of name or credential which could mislead referral sources or the public is improper.
  - E. A member must indicate any limitations in his or her practice, including the requirements for supervision.
  - F. A member should not represent his or her affiliation with any organization or agency in a manner which falsely implies sponsorship or certification by that organization.

## **COMPLIANCE PROCEDURES**

- A. Members bind themselves to accept the judgment of fellow members as to standards of professional ethics, subject to safeguards provided in this section.
- B. Membership implies consent to abide by act of discipline set forth herein by the Board of Directors of the Association for the treatment of Sexual Abusers (ASTA).
- C. It is the responsibility of each member to comply with these standards of ethical practice.
- D. Should any portion of the Ethical Standards of ATSA directly conflict with similar standards which are followed by a professional body that licenses the member, or with any local, state, or federal laws that govern the professional practice of the member, the member is directed to follow the standards of practice of their licensing body or applicable laws.
- E. Should the Ethical Standards of ATSA be found only to be more restrictive rather than in conflict, the member should then follow the ATSA standards.
- F. Should a member appear to violate the ATSA Ethical Standards he or she may initially be approached directly. Intervention may involve colleague consultation with the party in question.
- G. A member may file a formal complaint in accordance with the procedure accepted by the Association for the Treatment of Sexual Abusers.

# Appendix E

## RESEARCH SUPPORTING RESTRICTED CONTACT WITH CHILDREN

Revised June 2000

The Colorado Sex Offender Management Board has set the following guidelines and standards:

**5.510 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.**

**3.511 B** **Sex offenders should have no contact with children, including their own children, unless approved in advance and in writing by the prison treatment provider.**

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

This section of the Standards outlines the requirements that sex offenders must meet and the things that must be either assessed or put in place by the community supervision team prior to approving any contact with children or any other victims or potential victims.

Colorado Sex Offender Management Board applicable Guiding Principles:

- 1.      Sexual offending is a behavioral disorder which cannot be "cured."**
- 2.      Sex offenders are dangerous.**
- 3.      Community safety is paramount.**
- 4.      Victims have a right to safety and self determination.**

Research in support of the "no contact" condition:

1.      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. (Retraining Adult Sex Offenders: Methods and Models, Safer Society Press, by Fay Honey Knopp)
2.      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. (Sexual Abuse in America: Epidemic of the 21<sup>st</sup> Century, by Freeman-Longo and Blanchard, 1998, Safer Society Press, Brandon, VT)

3. 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. (Ahlmeyer, S., Heil, P., McKee, B., and English, K. (2000). The Impact of Polygraphy on Admissions of Victims and Offenses of Adult Sex Offenders, *Sexual Abuse: A Journal of Research and Treatment*, Vol. 12, No. 2, 2000 by,)
4. In 1998, Kim English analyzed a sample of 83 sex offenders who had participated in polygraph evaluations at the Colorado Department of Corrections. This sample included inmates and parolees. She determined that 48% of the offenders had crossed over in either age (36%) or the gender (25%) of the victims they offended against-- they had committed offenses with either victims of different ages (adults and children) or victims of different sexes (males and females). Again, 80% of this sample were still scoring deceptive on their polygraph evaluations. (Presentation at the Association for the Treatment of Sexual Abusers 17<sup>th</sup> Annual Research and Treatment Conference, Maximizing the Use of the Polygraph with Sex Offenders: Policy Development and Research Findings, Vancouver 1998)
5. In 1999, Sean Ahlmeyer analyzed a larger sample of 143 inmates who participated in polygraph evaluations at the Colorado Department of Corrections. In this sample, 89 % of the inmates self reported that they had crossed over in the type of the offenses they committed by either: committing offenses with either victims of different ages (adults and children) and/or victims of different sexes (males and females) and/or victims from different types of relationships.
  - It was determined that 71% of the total sample acknowledged crossing over in the age of the victims they assaulted.
  - Of the offenders who were only known 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. (Poster Presentation at the Association for the Treatment of Sexual Abusers 18<sup>th</sup> Annual Research and Treatment Conference, Lake Buena Vista, Florida 1999)

6. 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. (Information reported in the article, "Incest" by Judith Becker and Emily Coleman, in the Handbook of Family Violence, Van Hasselt et al, 1987.)
7. In 1988, Abel et al. conducted a eight year longitudinal study of 561 male sexual assaulters who sought voluntary assessment and/or treatment at the University of Tennessee Center for the Health Sciences in Memphis and at the New York State Psychiatric Institute in New York City. The study collected information on the offenders self reported patterns of deviant sexual behavior under a guarantee of confidentiality which was obtained under Federal Regulation 4110-88-M. After an extensive interview they diagnosed each offender and looked at the percentage of paraphiliacs (individual with a deviant sexual interest) who had multiple paraphilias (more than one type of deviant interest).

Diagnosis	Number of Subjects	Number of Paraphilias				
		1	2	3	4	5+
Pedophilia (nonincest) female	224	15.2%	23.7%	19.2%	14.7%	27.2%
Pedophilia (nonincest) 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 masturbation	17	5.9%	17.6%	0.0%	17.6%	58.8%

(The Nature and Extent of Sexual Assault, Handbook of Sexual Assault: Issues, Theories, and Treatment of the Offender, edited by W.L. Marshall, D.R. Laws, and H. E. Barbaree, 1990)

8. 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. (Office of Research and Statistics, Division of Criminal Justice, Colorado Department of Public Safety, March 2000)
9. 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. (An Evaluation of Court-Ordered contact Between Child Molesters and Children: Polygraph Examination as a Child Protective Service by Gary Davis, Laura Williams, and James Yokley. Paper presented at 15<sup>th</sup> Annual ATSA Conference, November 1996.)

10. 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.
11. 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)
12. 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)
13. 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 nonconsensual 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. (Factors Related to the Reporting of Childhood Rape by Rochelle F. Hanson, Heidi S. Resnick, Benjamin E. Saunders, Dean G. Kilpatrick, and Connie Best, *Child Abuse & Neglect*, Vol. 23, No. 6, pp. 559-569, 1999)



14. Hunter (2000) conducted research to determine differences between victims of sexual abuse who became offenders, victims of sexual abuse who did not become offenders, and offenders who were never victims. He evaluated 235 juvenile males between the ages of 13 and 17: 55 adolescent child molesters with a history of sexual victimization; 72 adolescent child molesters with no history of sexual victimization; 28 adolescents with a history of sexual victimization, but no history of sexual perpetration; 40 adolescents with a history of emotional or behavioral problems, but no history of sexual victimization or perpetration; and 40 adolescents with no emotional or behavioral problems and no history of sexual perpetration. The greater the number of molestations perpetrated against the child, the younger the age of the child and the greater the delay in reporting the molestations increased the likelihood that a victim would perpetrate against others. However, if the victim perceived their family as being supportive of him/her after the abuse was disclosed, they were less likely to sexually perpetrate against younger children. He came to the following conclusions: "The greater the family support experienced by an individual upon reporting the said molestations, the less likely the individual was to himself perpetrate a sexual molestation." His findings are consistent with Goodman, Taub, Jones, England, Port, Rudy, and Prado (1994) and Waterman (1994). These researchers also documented that child sexual abuse victims were more likely to sexually perpetrate against younger children when they perceived their families as unsupportive of them when their abuse was revealed. (The Influence of Personality and History of sexual Victimization in the Prediction of Juvenile Perpetrated Child Molestation by John A. Hunter, Behavior Modification, February 2000)

It is important to note that the majority of sexual abuse victims do not become sexual abusers. These findings, though, point out the importance of validating the trauma the child has experienced, and supporting and protecting the child in his/her recovery.

15. Rape in America: a Report to the Nation, in 1992 reports finding of a phone survey 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. (Rape in America: A Report to the Nation by the National Victim Center and the Dept. of Psychiatry and Behavioral Sciences at the Medical University of South Carolina, Charleston, SC, April 1992)
16. 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%. (Do Sexual Offenders Molest When Other Persons Are Present? A Preliminary Investigation by Rocky Underwood, Peter Patch, Gordon Cappelletty,

and Roger Wolfe, published in the July 1999 issue of *Sexual Abuse: A Journal of Research and Treatment*)

17. 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 were 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. (Incidence of Sex Offender Risk Behavior During Treatment, Research Project Final Report, by Jim Tanner, for Teaching Humane Existence, Inc. 2/4/99)

18. 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. (Dynamic Predictors of Sexual Reoffense Project 1997 presented at The Association for the Treatment of Sexual Abusers 16<sup>th</sup> Annual Conference, October 16, 1997, Arlington, Virginia)
19. 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."



## Appendix F

# 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 G

## SEX OFFENDER MANAGEMENT BOARD

### ADMINISTRATIVE POLICIES

February 2000

Revised

- 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 Board 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 board 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 board 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 and guidelines;
  - 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 and guidelines 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 Board 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 Board.

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 Board.

- I. Any applicant who is denied placement on the Provider List by the Application Review Committee may appeal the decision to the full Board. 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 Board will consider only information that addresses the reasons for denial outlined by the board in the denial letter. Other information will not be considered by the Board in the appeal process.
  - 3. The applicant may request either a hearing or a conference call with the Board 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 board 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 Board.
  - 4. The Board will consider appeals in open hearing and audio record the proceedings for the record.
  - 5. The applicant will be notified in writing of the Board's decision regarding the appeal.
  - 6. The decision of the Board 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 board. The Board will furnish a form to the complainant which must be completed for the Board to consider the complaint.

All complaints will be initially screened by the vice chair of the Board, or other Board 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 Board will inform complainants that it does not have the authority to intervene in these cases. The Board 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 Board, or other Board 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 Board may:
4. Request more information from the complainant
5. Request a response from the identified provider
6. Initiate and carry out or cause to be carried out an investigation of the complaint either directly or through staff, investigators or consultants.
7. Hold a hearing before the committee requesting both parties to appear.
8. 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 Board may recommend changes in the provider's services or additional training or supervision. The letter of admonition and the provider's response to the Board'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 Board'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 Board. 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 Board.
  2. The Board will consider only information that addresses the reasons for the finding outlined by the Board in their letter.
  3. Either the party requesting the appeal or the other party may request either a hearing with the Board or a conference call with a group of Board Members identified by the Board 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 Board 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 Board.
  4. The Board will consider appeals in open hearing and audio record the proceedings for the record.
  5. The Board will notify both parties of its decision in writing.
  6. The decision of the Board will be final in the appeal process.