

COLORADO SEX OFFENDER MANAGEMENT BOARD

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



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TABLE OF CONTENTS

INTRODUCTION	1
GUIDING PRINCIPLES.....	3
DEFINITIONS.....	11
1.000 PRESENTENCE INVESTIGATIONS OF JUVENILES WHO HAVE COMMITTED SEXUAL OFFENSES	19
FIGURE 1 Continuum of Care for Juveniles Who Have Committed Sexual Offenses.....	23
2.000 EVALUATION AND ONGOING ASSESSMENT OF JUVENILES WHO HAVE COMMITTED SEXUAL OFFENSES.....	25
3.000 STANDARDS OF PRACTICE FOR TREATMENT PROVIDERS	37
3.200 Confidentiality.....	44
3.300 Treatment Provider--Juvenile Contracts and Advisements.....	45
3.400 Completion or Termination of Sex Offense Specific Treatment....	46
3.500 Denial	48
3.600 Objective Measures of Sexual Arousal or Interest as Adjuncts to the Treatment of Juveniles Who Have Committed Sexual Offenses	50
3.610 Plethysmography.....	50
3.620 Abel Assessment.....	52
4.000 QUALIFICATIONS OF PROVIDERS, EVALUATORS AND PROGRAMS FOR JUVENILES WHO HAVE COMMITTED SEXUAL OFFENSES	55
4.100 Treatment Provider: Juvenile—Full Operating Level	55
4.200 Treatment Provider: Juvenile—Associate Level	59
4.300 Evaluator: Juvenile—Full Operating Level	61

4.400	Evaluator: Juvenile—Associate Level	63
4.500	Programs That Provide Out-of-Home and Day Treatment.....	64
Figure 1	Continuum of Care for Juveniles Who Have Committed Sexual Offenses	67
4.600	Polygraph Examiner: Juvenile - Full Operating Level.....	68
4.620	Polygraph Examiner: Juvenile-Associate Level.....	71
4.700	Plethysmograph Examiner.....	74
4.800	Application for Listing Guidelines.....	77
5.000	ESTABLISHMENT OF A MULTIDISCIPLINARY TEAM FOR THE MANAGEMENT AND SUPERVISION OF JUVENILES WHO COMMIT SEXUAL OFFENSES.....	79
5.100	Multidisciplinary Team Functions	79
5.200	Responsibilities of the Supervising Officer/Agent	82
5.300	Responsibilities of Treatment Providers	86
5.400	Responsibilities of the Polygraph Examiner	87
5.500	Responsibilities of the Department of Human Services	87
5.600	Responsibilities of the Division of Youth Corrections.....	88
5.700	Responsibilities of the Informed Supervisor and Therapeutic Care Provider.....	89
5.800	Responsibilities of Schools/School Districts	92
5.900	Responsibilities of Court Appointed Legal Representatives	92
6.000	ADDITIONAL CONDITIONS OF COMMUNITY SUPERVISION	95
7.000	POLYGRAPH EXAMINATION OF JUVENILES WHO HAVE COMMITTED SEXUAL OFFENSES	99
8.000	VICTIMS AND POTENTIAL VICTIMS: CLARIFICATION, CONTACT AND REUNIFICATION.....	105

APPENDICES:

APPENDIX A INFORMED SUPERVISION PROTOCOL 109

Appendix A1 Informed Supervision Agreement 111

Appendix A2 Initial Caregiver--Juvenile Supervision Plan..... 113

APPENDIX B THERAPEUTIC CARE PROTOCOL 115

APPENDIX C POLYGRAPH EXAMINATION 117

Appendix C1 Responding To Polygraph Results..... 121

APPENDIX D PLETHYSMOGRAPH EXAMINATION..... 137

APPENDIX E DENIAL 143

APPENDIX F SPECIAL POPULATIONS 145

**APPENDIX G SEX OFFENDER MANAGEMENT BOARD ADMINISTRATIVE
POLICIES REVISED JULY 2002 147**

APPENDIX H DENIAL OF PLACEMENT ON PROVIDER LIST 151

APPENDIX I SYNOPSES OF SUPPORTING RESEARCH..... 153

Introduction

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

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

These Standards are required for juveniles who are placed on probation or parole, committed to the State Department of Human Services, placed in the custody of the County Department of Human Services, or those in out-of-home placement for sexual offending or abusive behavior. Juveniles who have received deferred adjudications and those whose charges include an underlying factual basis of a sexual offense are also subject to these Standards.

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

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

¹ Association for the Treatment of Sexual Abusers (2000). Position on the Effective Legal Management of Juvenile Sexual Offenders. Beaverton, OR: Association for the Treatment of Sexual Abusers.

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

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

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

GUIDING PRINCIPLES

PRINCIPLE #1:

Community safety is paramount.

The highest priority of these Standards and Guidelines is community safety. Whenever the needs of juveniles who have committed sexual offenses conflict with community safety, community safety takes precedence.

PRINCIPLE #2:

Sexual offenses cause harm.

When a sexual offense is committed, there is always a victim. Research and clinical experience indicate that sexual assault can have devastating effects on the lives of victims, their families and the community³. The impact of sexual offenses on victims varies considerably based on numerous variables and there is potential for differing levels of harm. The long-term impact for victims of sexual abuse and/or sexual assault perpetrated by juveniles can be as damaging as when sexual offenses are perpetrated by adults. By defining the offending behavior and holding juveniles accountable, victims may potentially experience protection, support and recovery.

PRINCIPLE #3:

Safety, protection, developmental growth and the psychological well being of victims and potential victims must be represented within the multidisciplinary team established for each juvenile who commits a sexual offense.

Systemic responses have the potential for moderating or exacerbating the impact of the offense upon victims. Research indicates that the response of family, the community and the systems that intervene influence the victim's recovery³.

³ English, K. (1998). The Containment Approach: An Aggressive Strategy for the Community Management of Adult Sex Offenders. Psychology, Public Policy, and Law, 4(1/2),218-235.

PRINCIPLE #4:

The law defines sexual offense(s), however, there are behaviors that are not illegal, but are considered abusive. Evaluation, treatment and supervision must identify and address these issues within the continuum of care.

Sexual offending behavior occurs when there is a lack of consent, lack of equality or the presence of coercion. Laws define the equality of two participants in terms of age differences and/or one's authority over the other, but may not define the differences in terms of knowledge, development or power. For juveniles to participate in non-abusive sexual behavior they must choose to participate freely, without pressure or coercion and they must have similar knowledge regarding the nature of the sexual behavior, possible consequences, and societal attitudes regarding the behavior.

PRINCIPLE #5:

The charged offense(s) may or may not be definitive of the juvenile's underlying problem(s).

There is no singular profile of juveniles who commit sexual offenses; they vary in terms of age and developmental stage, gender, culture, background, strengths and vulnerabilities, levels of risk and treatment needs. Juveniles who commit sexual offenses may engage in more than one pattern of offending and may have multiple victims.

PRINCIPLE #6:

All juveniles who have committed sexual offenses, to whom these Standards apply, must have a comprehensive sex offense specific evaluation. Those juveniles whose behavior falls under the purview of the Guidelines should have a sex offense specific evaluation.

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

PRINCIPLE #7:

A multidisciplinary team will be convened for the evaluation, treatment, care and supervision of juveniles who commit sexual offenses.

The adoption of standards and guidelines is not likely to significantly improve public safety outcomes unless all agencies and parties are working cooperatively and collaboratively. Therefore, a multidisciplinary team is responsible for the supervision, treatment and care of juveniles who have committed sexual offenses.

PRINCIPLE #8

Evaluation, ongoing assessment, treatment and behavioral monitoring of juveniles who have committed sexual offenses should be non-discriminatory, humane and bound by the rules of ethics and law.

Individuals and agencies carrying out the evaluation, assessment, treatment and behavioral monitoring of juveniles who have committed sexual offenses must not discriminate based on race, religion, gender, sexual orientation, disability or socio-economic status. Juveniles who have committed sexual offenses and their families shall be treated with dignity and respect by all members of the multidisciplinary team regardless of the nature of the juveniles' offense(s) or conduct.

PRINCIPLE #9

Treatment, management and supervision decisions should be guided by empirical findings when research is available.

At this time, there is limited empirical data specific to juvenile sexual offending. It is expected that additional research is forthcoming which may change these Guiding Principles and Standards. In the absence of research, decisions should be made cautiously and in accordance with best practices to minimize unintended consequences.

PRINCIPLE #10

Risk assessment of juveniles who have committed sexual offenses is necessary for the identification of issues related to community safety, treatment, family support and placement options. Progress in treatment and level of risk are not constant over time and may not be directly correlated.

The evaluation and assessment of juveniles who have committed sexual offenses is best seen as a process. Ongoing evaluation and assessment must constantly consider changes in the juvenile, family and community. To manage risk, minimize the opportunities for re-offense and support positive growth and development of juveniles, ongoing assessment should form the basis for decisions concerning restrictions and intensity of supervision, placement, treatment and levels of care.

A juvenile's level of risk should not be based solely on the sexual offense. A complete knowledge of the history, extent, type of sexual offending and other factors is needed before risk of re-offense and risk to community safety can be adequately determined.

PRINCIPLE #11

Assessment of progress in treatment must be made on the basis of the juveniles' consistent demonstration of relevant changes in their daily functioning.

The individualized treatment plans for juveniles who have committed sexual offenses should address all needs and issues which the evaluation and assessment process has identified. Treatment plans must include goals relevant to decreasing the risk of further sexual offending, decreasing all types of deviance and dysfunction, and increasing overall health.

Treatment plans must designate measurable outcomes that will indicate successful completion of treatment. Completion of treatment cannot be measured solely in terms of time in treatment or completion of assignments.

PRINCIPLE #12

Decreased risk of sexual offending is likely to be most lasting when paired with increased overall health.

Many juveniles who commit sexual offenses have multiple problems and areas of risk. Research indicates that many of these juveniles are at greater risk for non-sexual re-offenses than for sexual re-offenses^{4,5}. Assessment and treatment must address areas of strengths, risks and deficits to increase the juveniles' abilities to be successful and to decrease the risks of further abusive or criminal behaviors. Treatment plans should specifically address the risks of further sexual offending, other risks that might jeopardize safety and successful pro-social functioning. Treatment plans should also reinforce developmental and environmental assets.

PRINCIPLE #13

Family members are an integral part of evaluation, assessment, treatment and supervision.

Family members possess invaluable information about the etiology of the problems experienced by juveniles who have committed a sexual offense. Family members may be the juveniles' primary support system through the course of treatment and supervision. Cooperative involvement of family members enhances juveniles' prognoses in treatment.

Conversely, non-cooperative family members may impede juveniles' progress, necessitating the removal from, or delaying or preventing return to, their families. The families' abilities to provide informed supervision and support positive changes are critical to providing community supervision and reducing risk of re-offense.

⁴Hagen, M.P. & Gust-Brey, K.L. (2000). A Ten-Year Longitudinal Study of Adolescent Perpetrators of Sexual Assault Against Children. Journal of Offender Rehabilitation, 13(1/2), 117-126.

⁵Weinrott, M.R. (1996). Juvenile Sexual Aggression: A Critical Review. (Center Paper 005). Boulder, CO: Center for the Study and Prevention of Violence.

PRINCIPLE #14

Treatment and management decisions regarding juveniles who have committed sexual offenses should minimize caregiver disruption and maximize exposure to positive peer and adult role models.

As juveniles move through the continuum of services emphasis should be given to maintaining positive and consistent relationships. Research indicates that exposure to deviant peers⁶, the absence of pro-social adult role models and the disruption of caregiver relationships increase the risk of deviant development.⁷

PRINCIPLE #15

A continuum of care for juvenile sex offense specific treatment and management options should be accessible in each community in this state.

Many juveniles who have committed sexual offenses can be managed in the community. In the interest of public safety, communities should have access to a continuum of care and supervision.

Generally, it is in the best interest of juveniles to grow up in the care of their families. Juveniles need to move between more or less structured settings as their abilities to accept responsibility and demonstrate responsible behavior increase or decrease. When it is safe for juveniles to remain with or be returned to their families, services should be provided in the communities where their families reside.

PRINCIPLE #16

Reunification of juveniles, with families that include children, can only occur when all children are safe and protected both emotionally and physically and the offending juveniles have demonstrated significant reduction of risk for further offending.

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

⁶ Prentky, R., Harris, B., Frizzell, K., and Righthand, S. (2000). An actuarial procedure for assessing risk in juvenile sex offenders. Sexual Abuse: A Journal of Research and Treatment, 12 (2), 71-93.

⁷ Bagley & Shewehuk-Dann (1991), Miner, Siekart, & Ackland (1997), and Morenz & Becker (1995) as cited in Righthand, S., & Welch, C. (2001) Juveniles who have Sexually Offended: A Review of the Professional Literature. Office of Juvenile Justice and Delinquency Prevention.

PRINCIPLE #17

Every effort should be made to avoid labeling juveniles as if their sexual offending behavior defines them.

It is imperative in understanding, treating and intervening with juveniles who commit sexual offenses to consider their sexual behavior in the context of the many formative aspects of their personal development. As juveniles grow and develop their behavior patterns and self-image constantly change. Terms such as child molester, pedophile, psychopath and predator should be used cautiously. Because identity formation is in progress during adolescence, labeling juveniles based solely on sexual offending behavior may cause potential damage to long-term pro-social development.

PRINCIPLE #18

Aftercare services are needed to support juveniles who have committed sexual offenses in managing ongoing risks.

The final phase of assessment and treatment must address ongoing risks through the development of long-term "relapse prevention" plans, including aftercare services. Relapse prevention plans should be carefully developed and must address static and dynamic risk factors. These plans should address the dilemmas posed by the inherent risk factors specific to the juvenile and family. A systemic approach supports the community's investment in treatment services and the juvenile's progress. Successful aftercare services will have a high benefit to cost ratio if they can effectively decrease the risk of re-offending.

PRINCIPLE #19

Assignment to community supervision is a privilege and juveniles who have committed sexual offenses must be completely accountable for their behaviors.

Community supervision may occur in residential placements, group homes, foster homes, or in the juveniles' own homes. The juvenile and parents/caregivers must understand that community safety is the highest priority. They must agree to the intensive and sometimes intrusive, conditions of community supervision required to maintain the juvenile in the community while under the jurisdiction of the court. Both juveniles who have committed sexual offenses and their parents/caregivers must demonstrate accountability and compliance with informed supervision. The abilities of parents to provide informed supervision in the home must be assessed in relation to the particular risks of the juvenile.

PRINCIPLE #20

Many juveniles who have committed sexual offenses will not continue to be at high risk for sexual offending after successful completion of treatment. Those who remain at high risk will be referred for long-term relapse prevention focusing on containment.

Research indicates the majority of juveniles who commit sexual offenses do not have a primary diagnosis indicative of sexual deviance and they are at lower risk than adults to recidivate after successful completion of treatment^{8,9}. Juveniles who have deviant sexual interests and/or arousal patterns who continue to demonstrate attitudes and behaviors characteristic of antisocial and exploitive patterns, those who do not successfully achieve the changes which constitute successful completion of treatment and those whose risk is assessed as moderate or high following intervention must be referred for ongoing services and management prior to release from court jurisdiction.

⁸ Worling, J.R. (2000). Adolescent Sexual Offender Recidivism: 10-year Treatment Follow-Up of Specialized Treatment & Implications for Risk Prediction. Paper presented at the 15th Annual Conference of the National Adolescent Perpetration Network, Denver, CO. Feb., 2000.

⁹ Weinrott, M.R. (1996). Juvenile Sexual Aggression: A Critical Review. (Center Paper 005). Boulder, CO: Center for the Study and Prevention of Violence.

DEFINITIONS

ACCOUNTABILITY

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

AFTERCARE

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

AFTERCARE PLAN

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

AMENABILITY TO TREATMENT

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

ASSESSMENTS

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

BOARD

Colorado Sex Offender Management Board

CAREGIVERS

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

CAREGIVER STABILITY

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

COERCION

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

COMMITMENT

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

COMMUNITY SUPERVISION

When a juvenile is residing in any unlocked location (home, foster placement, RTC placement, etc.) he/she is considered to be under community supervision. The multidisciplinary team, when in place, supervises the juvenile and often, there is a probation or parole officer assigned to the case. When the multidisciplinary team has not been developed yet, the custodial agency and/or Department of Human Services caseworker is generally the supervising agent.

COMPLETE CASE RECORD

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

CONSENT

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

CONTACT

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

PURPOSEFUL: a planned experience with an identified potential outcome

INCIDENTAL: unplanned or accidental; by chance

CONTINUUM OF CARE AND SERVICES

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

DEPENDENCY AND NEGLECT

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

DEVELOPMENTAL COMPETENCY

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

DEVIANCE

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

DIRECT CLINICAL CONTACT

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

DYADIC THERAPY

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

DYNAMIC RISK FACTORS

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

EMPATHIC RECOGNITION

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

EMPATHY

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

EVALUATION

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

GROOMING

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

GUIDELINE

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

INFORMED ASSENT¹⁰

Juveniles give assent, whereas adults give consent. Assent means compliance; a declaration of willingness to do something in compliance with a request; acquiescence; agreement. The use of the term "assent" rather than "consent" in this document recognizes that juveniles who have committed sexual offenses are not voluntary clients and that their choices are therefore more limited.

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

INFORMED CONSENT

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

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

INFORMED SUPERVISION

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

- a. Is aware of the juvenile's history of sexually offending behavior
- b. Does not deny or minimize the juvenile's responsibility for, or the seriousness of sexual offending
- c. Can define all types of abusive behaviors and can recognize abusive behaviors in daily functioning
- d. Is aware of the laws relevant to juvenile sexual behaviors
- e. Is aware of the dynamic patterns (cycle) associated with abusive behaviors and is able to recognize such patterns in daily functioning
- f. Understands the conditions of community supervision and treatment
- g. Can design, implement and monitor safety plans for daily activities

¹⁰ The purpose of defining "informed assent" and "informed consent" in this section is primarily to highlight the degree of voluntariness in the decisions which will be made by a juvenile who has committed a sexual offense and his/her parent/guardian. No attempt has been made to include full legal definitions of these terms.

- h. Is able to hold the juvenile accountable for behavior**
- i. Has the skills to intervene in and interrupt high risk patterns**
- j. Can share accurate observations of daily functioning**
- k. Communicates regularly with members of the multidisciplinary team**

MASTURBATORY SATIATION

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

MILIEU THERAPY

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

NEEDS

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

ON-SITE TREATMENT

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

OVERALL HEALTH

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

PARAPHILIAS

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

POTENTIAL VICTIM

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

PROVIDER LIST

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

RELAPSE PREVENTION

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

RECIDIVISM

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

SAFETY PLANNING

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

SECONDARY VICTIM

A relative or other person, closely involved with the primary victim, who is impacted emotionally or physically by the trauma suffered by the primary victim.

SEX OFFENSE SPECIFIC TREATMENT

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

SEXUAL ABUSE CYCLE

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

SEXUAL PARAPHILIAS/SEXUAL DEVIANCE

Sexual paraphilias/sexual deviance means a sub-class of sexual disorders in which the essential features are “recurrent intense sexually arousing fantasies, sexual urges, or behaviors generally involving (1) nonhuman objects, (2) the suffering or humiliation of oneself or one’s partner, or (3) children or other non-consenting persons that occur over a period of at least 6 months... The behavior, sexual urges or fantasies cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

Paraphiliac imagery may be acted out with a non-consenting partner in a way that may be injurious to the partner... The individual may be subject to arrest and incarceration. Sexual offenses against children constitute a significant proportion of all reported criminal acts”(DSM-IV-TR, pages 566-567).

This class of disorders is also referred to as “sexual deviations”. Examples include pedophilia, exhibitionism, frotteurism, fetishism, voyeurism, sexual sadism, sexual masochism and transvestic fetishism. This classification system includes a category labeled “Paraphilia Not Otherwise Specified” for other paraphilias which are less commonly encountered.

SPECIAL POPULATIONS

Any group of juveniles, who commit sexual offenses, who have needs which significantly differ from the majority of juveniles in this population. Special populations might include (but are not limited to) juveniles who: are female; are developmentally disabled; have co-occurring psychiatric disorders; or, those who have learning disabilities.

STANDARD

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

STATIC RISK FACTORS

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

SUPERVISING OFFICER/AGENT

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

TERMINATION

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

THERAPEUTIC CARE

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

THERAPEUTIC CAREGIVERS

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

THERAPEUTIC MILIEU

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

TRANSITION POINTS

Planned movement from one level of care to another.

ABBREVIATIONS

Child Placement Agency (CPA)

Department of Human Services (DHS)

For the purpose of these Standards, DHS is generally intended as a reference to county departments.

Division of Youth Corrections (DYC)

Multidisciplinary Team (MDT)

Residential Child Care Facility (RCCF)

Residential Treatment Center (RTC)

Sex Offender Management Board (SOMB)

Division of Criminal Justice, 700 Kipling Street, Suite 3000 Denver, CO 80215

1.000 PRESENTENCE INVESTIGATIONS OF JUVENILES WHO HAVE COMMITTED SEXUAL OFFENSES

1.100 Each juvenile should be the subject of a presentence investigation (PSI) which shall include a sex offense specific evaluation. This report should be prepared in all cases, including those which statutorily allow for the waiver of the presentence investigation.

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

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

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

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

1.300 Probation officers investigating juveniles during the presentence stage should have successfully completed recommended sex offense specific training (Section 5.218).

1.400 A presentence investigation (PSI) report should address all the criteria in section 19-2-905, C.R.S. and should include the following as applicable:

- 1. Victim Impact Statement**
- 2. Juvenile's statement of the offense**
- 3. Juvenile justice history, criminal history**
- 4. Risk assessment**
- 5. Sexual offending and abuse patterns, grooming and victim selection**

6. **Type of threat, use of coercion**
 7. **Sexual and non-sexual assaultiveness pattern or history (frequency and duration)**
 8. **Financial status**
 9. **Leisure/recreation—activities and affiliations**
 10. **Inter/intra-personal skills**
 11. **Assets and coping abilities**
 12. **Pertinent medical history**
 13. **Disabilities (developmental, etc.)**
 14. **Emotional/personal problems**
 15. **Interventions including legal, academic and therapeutic (including, but not limited to: prior dependency and neglect actions, placements, type(s) and number of treatment episodes)**
 16. **Officer's impressions of juvenile's attitude, orientation and amenability for supervision**
 17. **Sex offense specific evaluation**
 18. **Current degree of access to present, past or potential victim(s)**
 19. **Placement recommendations (Continuum of Care, Sections 1.000 and 4.000) and availability in Colorado**
 20. **Potential impact of each sentencing option on the victim(s)**
 21. **Restorative/reparative options**
 22. **Initial case plan**
 23. **Recommendations for sentencing including fees and surcharge**
 24. **Recommendations for additional conditions**
- 1.410 When out-of-home placement is being considered, placement evaluation information pursuant to section 19-3-701 (5), C.R.S. must also be addressed in the presentence investigation. The information source will be the DHS caseworker in most instances. Placement information shall include:**
- A. **Assessment of the juvenile's physical and mental health, developmental status, family and social history and educational status**

- B. List of recommended placements and the monthly cost of each**
- C. Treatment plan:**
 - 1. goals to be achieved by the placement**
 - 2. services to be provided and by whom**
 - 3. intensity of services**
 - 4. duration of services**
 - 5. identification of services which can only be provided in a residential setting**
 - 6. recommended duration of the placement**
- D. If a change in legal custody is being recommended:**
 - 1. other alternatives explored and reasons for rejection**
 - 2. particular placements that were explored, rejected and the reasons for rejection**
- E. Required fee charged to the parent pursuant to section 19-1-115 (4) (d), C.R.S.**

1.500 Based on the information gathered, the presentence investigation report should make recommendations concerning a juvenile's amenability to treatment and suitability for community supervision. If community supervision is recommended it should be for an initial period of two years.

1.600 When referring a juvenile for a sex offense specific evaluation, presentence investigators should send the following information to the evaluator, as part of the referral packet¹¹:

- 1. Police reports**
- 2. Victim Impact Statement**
- 3. Child protection reports**
- 4. Juvenile justice/criminal history**
- 5. School records**
- 6. Pertinent medical history**
- 7. Relevant family history**
- 8. Any available risk assessment materials**
- 9. Prior evaluations and treatment reports, e.g. psychiatric, psychological**
- 10. Results from objective measurements, if available**

¹¹ Marshall, W.L. (1999). Current Status of North American Assessment and Treatment Programs for Sexual Offenders. Journal of Interpersonal Violence. 14(3), 221-239.

11. Prior supervision records, when available
12. Any other information requested by the evaluator

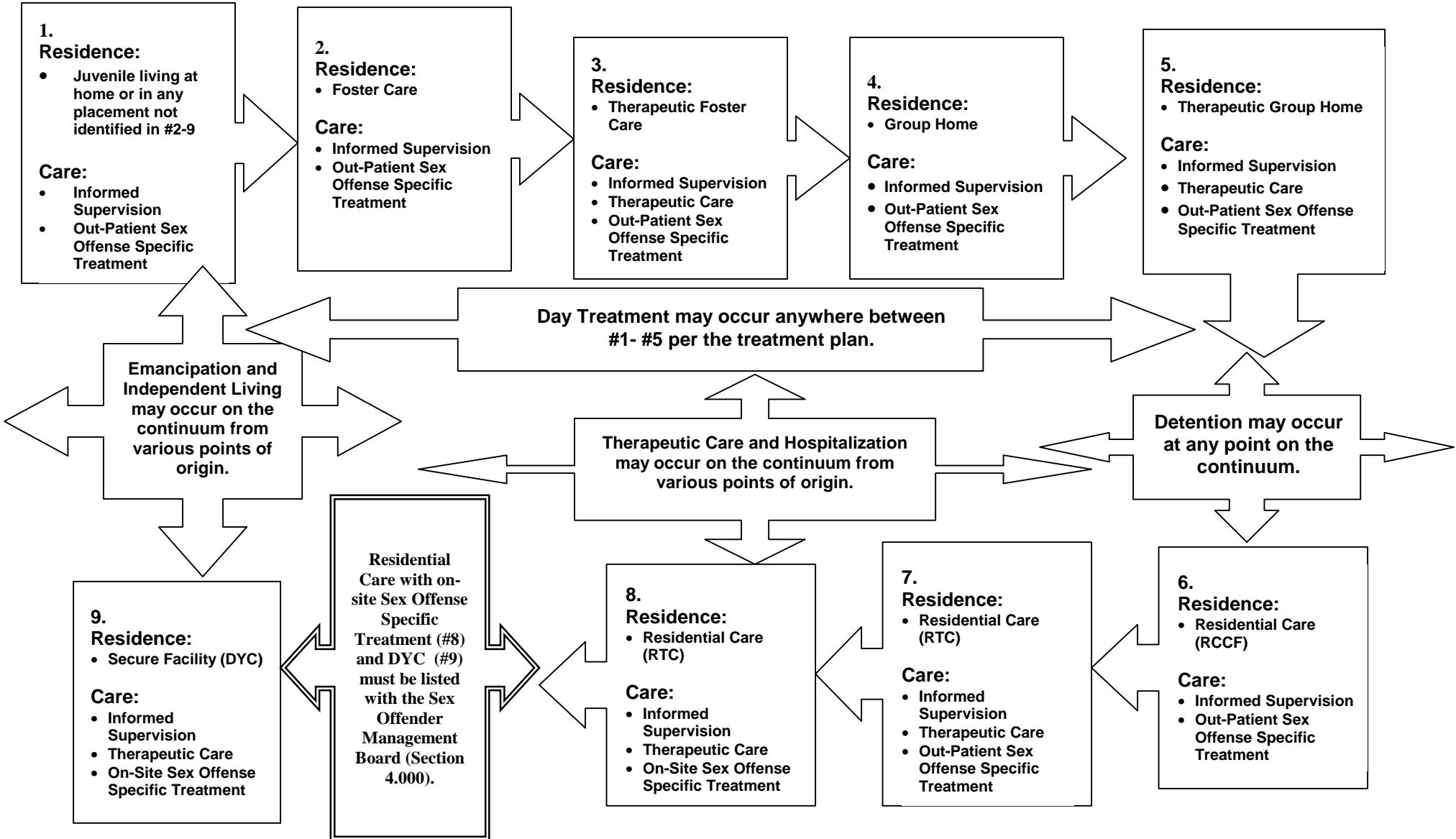
Evaluations received by the presentence investigator that have been performed prior to an admission of guilt by the juvenile may not meet the requirements of these Standards. It is the responsibility of the PSI writer to ensure all areas of information gathering and testing required by these Standards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

- 1.700 During the presentence investigation (or intake interview if no presentence investigation has been conducted) the investigating officer should provide the juvenile and the family/guardian(s) with a copy of the disclosure/advisement form, complete waiver of confidentiality and request signatures on these forms.

Discussion: The disclosure/advisement form notifies the juvenile, respondents and other concerned parties of the requirements the juvenile will have to meet in order to be granted community supervision.

Figure 1

Continuum of Care for Juveniles Who Have Committed Sexual Offenses



**All juveniles who have committed sexual offenses MUST have Informed Supervision (Section 5.500).
When out-of-state placement is recommended, the multidisciplinary team shall seek services that resemble, as closely as possible, those available in Colorado.**

2.000

EVALUATION AND ONGOING ASSESSMENT OF JUVENILES WHO HAVE COMMITTED SEXUAL OFFENSES

2.100 The evaluation of juveniles who have committed sexual offenses shall be comprehensive¹². Recommendations for intervention shall be included in the summary and the evaluation shall be provided in written form to the referring agent. The evaluation of juveniles who have committed sexual offenses has the following purposes:

- A.** To assess overall risk to the community
- B.** To provide protection for victims and potential victims
- C.** To provide written clinical assessment of a juvenile's strengths, risks and deficits
- D.** To identify and document treatment and developmental needs
- E.** To determine amenability for treatment
- F.** To identify individual differences, potential barriers to treatment, and static and dynamic risk factors
- G.** To make recommendations for the management and supervision of the juvenile
- H.** To provide information which can help identify the type and intensity of community based treatment, or the need for a more restrictive setting.

Comprehensive evaluation and assessment of juveniles who have sexually offended is an ongoing process.

Progress in treatment and level of risk are not constant over time and may not be directly correlated.

Risk and protective factors must be assessed on an ongoing basis.

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

¹² Quinsey, V.L., Harris, G.T., Rice, M.E., Cormier, C.A. (1998). Violent Offenders: Appraising and Managing Risk. American Psychological Association, 55-72.

2.210 There are five identified¹³ phases of evaluation and assessment. Evaluators and professionals providing ongoing assessments shall comply with these Standards at each phase.

1. **Pre-trial:** (investigative) The initial phase of information gathering may include involvement of law enforcement officers, child protective services and other professionals deemed necessary for investigative purposes and management of community safety. Information and/or assessments compiled before an admission of guilt is considered the least reliable and incomplete. A comprehensive evaluation is mandated by these Standards post-disposition and presentence except under the conditions described in Section 2.700. Evaluations conducted prior to an admission of guilt may not meet the requirements of the presentence investigation and may not meet the conditions of these Standards.
2. **Presentence and post-adjudication:** (dangerousness/risk, placement and amenability to treatment) An evaluation performed by a listed evaluator containing the elements set forth in these Standards must be done prior to sentencing to determine the juvenile's level of danger and risk, residential needs, level of care and treatment referrals. The multidisciplinary team is expected to have a collaborative relationship at this point and to fulfill the specific roles relative to agency involvement.
3. **Ongoing needs assessment:** (treatment planning, progress and continued assessment) The juvenile's progress in treatment and compliance with supervision must be assessed on an ongoing basis. Level of risk must be assessed at transition points and includes considerations of level of functioning, monitoring and follow-up. Measurements and testing instruments shall be utilized as clinically indicated.
4. **Release/termination:** (community safety, reduced risk and successful application of treatment tools) Prior to discharge from treatment, a final assessment is necessary. In cases when a juvenile is petitioning the court for termination of registration, a report must be presented to the court with recommendations for continuing or discontinuing registration. The final assessment shall make recommendations for follow-up and aftercare services.
5. **Follow-up monitoring:** (continued monitoring in the community) Probation/parole or other supervising agents must continue monitoring the juvenile's post-treatment release for as long as the court retains jurisdiction. Caseworkers shall continue active monitoring of juveniles who are in placement.

¹³ Based on the Five Phases of Involvement (National Task Force on Juvenile Sexual Offending, 1993).

2.300 The evaluation and subsequent assessments shall be sensitive to the rights and needs of the victim.

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

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

- A. Cognitive functioning**
- B. Personality, mental disorders, mental health**
- C. Social/developmental history**
- D. Developmental competence**
- E. Current individual functioning**
- F. Current family functioning**
- G. Sexual evaluation**
- H. Delinquency and conduct/behavioral issues**
- I. Assessment of risk**
- J. Community risks and protective factors**
- K. Awareness of victim impact**
- L. External relapse prevention systems including informed supervision**
- M. Amenability to treatment.**

Evaluation methods may include the use of clinical procedures, screening level tests, observational data, advanced psychometric measurements and special testing measures. Evaluation reports more than 6 months old should be regarded with caution.

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

2.600 Evaluation methodologies shall include:

- A. Examination of juvenile justice information and/or department of human services reports**
- B. Details of the offense/factual basis and any victim statements including a description of harm done to the victim**
- C. Examination of collateral information including information regarding the juvenile's history of sexual offending and/or abusive behavior**
- D. A sex offense specific risk assessment protocol**
- E. Use of multiple assessment instruments and techniques**
- F. Structured clinical interviews including sexual history**
- G. Integration of information from collateral sources**
- H. Standardized psychological testing if clinically indicated.**

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

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

- A. Use of instruments that have specific relevance to the evaluation of juveniles**
- B. Use of instruments with demonstrated reliability and validity (when possible) which are supported by research in the mental health and juvenile sex offender treatment fields.**

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

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

- Is the victim(s) in the home?*
- What was the level of intrusiveness of the sexual behavior?*
- Did the juvenile use force, threats, intimidation, coercion, or weapons during the alleged offense?*
- Are the juvenile's parent/guardians minimizing or denying the seriousness of the alleged offense?*
- Can the parent/guardian be reasonably expected to provide supervision in the home and the community as outlined in the Informed Supervision Protocol, at minimum?*
- Does the juvenile have access to other vulnerable persons?*
- What is the juvenile's history of delinquent or sexual offending behavior?*

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

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

Sex Offense Specific Evaluation of Juveniles

I. Cognitive Functioning

Evaluation Areas – Required	Possible Evaluation Procedures	Key (See below)
<ul style="list-style-type: none"> ▪ Intellectual Functioning Mental retardation, learning disabilities, literacy, adaptive functioning 	Cognitive Abilities Scales Clinical Interview Case File/Document Review Collateral Contact/Interview Clinical Mental Status Exam Differential Ability Scales Observational Assessment WISC-III WAIS-III Slosson Intelligence Test – Revised Slosson Full Range Intelligence Test Kaufman Brief Intelligence Test Shipley Institute of Living Scale Universal Nonverbal Intelligence Test Woodcock-Johnson Psychoeducational Battery-Revised Woodcock-Johnson III Woodcock-Munoz Psychoeducational Bateria Bilingual Verbal Abilities Test	CIJK AEFIKM AEGIKM AEGIKM AEFIKM CIJK AEIKM CEFIJK CEFKLM BEFIJKLM BEFIJKLM BEFJKLM BFKLM CIJK CIJKLM CIJKLM CIJKLMN BIJKLM
<ul style="list-style-type: none"> ▪ Neuropsychological Screening 	Clinical Interview Case File/Document Review Collateral Contact/Interview Clinical Mental Status Exam Observational Assessment Neurobehavioral Cognitive Status Examination (Cognistat) Kaufman Short Neuropsychological Assessment Procedure Wisconsin Card Sorting Test Bender Gesalt Visual Motor Test Boston Naming Test Boston Diagnostic Aphasia Exam Neuropsychological Evaluation NEPSY NEUROPSI (Brief neuropsychological evaluation in Spanish) Learning Disabilities Diagnostic Inventory	AEGIKM AEGIKM AEFIKM AEIKM BEFKLM BEFJKLM CEFJKLM CEFJKLM BDJL CEFJKLM DEFKLM CDJ BJKLM BE

KEY

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<ul style="list-style-type: none"> ▪ Educational History Memory and learning abilities 	Clinical Interview Case File/Document Review Collateral Contact/Interview Clinical Mental Status Exam Observational Assessment History of Academic Achievement and Functioning Test of Memory and Learning Wide Range Assessment of Memory and Learning Wide Range Achievement Test – 3 rd Edition Weschler Individual Achievement Test Woodcock Johnson Academic Achievement Woodcock-Munoz Psychoeducational Bateria (Spanish) Weschler Memory Scales for Children Weschler Memory Scales Woodcock Reading Mastery Tests – Revised Strong-Cambell Holland Interest Inventory Self Directed Search Woodcock-Munoz Academic Achievement Battery (Spanish) Kaufman Functional Academic Skills Test Mini-Battery of Achievement Kaufman Test of Academic Achievement Peabody Individual Achievement Test-Revised	AEGIKM AEGIKM AEFIKM AEIKM AEIKM CEFJKLM CEFJKLM BEFIJKLM CIJK CIJKLM CIJKLMN CEFIJK CEFKL CIJKLM FM CFKM FM CIJKLM BFJKL BIJKLM CIJK CIJK
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II. Overall Functioning, Personality, Mental Disorders and Mental Health		
Evaluation Areas – Required	Possible Evaluation Procedures	Key (See below)
<ul style="list-style-type: none"> ▪ General/Overall Functioning 	Clinical Interview Case File/Document Review Collateral Contact/Interview Clinical Mental Status Exam Observational Assessment	AEFIKM AEGIKM AEGIKM AEFIKM AEIKM
<ul style="list-style-type: none"> ▪ Mental Health Psychopathology, Psychiatric illness ▪ Personality Traits Assets and Strengths ▪ Mental Disorders Co-occurring 	Clinical Interview Case File/Document Review Collateral Contact/Interview Clinical Mental Status Exam Observational Assessment (BPRS) Brief Psychiatric Rating Scale (PANSS) Positive and Negative Syndrome Scales MMPI-A MMPI – 2 MACI (Millon Adolescent Clinical Inventory) MAPI (Millon Adolescent Personality Inventory) MCMI – III Rorschach Inkblot Test Beck Depression Inventory	AEGIKM AEGIKM AEFIKM AEIKM BEFGKM BEFGKM CFHJKN CFHLMN CFHJKN CFHJMN CFHLMN DEFHIJKLM BFKM

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III. Social and Developmental History

Evaluation Areas – Required	Possible Evaluation Procedures	Key (See below)
<ul style="list-style-type: none"> ▪ Social History History of delinquency (known and unknown) History of mental illness/ suicide/ psychiatric involvement (individual and family) Criminal history/ incarceration (individual and family) Social history History of psychiatric diagnosis 	Clinical Interview Case File/Document Review Collateral Contact/Interview Clinical Mental Status Exam Observational Assessment Behavior Assessment for Children Child Behavior Checklist (Teacher Report Form, Youth Self-Report) Survey Instrument III	AEGIKM AEGIKM AEFIKM AEIKM BEFGIJK CEFGIJK
<ul style="list-style-type: none"> ▪ Developmental History Developmental milestones History of abuse Disruptions in care Placement/transition history History of family structure History of counseling and intervention History of Social Services involvement Drug/Alcohol history Education history 	Clinical Interview Case File/Document Review Collateral Contact/Interview Clinical Mental Status Exam Observational Assessment MMPI – A (also in Spanish) MMPI – 2 (also in Spanish) MACI (Millon Adolescent Clinical Inventory) MAPI (Millon Adolescent Personality Inventory) MCMI – III MAYSI Screen (with Spanish translation) CARS (Autism rating scale) Gilliam Autism Rating Scales Sentence Completion Series Thematic Apperception Test Rorschach Inkblot Test Sexual Projective Card Sort Vineland (severity of developmental/adaptive functioning, also in Spanish) Scales of Independent Behavior	AEGIKM AEGIKM AEFIKM AEIKM CFHJK CFHLM CFHJKN CFHJKN CFHLMN BEFJKLM AEGIKM AEGKM ABFKM CEF DEFHIJKLM CEFKM CEGJKLM CGIKM

IV. Developmental Competence

Evaluation Areas – Required	Possible Evaluation Procedures	Key (See below)
<ul style="list-style-type: none"> ▪ Daily Living Skills ▪ Socialization ▪ Communication ▪ Motor Skills ▪ Resiliency ▪ Self-Esteem/Self-Concept ▪ Self-Mastery/Self-Competence 	Clinical Interview Case File/Document Review Collateral Contact/Interview Observational Assessment Vineland (adaptive functioning) Scales of Independent Behavior Learning Disabilities Diagnostic Inventory Test of Learning and Memory Vineland Scales of Independent Behavior WISC-III WAIS – R BASC	AEGIKM AEGIKM AEIKM CEGIKMN CGIJKLM IJK CIJK CEGJKLM CGIJKLM CEFJK CEFJK CEFJK

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V. Current Functioning – Individual

Evaluation Areas – Required	Possible Evaluation Procedures	Key (See below)
<ul style="list-style-type: none"> ▪ Current Mental Status Stress/coping strategies Engagement of sexual deviance (cycle, fantasies) Current level of denial (offense, risk, history) ▪ Stability in Current Living Situation Academic/vocational stability ▪ Communication/Problem Solving Skills Support group Acting out behaviors ▪ Cognitive Disorders ▪ Diagnostic Impressions 	Clinical Interview Case File/Document Review Collateral Contact/Interview Observational Assessment	AEGIKM AEGIKM AEIKM

VI. Current Functioning – Family

Evaluation Areas – Required	Possible Evaluation Procedures	Key (See below)
<ul style="list-style-type: none"> ▪ Current Family Composition History of divorce/separation Current mental illness ▪ Drug / Alcohol Use ▪ Cultural Issues 	Family Interview Case File/Document Review Collateral Contact/Interview Family Observation Clinical Assessment of Family Functioning MACI Scale F (Family Discord) Family History Family Genogram Maddock and Larson Incestuous Family Typology Ryan – Family Typology for Sexually Abusive Youth Beaver – Timberlawn Family Evaluation Scale McMaster Family Assessment Device FACES II Family Circumplex Revised Family Environment Scales (RFES) Family Origin Scale (FOS)	AEGIKM AEGIKM AEFGIKM CFHJK BEIKM BEIKM BFIKM BFIKM BE BE BEF BEF

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VII. Sexual Evaluation

Evaluation Areas – Required	Possible Evaluation Procedures	Key (See below)
<ul style="list-style-type: none"> ▪ Sex History Sexual knowledge (where learned) Sex education history Non-offending sexual history Masturbation (age of onset, frequency, fantasies) Sexual compulsivity/ impulsivity Sexual victimization Range of sexual behaviors Sexual arousal/interest Sexual preference/ orientation Sexual dysfunctions Sexual attitudes/distortions (hyper-masculinity) ▪ Sexually Abusive Behavior Types of sexually abusive behavior the youth has committed Indications of progression over time Level of aggression Frequency of behavior Style and type of victim access Preferred victim type Associated arousal patterns Changes in sexual abuse behaviors or related thinking The youth's intent and motivation The extent of the youth's openness and honesty Internal and external risk factors Victim empathy Victim selection characteristics/typology (diagnosis) 	Clinical Interview Case File/Document Review Child Sexual Behavior Inventory Callateral Contact/Interview Clinical Mental Status Exam Observational Assessment SONE Sexual History Behavior Assessment Scales for Children Penile Plethysmograph Abel Assessment Hanson Sexual Attitude Questionnaires Wilson Sex Fantasy Questionnaire Sexual Projective Card Sort Abel & Becker Adolescent Interest Card Sort Sexual History Polygraph: Section 7 PHASE Sexual Attitudes Questionnaire Bumby Cognitive Distortions Scale Multiphasic Sex Inventory – Adolescent Streetwise to Sexwise (sexuality education assessment) Adolescent Cognitions Scale MSI II-J The Math Tech Sex Test The Adolescent Modus Operandi Questionnaire SO-ISB	AEGIKM CDEI AEGIKM AEFIKM AEIKM FM BEFGIJK DEFHKLM DEKM BFKLM BFL CEFKM FK DEFHKLM BK BK CHJKLM BKM BFK CDFJ ABFKM

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VIII. Delinquency and Conduct Problems

Evaluation Areas – Required	Possible Evaluation Procedures	Key (See below)
<ul style="list-style-type: none"> ▪ Driving ▪ Adjudications ▪ Offenses <li style="padding-left: 20px;">Non-charged offenses <li style="padding-left: 20px;">Property offenses 	Clinical Interview Case File/Document Review Collateral Contact/Interview Observational Assessment Connors Rating Scales (ADHD) Polygraph Monitoring State-Trait Anger Inventory State-Trait Anxiety Inventory (SASSI-III) Substance Abuse Screening ACTers ADD Rating Scale PCL-SV (Psychopathy Checklist – Screening Version) PCL-R (Psychopathy Checklist – Revised)	AEGIKM AEGIKM AEIKM BEGIJK DKM BFJKLM BFJKLM BFJKLM BEGIJK BEGIJK CEFGKLM

IX. Assessment of Risk

Evaluation Areas – Required	Possible Evaluation Procedures	Key (See below)
<ul style="list-style-type: none"> ▪ Risk to Self <li style="padding-left: 20px;">Denial of offense/risk/history ▪ Risk to Others (Violent) Conduct ▪ Criminal Behavior <li style="padding-left: 20px;">Risk for sexual recidivism 	Ross & Loss Risk Assessment Interview Protocol For Adolescent Sexual Offenders O'Brien Protective Factors Checklist MMPI-A (scales 4,9) MMPI-2 (scales 4,9) MACI – scales 6a/6b (unruly/forceful) MCMI-III(scales 6a,6b) Violence Risk Assessment Guide/Sex Offender Risk Assessment Guide (normed on adults, some content maybe applicable to juveniles) Sexual Offense Risk Assessment Guide (SORAG) ERASOR Juvenile Sex Offender Assessment Procedure (J-SOAP) JSO Intake Risk Assessment Juvenile Risk Assessment Tool (J-RAT) Risk Assessment checklist (short and long term risk) PCL-SV (Psychopathy Checklist – Screening Version more appropriate for juveniles than revised version--normed on adults) PCL-R (Psychopathy Checklist - Revised) Clinical Assessment of Risk for Reoffense (phenomenological factors) Child Sexual Behavior Inventory MACI – scales GG (suicidal ideation) Structured Clinical Assessment of Suicide Risk Suicide Risk Checklist	AEDKLM BDEK CDEHJK CDFHJK CDFHJK CDFHLM CDEGKLM CDKLM CDK CDK BDK CDK CDK CDEGKLM CDEFGKLM ADEFGKLM CEDGI CDFHJK BDEGIKM BDEGIKM

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X. Community (Risks and Protective Factors)		
Evaluation Areas – Required	Possible Evaluation Procedures	Key (See below)
<ul style="list-style-type: none"> ▪ Native Environment ▪ Current Living Situation ▪ Current Support Group/Resources Friends/associates Extra-curricular activities 	Clinical Interview Case File/Document Review Collateral Contact/Interview Observational Assessment O'Brien Protective Factors Checklist CASPARS	AEGIKM AEGIKM AEIKM BEK

XI. Awareness of Victim Impact		
<ul style="list-style-type: none"> ▪ Awareness, Internalization of Own Behavior Against Others ▪ Attribution of Responsibility 	Victim Impact Statement Collateral information submitted by victim(s) or secondary victim(s) (in some cases)	

XII. External Relapse Prevention Systems Including Informed Supervision		
<ul style="list-style-type: none"> ▪ External Support ▪ Long Range Planning 	Review plan submitted by Informed Supervisors and Supervising Officer/Agent	

XIII. Amenability to Treatment		
<ul style="list-style-type: none"> ▪ Readiness for Services ▪ Attribution of Responsibility 	Clinical Interview Family Interview MSI II-J Ross & Loss Risk Assessment	CDFJ AEDKM

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3.000

STANDARDS OF PRACTICE FOR TREATMENT PROVIDERS

- 3.100** Sex offense specific treatment for juveniles who have committed sexual offenses shall be provided by persons (hereafter referred to as providers or listed providers) meeting qualifications described in Section 4.000 of these Standards.
- 3.120** Providers treating juveniles on probation, parole, in the custody of the county Department of Human Services or committed to the State Department of Human Services, sentenced to the Department of Corrections, or placed in out-of-home placement for a sexual offense, shall provide sex offense specific treatment and care as described in these Standards and Guidelines.

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

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

TRADITIONAL PSYCHOTHERAPY IS NOT SUFFICIENT FOR SEX OFFENSE SPECIFIC TREATMENT.^{14,15,16}

- 3.130** Providers, in concert with the multidisciplinary team, shall develop written treatment plans based on the individualized evaluation and assessment of the juvenile.

Treatment Plans

- A.** Sex offense specific treatment shall be designed to address strengths, risks and deficits and all areas of need identified by the evaluation (described in Section 2.000) and shall:

¹⁴ National Adolescent Perpetrator Network (1993). The Revised Report from the National Task Force on Juvenile Sex Offending. Juvenile and Family Court Journal, 44(4).

¹⁵ Marshall, W.L., & Barbaree, H.E.(1990). Outcome of Comprehensive Cognitive-Behavioral Treatment Programs. Handbook of Sexual Assault: Issues, Theories & Treatment of the Offender, W.L. Marshall, D.R. Laws, H.E. Barbaree (eds.) New York, New York: Plenum Press, pp 363-385.

¹⁶ Borduin, C.M., Henggeler, S.W., Blaske, D.M., Stein, R.J. (1990). Multisystemic Treatment of Adolescent Sexual Offenders. International Journal of Offender Therapy & Comparative Criminology, 34(2).

1. **Provide for the protection of past and potential victims, and protect victims from unsafe or unwanted contact with the juvenile**
2. **Include treatment goals and interventions that are individualized to improve family functioning and enhance the abilities of support systems to respond to juveniles' needs and concerns**
3. **Favor consistency in caregiver relationships**
4. **Implement interventions that address the juvenile's need for pro-social peer relationships, activities and success in educational/vocational settings**
5. **Describe participation and supervision expectations for the juvenile, the family/caregivers, educators and support systems which exist**
6. **Develop detailed, long-term relapse prevention and aftercare plans to address risks and deficits that remain unchanged**
7. **Describe relevant and measurable outcomes that will be the basis of determining successful completion of treatment.**

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

3.140 Sex offense specific treatment methods and intervention strategies shall be based on the individual treatment plan that has been developed by the multidisciplinary team, in response to the individual evaluation and ongoing assessments. A combination of individual, group and family therapy shall be used unless contraindicated.^{17,18,19,20,21}

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

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

¹⁷ Sirles, E.A., Araji, S.K., Boser, R.L. (1997). Redirecting Children's Sexually Abusive and Sexually Aggressive Behaviors: Programs & Practices. Sexually Aggressive Children, S.K. Araji (ed). Thousand Oaks: Sage. Pp.161-192.

¹⁸ National Adolescent Perpetrator Network (1993). The Revised Report from the National Task Force on Juvenile Sex Offending. Juvenile and Family Court Journal. 44(4),1-120.

¹⁹ Bernet, W., Dulcan, M.K. (1999). Practice Parameters for the Assessment and Treatment of Children and Adolescents who are Sexually Abusive of Others. Journal of the American Academy of Child and Adolescent Psychiatry. 38(12),55S-76S.

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

²¹ Miner, M.H., & Crimmins, C.L. (1997). Adolescent Sex Offenders -- Issues of Etiology and Risk Factors. The Sex Offender: New Insights, Treatment Innovations, and Legal Developments Vol II, B.K. Schwartz & H.R. Cellini (Eds.) Kingston, New Jersey: Civic Research Institute.

Treatment Modalities

- A. Group therapy provides psycho-education, promotes development of pro-social skills, provides positive peer support and/or is used for group process (Provider: Client ratios shall be no less than 1:8; 2:12).**
- 1. Treatment providers must monitor and control groups to minimize exposure to deviance, deviant peer modeling and to provide for the safety of all group members**
 - 2. Co-therapy is always recommended²²**
 - 3. Male and female co-therapists are preferred.²²**
- Discussion: Juveniles who commit sexual offenses present a complex set of challenges for group facilitators. Not only are the dynamics multifaceted, the safety of group members is of concern. The intensity of these groups requires a strong team approach, therefore, staff to client ratios may be higher than in other types of groups. It is understood that occasional illness or absence of co-providers may affect ratios.*
- B. Individual therapy is used to address mental health issues and/or to support the juvenile in addressing issues in group, family or milieu therapy (Provider: Client ratio shall be no less than 1:1).**
- C. Family therapy addresses family systems issues and dynamics. This model shall address, at a minimum, informed supervision, therapeutic care, safety plans, relapse prevention, reunification and aftercare plans (Provider: Client ratios shall be no less than 1:8; 2:12).**
- D. Multi-family groups provide education, group process and/or support for the parent and/or siblings of the juvenile. Inclusion of the juvenile is optional. The treatment provider monitors and supervises confidentiality (Standard 3.200). Staff to client ratios shall be designed to provide safety for all participants (Provider: Client ratios shall be no less than 1:8; 2:15; 3:18; 4:24).**
- E. Clarification sessions shall occur as prescribed in Section 8.000 of these Standards.**
- F. Dyadic therapy is used when approved by the multidisciplinary team.**
- G. Psycho-education is used for teaching definitions, concepts and skills (Provider: Client ratios shall be no less than 1:12; 2:20).**
- H. Milieu therapy is used to promote growth, development and relationship skills; to practice pro-social life skills; and to supervise, observe and intervene in the daily functioning of the juvenile. A combination of male and female role models are**

²² Marshall, W.L., & Barbaree, H.E. (1990). Outcome of Comprehensive Cognitive-Behavioral Treatment Programs. Handbook of Sexual Assault: Issues, Theories & Treatment of the Offender, W.L. Marshall, D.R. Laws, H.E. Barbaree (Eds.) New York, New York: Plenum Press, pp 363-385.

preferred in staffing milieus (Provider: Client ratios shall not be less than the following: 10-12 year olds, 1:8; 13 and older, 1:10).

- I. Self-help or time limited treatments are used as adjuncts to enhance goal oriented treatment. Adjunct treatments must be complementary to sex offense specific treatment.

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

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

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

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

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

Treatment content shall include, but not be limited to:

1. Awareness of victim impact without objectification or stereotyping of the victim
2. Recognition of harm done to victim(s)
3. Impact of sexual offending on victim(s), families, community and self
4. Restitution/reparation to victims (including victim clarification) and others impacted by the offense including the community
5. Recognition of victim(s) experience through role taking and perspective taking
6. Ability to define abusive behaviors: abuse of self, others, property, and/or physical, sexual and verbal abuse
7. Acceptance of responsibility for offending and abusive behaviors, past and present, without minimization or externalization of responsibility or blame
8. Identification of patterns (cycle) of thoughts, feelings and behaviors associated with offending and abusive behaviors
9. Identification of cognitions supportive of antisocial or violence themed attitudes

10. The role of sexual arousal in sexual offending or abusive behaviors; definition of non-offensive and non-abusive sexual fantasy; reduction and disruption of deviant sexual thoughts and arousal, when indicated
 11. Disinhibiting influences such as stress, substance use, impulsivity, peer influence
 12. Anger management, conflict resolution, problem solving, stress management, frustration tolerance, delayed gratification, cooperation, negotiation and compromise
 13. Recognition and management of risk factors
 14. Skills for safety planning, risk management, relapse prevention strategies
 15. Identification of physical health and safety needs
 16. Accurate information about human sexuality; positive sexual identity
 17. Developmental deficits, delays, skills for successful functioning
 18. Relationship skills such as assessment of personal trustworthiness and basic trust of others
 19. Locus of control, i.e. internal sense of mastery, control, competency
 20. Family dysfunction and/or deviance including intimacy and boundaries, attachment disorders, role reversals, sibling relationships, criminality and psychiatric disorders
 21. Recognition of how attitudes of family, peer group, community and culture influence tolerance of offending/abusive behavior
 22. Experiences of victimization, trauma, maltreatment, loss, abandonment, neglect, exposure to violence in the home or community
 23. Legal parameters and consequences relevant to sexual offending
 24. Diagnostic assessment, stabilization, pharmacological treatments and management of concurrent psychiatric disorders.
- 3.151 Sex offense specific treatment shall be designed to maximize measurable outcomes relevant to the dynamic functioning of the juvenile in the present and future by:
- A. Decreasing risk of sexual and non-sexual deviance, dysfunction and offending,
- Outcomes relevant to decreased risk include (but are not limited to):
1. Juvenile consistently defines all types of abuse (self, others, property)

2. **Juvenile acknowledges risks and uses foresight and safety planning to moderate risk²³**
3. **Juvenile consistently recognizes and interrupts patterns of thought and/or behavior associated with his/her abusive behavior (cycle)**
4. **Juvenile consistently demonstrates emotional recognition, expression and empathic responses to self and others (empathy)²³**
5. **Juvenile demonstrates functional coping patterns when stressed²⁴**
6. **Juvenile makes accurate attributions: takes responsibility for own behavior and does not try to control or take responsibility for others' behavior (accountability)²³**
7. **Juvenile has demonstrated the ability to manage frustration and unfavorable events, anger management and self-protection skills²³**
8. **Juvenile rejects abusive thoughts.**

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

Outcomes relevant to increased overall health include (but are not limited to):

1. **Juvenile demonstrates pro-social relationship skills and is able to establish closeness, trust and assess trustworthiness of others²³**
2. **Juvenile has improved/positive self-image and is able to be separate, independent and competent**
3. **Juvenile is able to resolve conflicts and make decisions; is assertive, tolerant, forgiving, cooperative and is able to negotiate and compromise**
4. **Juvenile is able to relax, play, and is able to celebrate positive experiences**
5. **Juvenile seeks out and maintains pro-social peers²³**
6. **Juvenile has the ability to plan for and participate in structured pro-social activities**
7. **Juvenile has identified family and/or community support systems**

²³ Hanson, K.R., Harris, A. (1998-2001). Dynamic Predictors of Sexual Recidivism. Department of the Solicitor General Canada. <http://www.sgc.gc.ca/epub/corr/e199801b/e199801b.htm>.

²⁴ Cortoni, F., & Marshall, W.L. (2001). Sex as a Coping Strategy and its Relationship to Juvenile Sexual History and Intimacy in Sexual Offenders. *Sexual Abuse: A Journal of Research and Treatment*, 13(1).

8. Juvenile is willing to work to achieve delayed gratification; persists in pursuit of goals; respects reasonable authority and limits
9. Juvenile is able to think and communicate effectively; demonstrates rational cognitive processing, adequate verbal skills, and is able to concentrate
10. Juvenile has an adaptive sense of purpose and future.

3.152 Sex offense specific treatment providers shall continue to advocate for treatment until the outcomes in the individual treatment plan have been achieved. Relapse prevention planning and aftercare shall be an element of the treatment plan and shall be developed based on risk and the ongoing needs of the juvenile.

3.160 When therapeutic care (Definitions and Section 5.712) is indicated by the treatment plan, content areas shall be addressed including all items set out in 3.150 and shall include:

- A. Physical safety in the living environment and community
- B. Psychological safety in the living environment and within relationships
- C. Defining types of offending and abusive behaviors in the living environment and community
- D. Recognition of patterns associated with abusive behaviors (cycle) in daily functioning
- E. Activities which increase developmental skills and competencies
- F. Trustworthy relationships, emotional expression, communication, empathic interactions
- G. Exposure to male and female, adult and peer, positive role models
- H. Participation in normative experiences and pro-social activities
- I. Relaxation, recreation and play
- J. Design, implementation and evaluation of safety planning for daily activities
- K. Development and promotion of pro-social attitudes.

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

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

- A. Evaluations, assessments, presentence investigations and treatment plans
- B. Documentation of treatment goals and interventions
- C. Documentation of clarification assignments and progress

- D. Documentation of progress (or lack of) toward measurable outcomes
- E. Critical incidents occurring during treatment
- F. Impediments to success and/or lack of resources and systemic response to the issue
- G. Non-compliance by juvenile, family, or support system
- H. Discharge criteria, relapse prevention plan and recommendations for aftercare
- I. Availability (or lack of) family and/or community resources to support aftercare
- J. For juveniles who meet the identified criteria, reasons why registration should/should not continue (applicable to juveniles who are eligible to petition the court to discontinue registration per section 18-3-412.5, C.R.S.).

Discussion: It is considered best practice to have records that are as complete as possible. The complete case record must provide information obtained in all areas of a juvenile's life that are impacted by the offense and subsequent interventions. When services are not available it must be noted and the alternative plan delineated.

When a juvenile who has committed a sexual offense wants to discontinue registration the juvenile must petition the court. The conditions of this action are set out in section 18-3-412.5, C.R.S. It is important to note that the statute clearly states that the court shall base its determination on recommendations from the juvenile's probation or parole officer, the treatment provider and the prosecuting attorney in addition to information contained in the presentence report. Therefore, it is imperative that the records contain a thorough compilation of information to support thoughtful recommendations. Because the complete case record contains information compiled over the course of time, it is considered a valuable resource to the multidisciplinary team and researchers (research to measure progress and success in treatment is mandated by section 16-11.7-103 (A)(h), C.R.S.). Case files should be carefully maintained and stored. Complete case records should not be destroyed.

3.200 Confidentiality

Juveniles who have committed sexual offenses must waive confidentiality for purposes of evaluation, treatment, supervision and case management to obtain the privileges attached to community supervision. This waiver of confidentiality must be based on complete informed consent of the parent/legal guardian and voluntary assent of the juvenile. The juvenile and parent/guardian must be fully informed of alternative dispositions that may occur in the absence of consent/assent.

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

- 3.210 The multidisciplinary team shall obtain the required signed waivers of confidentiality with the informed consent of the parent/guardian and the assent of the juvenile who has committed a sexual offense (Sections 3.300 and 5.202 of these Standards).

- 3.220 Providers shall notify all clients of the limits of confidentiality imposed by the mandatory reporting law, section 19-3-304, C.R.S.
- 3.230 Providers shall ensure that a juvenile who has committed a sexual offense and the parent/guardian understand the scope and limits of confidentiality in the context of his/her situation, including collateral information that may have been previously confidential.
- 3.240 Providers shall inform all persons participating in any group that participants shall respect the privacy of other members and shall agree to maintain confidentiality regarding shared information and the identity of those in attendance.

3.300 Treatment Provider--Juvenile Contracts and Advisements

Discussion: The purpose of treatment contracts and advisements is to convey information to the juvenile and the parent/guardian regarding treatment program expectations and policies. Treatment contracts and advisements may also take the form of acknowledgements, agreements, or disclosures. Issues such as the juvenile's developmental stage, level of cognitive functioning and the purpose of the document should be taken into account. These documents may be useful with juveniles to foster accountability and responsibility.

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

- A. At a minimum, the treatment contract/advisement shall explain the responsibility of a provider to:
1. Define and provide timely statements of the applicable costs of evaluation, assessment and treatment, including all medical and psychological testing, physiological tests, and consultations
 2. Describe the waivers of confidentiality, describe the various parties, including the multidisciplinary team, with whom treatment information will be shared during the course of treatment; and inform the juvenile and parent/guardian that information may be shared with additional parties on a need to know basis
 3. Describe the right of the juvenile or the parent/legal guardian(s) to refuse treatment and/or to refuse to waive confidentiality, and describe the risks and the potential outcomes of that decision
 4. Describe the procedure necessary for the juvenile or the parent/legal guardian(s) to revoke the waiver and describe the relevant time limits
 5. Describe the type, frequency and requirements of treatment and outline how the duration of treatment will be determined

6. Describe the limits of confidentiality imposed on providers by the mandatory reporting law, section 19-3-304,C.R.S.
- B. At a minimum, the treatment contract/advisement shall explain the responsibilities of the juvenile and his/her parent/guardian(s) and shall include but is not limited to:**
1. Compliance with the limitations and restrictions placed on the behavior of the juvenile as described in the terms and conditions of diversion, probation, parole, Department of Human Services, community corrections or the Department of Corrections, and/or in the agreement between the provider and the juvenile
 2. Compliance with conditions that provide for the protection of past and potential victims, and that protect victims from unsafe or unwanted contact with the juvenile
 3. Participation and progress in treatment
 4. Payment for the costs of assessment and treatment of the juvenile and family
 5. Notification of third parties (i.e. employers, partners, etc.) as directed by the multidisciplinary team
 6. Notification of the treatment provider of any relevant changes or events in the life of the juvenile or the juvenile's family/support system.

3.400 Completion or Termination of Sex Offense Specific Treatment

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

- A. Successful completion of sex offense specific treatment requires the following:**
1. Accomplishment of the goals identified in the treatment plan
 2. Accomplishment of goals in Section 3.150 (1-24)
 3. Accomplishment of the treatment outcomes listed in Section 3.151 B
 4. Demonstrated application in the juvenile's daily functioning of the principles and tools learned in sex offense specific treatment
 5. Consistent compliance with treatment conditions
 6. Consistent compliance with supervision terms and conditions

7. Completed written relapse prevention and aftercare plan that addresses remaining risks and deficits, and that has been reviewed and agreed upon by the multidisciplinary team, the family and the community support system.
- B. Any exception made to any of the requirements for successful completion shall be made by a consensus of the multidisciplinary team. In this case, the multidisciplinary team shall document the reasons for the determination that treatment has been completed without meeting all of the Standards requirements and note the potential risk to the community.
- 3.411 Those juveniles who pose an ongoing threat to the victim or community, even though determined to have successfully completed treatment, will require ongoing supervision and/or treatment to manage their risk in aftercare. Therefore, the multidisciplinary team shall determine how to continue supervision and/or aftercare.
- 3.412 The multidisciplinary team shall meet and reach consensus regarding successful completion, discharge or termination of treatment for each juvenile. The treatment completion decision shall follow the evaluation, assessment and treatment plan. In making this determination, the multidisciplinary team shall:
- A. Consider all sources of collateral information in making transition, discharge or termination decisions
 - B. Assess and document evidence that the goals of the treatment plan have been met, specifically the outcomes listed in Section 3.151 (B) of these Standards; the actual changes that have been accomplished regarding the juvenile's potential to re-offend; and which risk factors remain, particularly those effecting the emotional and physical safety of the victim(s) and potential victims
 - C. Repeat, when indicated, those assessments that might show changes in the juvenile's level of risk and functioning
 - D. Seek input from others who are aware of the juvenile's progress and current level of functioning
 - E. Assess the viability of support and resources in the juvenile's transitional environment if aftercare includes transition as part of the living environment
 - F. Develop a treatment summary with aftercare plan recommendations.

Discussion: Expectations regarding outcomes must consider the assessment of developmental stages and functional impairments. Younger, lower functioning or developmentally delayed juveniles cannot be expected to have the same competencies as older, higher functioning juveniles. In such cases, evidence that the juvenile is aware of risks and is able to manage them may be demonstrated by his/her willingness to ask for help, cooperate with adult caregivers, and comply with legitimate authority. Aftercare and long-term relapse prevention for juveniles who are still highly dependent or cannot reasonably master relevant outcomes will require commitment from their support systems.

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

3.430 Termination without completion of sex offense specific treatment should not be determined by the multidisciplinary team. When the multidisciplinary team has determined that a juvenile is not making progress and will not benefit from continued sex offense specific treatment, the juvenile shall be returned to the mandating agency for further action.

3.500 Denial

Discussion: Denial is a common defense mechanism that protects individuals from being overwhelmed by unmanageable stress. Denial may also be a conscious action to avoid internal or external consequences associated with one's behavior. Initial denial of allegations of a sexual offense is not uncommon, and it is not always clear whether it is a conscious ploy to avoid consequences or a defensive coping mechanism. Therefore, assessment of the nature and extent of denial must be part of each sex offense specific evaluation.

Though the research is limited, a few investigators have been able to develop typologies and a classification system (Appendix E) that may be useful in guiding decisions about interventions with juveniles who commit sexual offenses.

3.510 Some level of denial is common among juveniles who commit sexual offenses and their families, and may be reduced through intervention. The existence of some level of denial regarding sexual offending behaviors shall not in itself exclude the juvenile from treatment, but may be a factor in determining the level of structure for the juvenile along the continuum of care.

3.511 Through evaluation it may be determined that the juvenile's level of denial is such that continued evaluation or sex offense specific treatment may be contraindicated. The evaluator must document the rationale for a recommendation to postpone further evaluation or treatment and provide a recommendation for appropriate intervention.

3.520 Level of denial and defensiveness shall be assessed during the initial sex offense specific evaluation (Section 2.000). While some level of denial and/or defensiveness may be expected initially, high levels of denial may be an impediment to reasonable risk management. High levels of denial may support a consideration of a more restrictive placement. In cases where the level of denial is assessed as high, evaluators and providers shall make recommendations based on individual needs rather than availability of resources.

3.521 Research is ongoing in the area of denial. Appendix E outlines typologies. Treatment of denial shall be developed based upon an individual juvenile's need and may be structured based on these typologies outlined in Appendix E.

3.530 Treatment interventions to address denial shall only be provided by treatment providers who also meet the requirements to provide sex offense specific treatment (Section 4.000).

3.540 Initial treatment intervention shall specifically address denial and defensiveness.^{25,26,27} Sex offense specific treatment cannot begin until approved by the multidisciplinary team based on criteria set forth in Section 3.550.

Discussion: Contact with positive peers who have progressed through their own denial may be helpful in impacting a juvenile's level of denial. Group settings in sex offense specific treatment may be used to introduce juveniles struggling with denial to those who are progressing.

3.550 The multidisciplinary team shall determine the juvenile's eligibility to begin sex offense specific treatment based upon:

- A. The juvenile's decreased resistance to treatment as evidenced by consistent cooperation and active participation in treatment for denial**
- B. The juvenile's decreased defensiveness and denial as evidenced by the juvenile's acknowledgement of committing sexually abusive and/or sexual offending behavior**
- C. Victim empathy as evidenced by the juvenile's willingness to be accountable for the harm he/she caused and to recognize his/her impact on the victim(s).^{26,28}**

3.560 If the juvenile does not reduce his/her level of denial sufficiently enough to be placed in a sex offense specific treatment program, the multidisciplinary team shall take action that may include, but is not limited to: taking the case back to court; changing the placement; or initiating an alternative form of treatment.

²⁵ Becker, J.V., & Hunter, J.A. (1997). Understanding and Treating Child and Adolescent Sexual Offender. Advances in Clinical Child Psychology: Vol. 19, T.H. Ollendick & R.J. Prinz (Eds.) New York: Plenum Press, Pp. 177-197.

²⁶ Ryan, G.D., & Lane, S.L. (1997). Juvenile Sexual Offending. San Francisco: Josey-Bass.

²⁷ Barbaree, H.E. & Cortini, F.A. (1993). Treatment of the Juvenile Sex Offender within the Criminal Justice and Mental Health Systems. The Juvenile Sex Offender, H.E. Barbaree, W.L. Marshall, & S.M. Hudson (Eds.). New York: Guilford Press, Pp. 243-263.

²⁸ Kahn, T.J. & Chambers, H.J. (1991). Assessing Re-Offense Risk with Juvenile Sexual Offenders. Child Welfare, Vol. LXX (3).

3.600 Objective Measures of Sexual Arousal or Interest as Adjuncts to the Treatment of Juveniles Who Have Committed Sexual Offenses

Plethysmography

3.610 Plethysmography is a laboratory assessment of a juvenile's sexual arousal patterns using non-pornographic audio and/or visual stimuli having a validity base with juveniles. The multidisciplinary team shall consult with a plethysmograph examiner and should consider a referral for plethysmography when any of the following indicators are evidenced through legal history, an evaluation or an individual's risk profile:

- A. Pre-pubescent male and/or female victims(s)**
- B. Three or more known victims²⁹**
- C. Pairing of aggression and physiological arousal**
- D. Self-report of deviant arousal**
- E. Offense history indicative of a persistent pattern²⁸**

Discussion: Physiological data may be useful in assessing progress and risk for some juveniles. Providers who utilize plethysmography shall recognize that the data should be interpreted in the context of a comprehensive evaluation and/or treatment process.

Deviant sexual arousal or interest is not a component of many juveniles' risk profile. Physiological data cannot determine whether an individual has committed or is going to commit a specific sexual act.

Research has not been conducted to assess the arousal patterns of juveniles in the general population, therefore, there is no normative data. Research using samples of college age males (older teens and young adults) has shown that even as older teens and young adults, many males in this culture experience a wide range of sexual interests and arousal. At present the assessment is only conducted in the English language. There is no research available regarding plethysmography with females.

Uses for plethysmograph examination:

- A. To compare the juvenile's relative physiological arousal to his/her own self-report in order to assess his/her self-awareness and enhance his/her understanding of his/her own sexuality**
- B. To compare the juvenile's relative physiological arousal to a variety of stimulus cues**

²⁸ Kahn, T.J. & Chambers, H.J. (1991). Assessing Re-Offense Risk with Juvenile Sexual Offenders. Child Welfare, Vol. LXX (3).

²⁹ Langstrom, N. & Grann, M. (200). Risk for Criminal Recidivism Among Young Sex Offenders. Journal of Interpersonal Violence, 15 (8).

- C. To discern change in the juvenile's patterns of arousal over time, e.g. to measure increased arousal to non-problematic stimuli and/or decreased arousal to problematic stimuli
 - D. To assess the effectiveness of conditioning processes and suppression techniques the juvenile has learned in treatment, e.g. to measure the juvenile's ability to suppress unwanted and problematic arousal
 - E. To carefully control the administration of and monitor the effects of more intrusive conditioning techniques and/or the efficacy of psycho-pharmaceutical intervention.
- 3.612 Plethysmograph examiners must meet the standards for plethysmography as defined in the ATSA Practitioner's Handbook (1997) (Appendix D) and have training specific to the assessment and treatment of juveniles. If an examiner uses visual stimuli in addition to or in place of audio stimuli, it should not be used with persons under the age of 14. Visual and auditory stimuli should be non-pornographic and non-erotic.**
- 3.613 Plethysmograph examiners shall adhere to the following specific procedures during the administration of each examination:**
- A. Before commencing any plethysmograph examination with any juvenile who has committed a sexual offense, the plethysmograph examiner shall document that each juvenile, at each examination, has been provided thorough explanation of the plethysmograph examination process and the potential relevance of the procedure to the juvenile's treatment and/or supervision. Review and documentation of informed assent will include information regarding the juvenile's right to terminate the examination at any time, and speak with his/her attorney if desired.

Parental consent should be secured and a review of the procedures should be explained to the parent/guardian.
 - 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 multidisciplinary team.
 - C. The examiner shall elicit relevant biographical and medical history information from the examinee prior to administering the actual plethysmograph examination.
 - D. Prior to testing, 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. The plethysmograph examination should not be done without a review of such information.
- 3.614 Plethysmograph testing shall be used as an adjunct tool, it does not replace other forms of monitoring. Information and results obtained from plethysmograph examinations should never be used in isolation when making treatment or supervision decisions.**

Information and results obtained through plethysmograph examination, shall be considered, but shall not become the sole basis for decisions regarding transition, progress and completion of treatment.

3.615 Information and results obtained from the plethysmograph by the multidisciplinary team shall be considered and responded to by the multidisciplinary team in determining the intensity of supervision, level of behavioral restrictions in placement or in relation to activities in the community, and in the transition planning process. Sanctions, additional restrictions or follow-up shall be documented by members of the multidisciplinary team.

3.620 Abel Assessment

The Abel Assessment is a psychological test which consists of:

- A. An objective measure of a juvenile's sexual interests (obtained in a way that is beyond the juvenile's awareness)
- B. A subjective measure (self-report) of sexual interests
- C. A questionnaire which provides information about sexual fantasies, attitudes about sex, and past sexual behavior.

Uses for Abel Assessments:

- A. To compare the juvenile's self-awareness and acknowledgement of sexual interest to an objective measure
- B. To obtain information about sexual interest using a relatively less intrusive measure than a physiological arousal assessment
- C. To provide an additional source of risk assessment
- D. To facilitate disclosure and discussion of sexual interest with the juvenile.

3.621 Generally, it is not recommended that juveniles under the age of 13 take the Abel Assessment. However, the multidisciplinary team may determine, in consultation with an Abel Assessment examiner, if it is reasonable to test a younger juvenile.

3.622 The results of the Abel Assessment cannot be interpreted as indicators of guilt or innocence regarding any specific sexual act.

3.623 The Abel Assessment shall be used as an adjunct tool; it does not replace other forms of monitoring. Information and results obtained from Abel Assessments should never be used in isolation when making treatment or supervision decisions.

Information and results obtained through Abel Assessments shall be considered, but shall not become the sole basis for decisions regarding transition, progress and completion of treatment.

3.624 Information and results obtained from Abel Assessments shall be considered and responded to by the multidisciplinary team in determining the intensity of supervision, level of behavioral restrictions in placement or in relation to activities in the community, and in the transition planning process. Sanctions, additional restrictions or follow-up shall be documented by members of the multidisciplinary team.

3.625 An Abel Assessment examiner shall demonstrate competency according to professional standards and conduct Abel Assessment examinations in a manner that is consistent with the reasonable accepted standard of practice for this instrument.

A. Before commencing any Abel Assessment examination with any juvenile who has committed a sexual offense, the Abel Assessment examiner shall document that each juvenile, at each examination, has been provided thorough explanation of the Abel Assessment process and the potential relevance of the procedure to the juvenile's treatment and/or supervision. Review and documentation of informed assent will include information regarding the juvenile's right to terminate the examination at any time, and speak with his or her attorney if desired.

B. The examinee shall also sign a standard waiver/release of information statement. The language of the statement should be coordinated prior to the Abel Assessment with the multidisciplinary team.

C. The examiner shall elicit relevant biographical and medical history information from the examinee prior to administering the actual Abel Assessment.

D. Test results shall be reviewed with the examinee.

E. The examiner must have received all pertinent and available case facts within a time frame sufficient to prepare for the examination.

3.626 An Abel Assessment 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 he or she has been trained and licensed as a site to utilize the instrument.

3.630 Other Phallometric Methods

If methods such as the use of Depo-Provera or Depo-Lupron, masturbatory satiation or olfactory conditioning are employed as an adjunct to treatment, then the multidisciplinary team shall use plethysmography to measure the efficacy of these interventions.

Interventions such as those listed above and any other phallometric or pharmacological method shall be approved by the multidisciplinary team in consultation with the examiner before being employed.

4.000

QUALIFICATIONS OF PROVIDERS, EVALUATORS AND PROGRAMS FOR JUVENILES WHO HAVE COMMITTED SEXUAL OFFENSES

There are distinct clinical functions within the levels of full operating and associate level providers. The following sections outline qualifications for treatment providers, evaluators, polygraph examiners, plethysmograph examiners and Abel Assessment examiners.

Programs that provide treatment to juveniles in out-of-home placements and in day treatment settings have different levels of qualifications inherent in the design of the program and staffing models. Standards have been developed for programs that provide on-site sex offense specific treatment.

Foster homes and group homes that do not provide sex offense specific treatment or a therapeutic milieu shall provide informed supervision at a minimum and should follow these Standards and Guidelines.

4.100 Treatment Provider: Juvenile -- Full Operating Level

A treatment provider at the full operating level may treat juveniles who have committed sexual offenses and may supervise a treatment provider operating at the associate level. To qualify to provide sex offense specific 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 State of Colorado 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) supervised hours (supervision must have been by a full operating level provider) of clinical experience specifically in the areas of assessment and treatment of juveniles who commit sexual offenses, at least half of which shall have been direct clinical contact. Such clinical experience may have been obtained while seeking licensure or after licensure.

Discussion: Providers should be aware of areas where consultation and supervision are desirable, (i.e. clinical, medical, psychiatric) and arrange for adjunct resources to meet these needs. Peer review is an important resource and should be utilized by providers.

- C. Within the last five (5) years the individual shall have completed at least eighty (80) hours of documented training, which includes 16 hours of training in the area of victimization. Forty (40) of the eighty (80) hours must come from subject areas listed below as sex offense specific training. General topics are listed after those addressing juvenile sexual offending, evaluation, assessment, treatment and management (as described in Sections 2.000 and 3.000 of these Standards). Both areas may include, but are not limited to:

Sex offense specific training (40 hours required from these areas):

- **Prevalence of sexual offending by juveniles/victimization rates**
- **Typologies of juveniles who commit sexual offenses**
- **Sexual deviance theories and their applicability to developmental stages**
- **Evaluation and assessment**
- **Treatment planning and assessing treatment outcomes**
- **Community and milieu supervision techniques including Informed Supervision**
- **Risk assessment**
- **Treatment modalities, specific recommended applications, justification for use and contraindicators, including:**
 - **Group**
 - **Individual**
 - **Family**
 - **Multi-family groups**
 - **Clarification sessions**
 - **Dyadic sessions**
 - **Psycho-education**
 - **Milieu**
 - **Self-help**
- **Sex offense specific treatment techniques including:**
 - **Evaluating and reducing denial**
 - **Behavioral treatment techniques**
 - **Cognitive behavioral techniques**
 - **Relapse prevention**
 - **Offense cycle**
 - **Empathy training**
 - **Confrontation techniques**
 - **Safety planning**
- **Juvenile offender/offense characteristics**
- **Objective measures including:**
 - **Abel Assessment**
 - **Plethysmograph Examination**
 - **Polygraph Examination**
- **Special juvenile sex offender populations including:**
 - **Violent offenders**
 - **Developmentally disabled**
 - **Compulsive**
 - **Female**
 - **Sexually reactive**

- **Safety and containment planning**
- **Elements of harm, restorative and reparative actions**
- **Clarification and contact between the juvenile, family and/or victim(s)**
- **Family reunification**
- **Knowledge of laws, policies and ethical concerns relating to confidentiality, mandatory reporting, risk management (offender and milieu), and juveniles' participation in treatment**
- **Ethics**
- **Philosophy and principles of the Sex Offender Management Board**
- **Continuing research in the field of juvenile sexual offending.**

General topic areas (40 hours):

- **Knowledge of juvenile justice and/or district court systems, legal parameters and the relationship between the provider and the courts, including expectations related to testifying in court**
- **Child and adolescent development**
- **Healthy sexuality and sex education**
- **Family dynamics and dysfunction**
- **Co-morbid conditions, differential diagnosis**
- **Pharmacotherapy**
- **Victims issues including impact and treatment**
- **Trauma theory: secondary and vicarious**
- **Learning theory**
- **Anger management**
- **Multi-cultural sensitivity**
- **Understanding transference and counter-transference**
- **Impact: Professional's experience of secondary trauma.**

To receive credit for training not identified on this list it is incumbent upon the trainee to write a justification demonstrating relevance to juvenile sexual offending evaluation, assessment, treatment and management as described in these Standards.

- D.** In concert with the generally accepted standards of practice of the individual's mental health profession the provider and/or evaluator shall adhere to the Professional Code of Ethics (2001) published by the Association for the Treatment of Sexual Abusers (ATSA). It is the responsibility of each member of ATSA to comply with the Professional Code of Ethics. The provider/evaluator shall demonstrate competency according to the individual's respective professional standards and conduct all evaluations and treatment in a manner that is consistent with the reasonably accepted standard of practice in the offense specific treatment community.

Should any portion of the ATSA Professional Code of Ethics (2001) 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.** The individual shall never have been convicted of or received a deferred judgment for any offense involving criminal sexual or violent behavior, or a felony that would bring into question the competence or integrity of the individual to provide sex offense specific treatment of juveniles.

4.110 Continued Placement on the Provider List: Full Operating Level Treatment Provider

Full operating level treatment providers must apply for continued placement on the list every three (3) years following their initial approval date. 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 of which shall be direct clinical contact with juveniles who commit sexual offenses.

Direct clinical contact includes:

- Intake
- Face-to-face therapy
- Case/treatment staffing with the juvenile
- Treatment plan review with the juvenile
- Polygraph, plethysmograph, Abel Screen results review with the juvenile
- Crisis management
- Milieu intervention

Other applicable clinical experience includes:

- Video/audio taped supervision
- Psychiatric review
- Clinical case management
- One-way mirror observation and supervision

- C.** Treatment providers shall complete a minimum of 24 hours of training ANNUALLY (72 hours total in the 3 year period) as described in these Standards; 8 hours may be from the general topic area, 4 hours must be victim(s) issues, and 12 hours must be from the sex offense specific category.

- D. Provide satisfactory references as requested by the Sex Offender Management Board (SOMB). The SOMB may also solicit such additional references as necessary, including information from the multidisciplinary team, to determine compliance with the Standards and Guidelines.
- E. Submit to a current background check and be fingerprinted (section 16-11.7-106 (2) C.R.S.).
- F. Report any practice that is in significant conflict with the Standards.
- G. Comply with all other requirements outlined in the SOMB administrative policies (see Appendix G).

4.200 Treatment Provider: Juvenile -- Associate Level

A treatment provider at the associate level may treat juveniles who have committed sexual offenses under the supervision of a treatment provider of juveniles listed at the full operating level under these Standards. To qualify to provide sex offense specific 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 provider must hold a professional license or be listed with the Department of Regulatory Agencies as an unlicensed psychotherapist.
- C. 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 sex offense specific treatment with juveniles. At least half (250) of these hours must be in direct clinical contact with juveniles who commit sexual offenses. In addition, at least one hundred sixty (160) of these direct clinical contact hours must have been in co-therapy, in the same room, with a full operating level listed treatment provider.
- D. The individual must have received at least fifty (50) hours of face-to-face professional 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).
- E. The individual shall have had at least forty (40) hours of documented training specifically related to evaluation and treatment methods described in Section 2.000 and 3.000 of these Standards, including eight (8) hours of training in the area of victimization within the last five years. The individual must demonstrate a balanced training history with half (20) of the hours coming from subject areas listed as general topics and half (20) hours coming from sex offense specific training as described in Section 4.100 (C).
- F. In concert with the generally accepted standards of practice of the individual's mental health profession the provider and/or evaluator shall adhere to Professional Code of Ethics (2001) published by the Association for the Treatment of Sexual Abusers (ATSA). The provider/evaluator shall demonstrate competency according

to the individual's respective professional standards and conduct all evaluations and treatment in a manner that is consistent with the reasonably accepted standard of practice in the offense specific treatment community.

- G. The individual shall never have been convicted of or received a deferred judgment for any offense involving criminal sexual or violent behavior, or a felony that would bring into question the competence or integrity of the individual to provide sex offense specific treatment of juveniles.

4.210 Professional Supervision

A professional supervision agreement shall be signed by both the applicant and his/her supervisor. The supervision agreement should specify such things as: the frequency and length of supervision; type of supervision; and it shall specify accumulated supervision hours of at least one (1) hour of supervision directly related to sex offense specific treatment/evaluation for every thirty (30) hours of clinical contact with juveniles who have committed sexual offenses.

Professional supervision is differentiated from clinical supervision, the latter is understood to be the supervision of an employee by a supervisor within the same agency.

4.220 Continued Placement on the Provider List: Associate Level Treatment Provider

Associate level treatment providers must apply for continued placement on the list every three (3) years following their initial approval date. Requirements are as follows, the individual:

- A. Must demonstrate continued compliance with the Standards and Guidelines.
- B. Shall accumulate a minimum of six hundred (600) hours of clinical experience every three (3) years, half (300) of which shall be direct clinical contact with juveniles who commit sexual offenses.
- C. Shall obtain a minimum of one (1) hour of face-to-face professional supervision, from a listed full operating level treatment provider for every 30 hours of clinical contact with juveniles who commit sexual offenses. 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. Shall complete a minimum of 24 hours of training ANNUALLY (72 hours total in the 3 year period) as described in these Standards; 8 hours may be from the general topic area, 4 hours regarding victim(s) issues, and 12 hours from the sex offense specific category.
- E. Shall provide satisfactory references as requested by the Sex Offender Management Board (SOMB). The SOMB may also solicit such additional references as necessary to determine compliance with the Standards and Guidelines. The references shall include other members of the multidisciplinary team.
- F. Shall submit to a current background check and be fingerprinted (section 16-11.7-106 (2) C.R.S.).

- G. Shall report any practice that is in significant conflict with the Standards.
- H. Shall comply with all other requirements outlined in the SOMB administrative policies (see Appendix G).

4.230 Movement to Full Operating Level Treatment Provider

Associate level treatment providers wishing to move to full operating status must complete and submit documentation of:

- A. A total of 1000 hours of supervised clinical experience
- B. 100 hours of clinical supervision, half of these must be face-to-face
- C. 80 hours of training per these Standards
- D. A letter from the applicant's supervisor indicating the applicant's readiness to move to full operating status.

4.240 Out-of-State Applicants

Practitioners who hold professional licensure and reside outside of Colorado may seek provisional status as a full operating level provider or associate level provider if they meet all the qualifications listed in these Standards. The practitioner must have an application for licensure pending in Colorado to apply for provisional listing with the SOMB.

Unlicensed practitioners who relocate to Colorado who: have substantive experience in sex offense specific treatment or evaluation of juveniles who have committed sexual offenses; and can demonstrate supervision, training and experience equivalent to the requirements listed in these Standards may apply for listing at the associate level. They must petition the SOMB for a waiver of some or all of the one hundred and sixty (160) hours of required co-therapy with a full operating level provider.

4.300 Evaluator: Juvenile -- Full Operating Level

An evaluator at the full operating level may evaluate juveniles who have committed sexual offenses and may supervise evaluators at the associate level. To qualify to provide 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 applicant must be listed as a full operating level treatment provider for juveniles who commit sexual offenses at the time of initial application (Section 4.100).
- B. The individual shall have attained the underlying credential of State of Colorado 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.
- C. An evaluator shall have completed a minimum of thirty (30) sex offense specific evaluations with juveniles within the past five (5) years.

- D. The individual shall have had at least eighty (80) hours of documented training specifically related to evaluation, assessment and treatment methods described in Section 2.000 and 3.000 of these Standards, including 16 hours in the area of victimization within the last five years. The individual must demonstrate a balanced training history with forty hours (40) from the offense specific area listed in these Standards in Section 4.100(C), twenty hours (20) specifically regarding the evaluation techniques of juveniles who commit sexual offenses and twenty (20) hours in the general topic area also listed in Section 4.100 (C).
- E. In concert with the generally accepted standards of practice of the individual's mental health profession the provider and/or evaluator shall adhere to the Professional Code of Ethics (2001) published by the Association for the Treatment of Sexual Abusers (ATSA). The provider/evaluator shall demonstrate competency according to the individual's respective professional standards and conduct all evaluations and treatment in a manner that is consistent with the reasonably accepted standard of practice in the offense specific treatment community.
- F. The individual shall never have been convicted of or received a deferred judgment for any offense involving criminal sexual or violent behavior, or a felony that would bring into question the competence or integrity of the individual to provide sex offense specific treatment of juveniles.

4.310 Continued Placement on the Provider List: Full Operating Level Evaluator

Full operating level evaluators must apply for continued placement on the list every three (3) years following their initial approval date. Requirements are as follows, the individual:

- A. Must demonstrate continued compliance with the Standards and Guidelines.
- B. Must have completed six (6) comprehensive sex offense specific evaluations ANNUALLY, and 50 face-to-face clinical contact hours per year (150 total for the 3 year period).
- C. Shall have completed 24 hours of training ANNUALLY, 12 hours shall be in the general topic area, 8 shall be sex offense specific as outlined in these Standards, and 4 hours shall be specific to evaluation and assessment.
- D. Shall provide satisfactory references as requested by the Sex Offender Management Board (SOMB). The SOMB may also solicit such additional references as necessary to determine compliance with the Standards and Guidelines. The references shall include other members of the multidisciplinary team.
- E. Shall submit to a current background check and be fingerprinted (section 16-11.7-106(2) C.R.S.).
- F. Shall report any practice that is in significant conflict with the Standards.
- G. Shall comply with all other requirements outlined in the SOMB administrative policies (see Appendix G).

4.400 Evaluator: Juvenile -- Associate Level

An evaluator at the associate level may evaluate juveniles who have committed sexual offenses under the supervision of a listed full operating level evaluator. An evaluator at the associate level is one who has completed fewer than thirty (30) sex offense specific evaluations in the last five (5) years. To qualify to provide evaluations of juveniles at the associate level under section 16-11.7-106, C.R.S., an individual must meet all the following criteria:

- A. At the time of initial application the applicant must be listed as an associate level or full operating level treatment provider for juveniles who commit sexual offenses.**
- B. The provider must hold a professional license or be listed with the Department of Regulatory Agencies as an unlicensed psychotherapist.**
- C. The individual shall have completed three (3) offense specific evaluations ANNUALLY for the past five years.**
- D. The associate level evaluator must have a clinical supervisor who is a listed full operating level evaluator sign-off on each evaluation conducted at the associate level.**
- E. The individual must have received at least fifty (50) hours of face-to-face clinical supervision by an evaluator at the full operating level. The supervision must be reasonably distributed over the time in which the above clinical experience was being obtained (approximately one (1) hour of supervision for every ten (10) hours of clinical experience).**
- F. The individual shall have had at least forty (40) hours of documented training specifically related to evaluation, assessment and treatment methods described in Sections 2.000 and 3.000 of these Standards, including 8 hours in the area of victimization within the last five (5) years. The individual must demonstrate a balanced training history with twenty hours (20) from the sex offense specific area listed in these Standards in Section 4.100 (C), ten hours (10) specifically regarding the evaluation techniques of juveniles who commit sexual offenses and ten (10) hours in the general topic area also listed in Section 4.100 (C).**
- G. In concert with the generally accepted standards of practice of the individual's mental health profession, the provider and/or evaluator shall adhere to the Professional Code of Ethics (2001) published by the Association for the Treatment of Sexual Abusers (ATSA). The provider/evaluator shall demonstrate competency according to the individual's respective professional standards and conduct all evaluations and treatment in a manner that is consistent with the reasonably accepted standard of practice in the offense specific treatment community.**
- H. The individual shall never have been convicted of or received a deferred judgment for any offense involving criminal sexual or violent behavior, or a felony that would bring into question the competence or integrity of the individual to provide sex offense specific treatment of juveniles.**

4.410 Professional Supervision

A professional supervision agreement shall be signed by both the applicant and his/her supervisor. The supervision agreement should specify such things as: the frequency and length of supervision; type of supervision; and it shall specify accumulated supervision hours of at least one (1) hour of supervision directly related to sex offense specific treatment/evaluation for every thirty (30) hours of clinical contact with juveniles who have committed sexual offenses.

Professional supervision is differentiated from clinical supervision, the latter is understood to be the supervision of an employee by a supervisor within the same agency.

4.420 Continued Placement on the Provider List: Associate Level Evaluator

Associate level evaluators must apply for continued placement on the list every three (3) years following their initial approval date. Requirements are as follows, the individual:

- A. Must demonstrate continued compliance with these Standards and Guidelines.
- B. Shall be listed as an associate level treatment provider and complete a minimum of twenty (20) sex offense specific evaluations in the three (3) year period.
- C. Shall complete 12 hours of training ANNUALLY, 6 hours shall be in the general topic area, 4 shall be in sex offense specific as outlined in these Standards, and 2 hours shall be specific to evaluation and assessment.
- D. Shall provide satisfactory references as requested by the Sex Offender Management Board (SOMB). The SOMB may also solicit such additional references as necessary to determine compliance with the Standards and Guidelines. The references shall include other members of the multidisciplinary team.
- E. Shall submit to a current background check and be fingerprinted (section 16-11.7-106(2) C.R.S.).
- F. Shall report any practice that is in significant conflict with the Standards.
- G. Shall comply with all other requirements outlined in the SOMB administrative policies (see Appendix G).

Note: Evaluators making re-application do not need to continue their listing as a treatment provider, it is a requirement only at the time of initial application.

4.500 Listing of Programs that Provide Out-of-Home and Day Treatment

Programs and placement settings such as residential treatment centers (RTC), residential childcare facilities (RCCF), Division of Youth Corrections institutions (DYC), group homes, foster homes and day treatment settings that provide on-site sex offense specific treatment shall be listed by the Sex Offender Management Board (SOMB).

Foster homes and group homes that do not provide sex offense specific treatment or a therapeutic milieu as described in Section 3.000 and Section 5.000 shall provide informed supervision at a minimum and should follow these Standards and Guidelines.

4.510 In addition to meeting the rules and regulations for licensure and certification per Volumes 7 and 8 (as applicable) of the Colorado Department of Human Services staff manual, staff and programs that wish to provide on-site sex offense specific treatment or therapeutic care (Section 5.712) for juveniles who commit sexual offenses shall meet these additional requirements:

- A.** The program shall be able to come into compliance with these Standards within the specified time frame. Programs must comply with section 16-11.7-105 and 16-11.7-106, C.R.S., and follow state mandates for residential facilities.
- B.** Program administrators and boards shall be aware of the Guiding Principles of these Standards, the content and intent of these Standards and shall agree to treat juveniles who commit sexual offenses in compliance with these Standards.
- C.** The program shall have an identified person(s) who ensures that:
- D.** Primary therapist(s) providing juvenile sex offense specific treatment are listed at the associate or full operating level and providing treatment in compliance with these Standards.
- E.** All milieu childcare staff are trained to provide informed supervision (Appendix A2 for Initial Caregiver--Juvenile Supervision Plan).
- F.** On-site educators are trained to provide informed supervision.
- G.** Two thirds of the milieu childcare staff are trained to fulfill the role of therapeutic care providers as described in Section 5.712.
- H.** At least one person is on duty, on site, at all times who meets the criteria of an informed supervisor.
- I.** A member of the milieu staff is appointed to the multidisciplinary team and actively participates in team decisions.
- J.** A plan is in place in the event the listed provider leaves the program. The program shall notify the multidisciplinary team and the SOMB within 72 hours and shall not be out of compliance with these Standards for longer than fourteen (14) days. The multidisciplinary team shall notify the Sex Offender Management Board if the provider is not in compliance within thirty (30) days.

Discussion: It is expected that agencies that provide programs will do so with a clear understanding of these Standards and Guidelines, and a commitment to administer their programs accordingly. Senior staff should be fully aware of the risks associated with treating juveniles who commit sexual offenses. Senior staff and management should be knowledgeable in sex offense specific safety, treatment and intervention issues. Staff in all positions should be trained or be able to receive training commensurate with the level of expertise required for the position and must be able to provide documentation of such training.

The individualized evaluation guides the multidisciplinary team's decisions. The team then recommends the level of care, treatment and corresponding placement. For the majority of juveniles to whom these Standards and Guidelines apply, the level of placement will be court ordered. All providers involved in a case are considered members of the multidisciplinary team and their role is charted on the Continuum of Care (Figure 1, p.23 or 67).

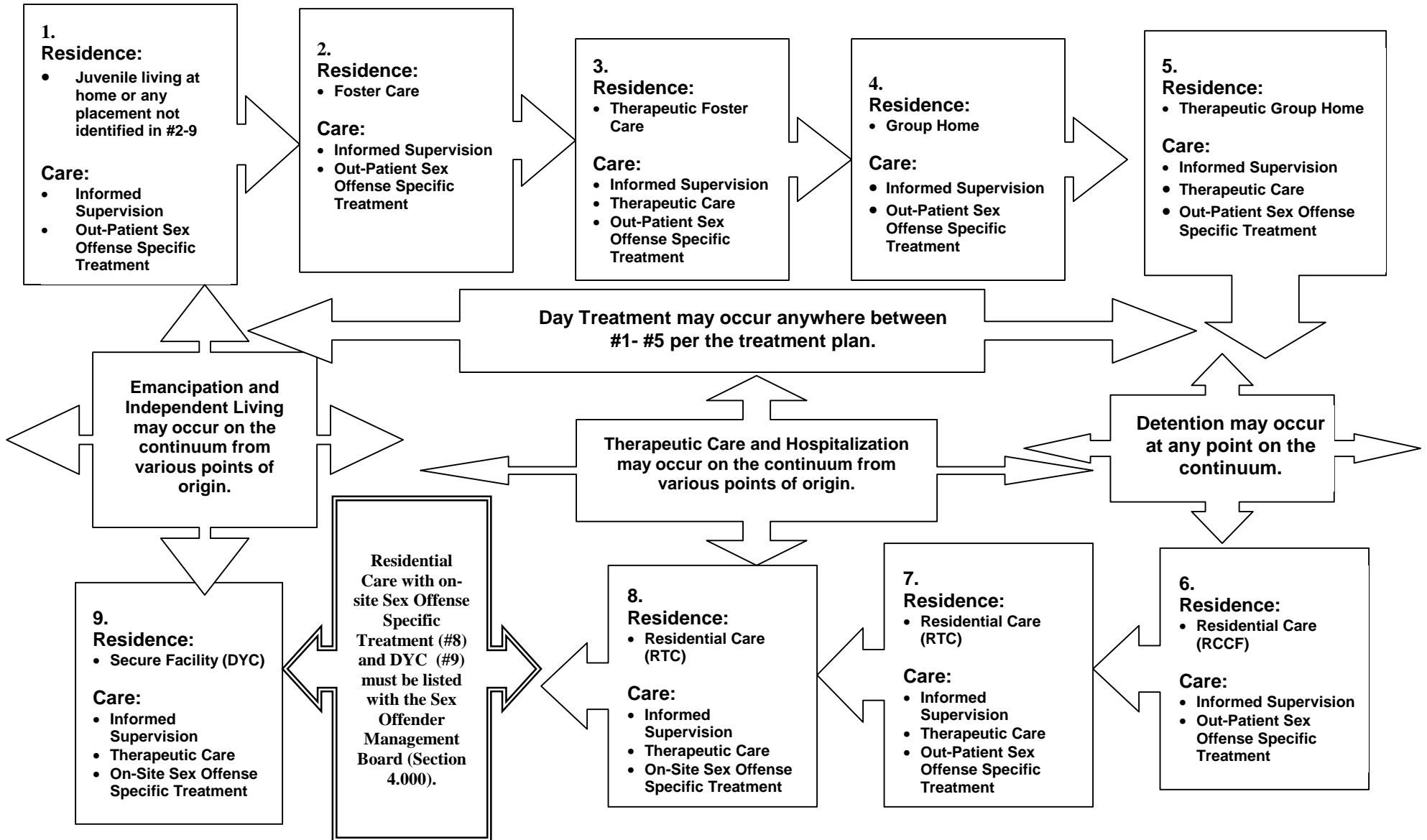
4.520 Out-of-State Placement

Prior to placing juveniles who have committed sexual offenses out of state, the multidisciplinary team shall investigate the placement to confirm there is comparable sex offense specific treatment available and informed supervision meets or exceeds that in Colorado.

The multidisciplinary team shall document the level of care, as illustrated on the Continuum of Care, available to the juvenile. The documentation shall detail areas that are comparable, as well as those that are in contrast, to the care mandated in Colorado per these Standards.

Figure 1

Continuum of Care for Juveniles Who Have Committed Sexual Offenses



**All juveniles who have committed sexual offenses MUST have Informed Supervision (Section 5.500).
 When out-of-state placement is recommended, the multidisciplinary team shall seek services that resemble, as closely as possible, those available in Colorado.**

4.600 Polygraph Examiner: Juvenile -- Full Operating Level

Polygraph examiners who test juveniles who have committed sexual offenses must meet the minimum standards as indicated by the American Polygraph Association, the American Society for Testing and Measures, and the Association for the Treatment of Sexual Abusers, as well as the requirements throughout these Standards.

Polygraph examiners who conduct examinations on juveniles who have committed sexual offenses shall adhere to best practices as recommended within the polygraph profession.

To qualify at the full operating level to perform examinations of juveniles an applicant must meet all the following criteria:

- A. The individual shall have graduated from an accredited American Polygraph Association (APA) school.**
- B. Sixty-four (64) hours of training are required for listing as a full operating level polygraph examiner.**

Following completion of the curriculum (APA school) cited in Section 4.600 (A) of these Standards, the applicant shall have completed an APA approved forty (40) hour training specific to post-conviction sexual offending which focuses on the areas of evaluation, assessment, treatment and behavioral monitoring and includes, but is not limited to the following:

- Pre-test interview procedures and formats**
- Valid and reliable examination formats**
- Post-test interview procedures and formats**
- Reporting format (i.e., to whom, disclosure content, forms)**
- Recognized and standardized polygraph procedures**
- Administration of examinations in a manner consistent with these Standards**
- Participation on the multidisciplinary team**
- Use of polygraph results in the treatment and supervision process**
- Professional standards and conduct**
- Expert witness qualifications and courtroom testimony**
- Interrogation technique**
- Maintenance/monitoring examinations**
- Behavior and motivation of persons who commit sexual offenses**
- Denial**
- Trauma factors associated with victims/survivors of sexual assault**
- Overview of assessment and treatment modalities for persons who commit sexual offenses.**

- C. The applicant must also complete twenty four (24) hours of training specific to juvenile issues in the following areas:
1. Child and adolescent development (10 hours)
 2. Adolescent sexual development
 3. Juveniles who commit sexual offenses (coursework from Section 4.100 of these Standards)

The aggregate of Section 4.600 B and C make up the 64 hours of training post-graduation from an APA accredited polygraph school.

If an applicant wishes to substitute any training not listed here, it is incumbent upon the applicant to write a justification demonstrating the relevance of the training to these Standards.

- D. The applicant must hold a four year baccalaureate degree from an accredited college or university.

- E. The applicant shall have conducted at least two hundred (200) criminal specific-issue examinations broken down into the following categories:

1. Of these 200 examinations, a minimum of half or one hundred (100) must be post-conviction sexual offender (adult or juvenile) polygraph examinations
2. Of these one hundred (100) examinations, a minimum of half or fifty (50) must be post-adjudication juvenile subjects who have committed sexual offenses and who were a juvenile at the time of the offense
3. Of these fifty (50) examinations, twenty (20) must be sexual history (see note); twenty (20) must be maintenance/monitoring; and the remaining ten (10) may be from any or a combination of the three (3) categories (specific issue, sexual history, maintenance/monitoring).

Note: A sexual history examination is identified by question areas that verify a subject's entire sexual history and may include documentation provided by the subject prior to the examination.

- F. 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 multidisciplinary team.

- G. In concert with the generally accepted standards of practice of the polygraph profession, the individual shall adhere to the Professional Code of Ethics (2001) published by the Association for the Treatment of Sexual Abusers (ATSA). The individual shall demonstrate competency according to the individual's respective professional standards and conduct all evaluations and treatment in a manner that is consistent with the reasonably accepted standard of practice in the offense specific treatment community.

- H. The individual shall never have been convicted of or received a deferred judgment for any offense involving criminal sexual or violent behavior, or a felony that would bring into question the competence or integrity of the individual to provide sex offense specific treatment of juveniles.

4.610 Continued Placement on the Provider List: Full Operating Level Polygraph Examiner

Polygraph examiners must apply for continued placement on the list every three (3) years following their initial approval date. Requirements are as follows, the individual:

- A. Must demonstrate continued compliance with these Standards and Guidelines.
- B. Shall complete a minimum of forty (40) hours of continuing education every three (3) years in order to maintain proficiency in the field of polygraph testing and to remain current on any developments in the assessment, treatment and monitoring of juvenile's who commit sexual offenses. A minimum of eighteen (18) of those hours of training must be specific to juvenile issues (Section 4.100). A minimum of six (6) hours must be completed ANNUALLY.
- C. Shall conduct a minimum of one hundred (100) post-conviction sex offense polygraph examinations in the three (3) year listing period. Polygraph examinations with juvenile's who commit sexual offenses must be conducted ANNUALLY (8 per year minimum) for a minimum total of twenty-four (24) in a three (3) year period.
- D. Shall provide satisfactory references as requested by the Sex Offender Management Board (SOMB). The SOMB may also solicit such additional references as necessary to determine compliance with the Standards and Guidelines. The references shall include other members of the multidisciplinary team.
- E. Shall submit to a current background check including fingerprinting.
- F. Shall submit documentation that the examiner has engaged in periodic peer review by other polygraph examiners registered at the full operating level and operating separately from the examiner's agency. Peer review must be conducted bi-annually at a minimum.
- G. Shall report any practice that is in significant conflict with these Standards.
- H. Shall comply with all other requirements outlined in the SOMB administrative policies (see Appendix G).

4.620 Polygraph Examiner: Juvenile -- Associate Level

A polygraph examiner at the associate level is an individual who otherwise meets these Standards for full operating level but who does not have:

- A. A baccalaureate degree from a four year college or university, and/or
- B. Who has not yet completed two hundred (200) post-conviction polygraph examinations broken out into the following categories:
 - 1. Of these 200 examinations, a minimum of half or one hundred (100) must be post-conviction sexual offender (adult or juvenile) polygraph examinations
 - 2. Of these one hundred (100) examinations, a minimum of half or fifty (50) must be post-adjudication juvenile subjects who have committed sexual offenses and who were a juvenile at the time of the offense
 - 3. Of these fifty (50) examinations, twenty (20) must be sexual history; twenty (20) must be maintenance/monitoring; and the remaining ten (10) may be from any or a combination of the three (3) categories (specific issue, sexual history, maintenance/monitoring).

The examiner shall obtain supervision from a polygraph examiner at the full operating level under these Standards for each remaining polygraph examination up to the completion of two hundred (200) polygraph examinations as specified in Standard 4.600. The supervision agreement must be in writing.

All applicants must have an application on file with the SOMB that includes the supervision agreement. Supervision must continue for the entire time the examiner remains at the associate level.

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

If the associate level polygraph examiner has met all the requirements for full operating level status except for obtaining a bachelor's degree, the requirement that supervisors sign-off on each examination may be waived by the SOMB Application and Review Committee if the following conditions are met:

The associate level polygraph examiner submits:

- A. Documentation that all other criteria for full operating level status have been met.
- B. Evidence of continuing work toward obtaining a B.A. or B.S. degree with a proposed completion date.
- C. Evidence that the examiner is continuing to conduct polygraph examinations.

D. A letter from the applicant's supervisor indicating the applicant's proficiency and the supervisor's willingness to lower the intensity of supervision to one hour per month.

E. The applicant shall have completed all training as outlined in Section 4.600 of these Standards.

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

F. In concert with the generally accepted standards of practice of the polygraph profession, the individual shall adhere to the Professional Code of Ethics (2001) published by the Association for the Treatment of Sexual Abusers (ATSA). The individual shall demonstrate competency according to the individual's respective professional standards and conduct all evaluations and treatment in a manner that is consistent with the reasonably accepted standard of practice in the offense specific treatment community.

G. The individual shall never have been convicted of or received a deferred judgment for any offense involving criminal sexual or violent behavior, or a felony that would bring into question the competence or integrity of the individual to provide sex offense specific treatment of juveniles.

H. 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 these Standards and Guidelines. These references shall include, but not limited to, other members of the multidisciplinary team.

I. Submit to a current background check including fingerprinting.

J. Submit documentation that the examiner has engaged in periodic peer review by other polygraph examiners listed at the full operating level and operating separately from the examiner's agency. Peer review must be conducted bi-annually at a minimum.

K. Report any practice that is in significant conflict with these Standards.

L. Comply with all other requirements outlined in the Sex Offender Management Board administrative policies.

4.621 Professional Supervision

A supervision agreement shall be signed by both the polygraph examiner and his/her supervisor. The supervision agreement should specify such things as the frequency and length of supervision, type of supervision, and it shall specify accumulated supervision hours.

Supervision must be a minimum of thirty (30) minutes for each of the 100 sex offense polygraphs (50 of which are specific to juveniles) for a total minimum of fifty (50) face-to-face supervision hours provided by a full operating level polygraph examiner.

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

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

Continued Placement on the Provider List: Associate Level Polygraph Examiner

Polygraph examiners must apply for continued placement on the Provider List every three (3) years by the date provided by the Board. Requirements are as follows, the individual:

- A. Must demonstrate continued compliance with these Standards and Guidelines.

Associate level polygraph examiners shall complete a minimum of forty (40) hours of continuing education every three (3) years in order to maintain proficiency in the field of polygraph testing and to remain current on any developments in the assessment, treatment and monitoring of sexual offenders. Eighteen (18) of the 40 hours must be specific to:

1. Child and adolescent development (10 hours)
2. Adolescent sexual development
3. Juveniles who commit sexual offenses (general subject areas).

The training areas are listed in Section 4.100 of these Standards. Six (6) of the hours must be completed ANNUALLY.

- B. Shall conduct a minimum of 75 polygraph examinations in the three (3) year registration period. Twenty-five (25) examinations must be juvenile sex offense specific.
- C. Shall 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 these Standards and Guidelines, including, but not limited to other members of the multidisciplinary team.
- D. Shall submit to a current background check including fingerprints.
- E. Shall submit documentation that the examiner has engaged in periodic peer review by other polygraph examiners registers at the full operating level and operating separately from the examiners agency. Peer review must be conducted biannually at a minimum.

- F. Shall report any practice that is in significant conflict with the Standards.**
- G. Shall never have been convicted of or received a deferred judgment for any offense involving criminal sexual or violent behavior, or a felony that would bring into question the competence or integrity of the individual to provide sex offense specific treatment of juveniles.**
- H. Shall comply with all other requirements outlined in the Sex Offender Management Board administrative policies.**

4.623 Movement to Full Operating Level

Associate level polygraph examiners wishing to move to full operating level status must complete and submit documentation of:

- A. Obtaining a baccalaureate degree**
- B. Conducting two hundred (200) criminal specific issue examinations as outlined in Section 4.600 of these Standards, including ten (10) juvenile sex offense specific polygraph examinations within the past twelve (12) month period**
- C. A letter from his/her supervisor indicating the applicant's readiness to become a full operating examiner including documentation of having completed the professional supervision components (Section 4.621).**

4.700 Plethysmograph Examiner

4.710 A plethysmograph examiner shall adhere to the "Guidelines for the Use of the Penile Plethysmograph," published by the Association for the Treatment of Sexual Abusers (ATSA) Practitioner's Handbook (1997) (Appendix D of these Standards) 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.

4.711 A plethysmograph examiner shall be listed as a treatment provider under the SOMB Adult 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.

4.712 A plethysmograph examiner shall have completed thirty (30) hours of additional training in the areas of:

- A. Child and adolescent development (10 hours)**
- B. Adolescent sexual development (10 hours)**
- C. General subject areas regarding juveniles who commit sexual offenses. The training areas are listed in Section 4.100 of these Standards.**

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

4.713 A plethysmograph examiner shall be proficient in the use of stimulus materials including:

- 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.**

4.714 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.**

4.715 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.**

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

A. Assessment/evaluation:

- 1. Assessing cross-over of deviant interests**
- 2. Assessing reliability of self-report**
- 3. Determining existence of deviant arousal**
- 4. Determining baseline data for treatment of deviant arousal reduction/control**

B. Treatment:

- 1. Providing objective measure of treatment progress in terms of deviant arousal**
- 2. Providing recommendations based on knowledge of treatment methodologies**

C. Denial:

- 1. Understanding limitations**
- 2. Understanding proper/improper uses**

D. Validity/Reliability:

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

4.717 Continued Placement on the Provider List -- Plethysmograph Examiner

Plethysmograph examiners must apply for continued placement on the Provider List every three (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.

Twelve (12) hours must be completed ANNUALLY for a total of thirty-six (36) hours in the following categories:

A. Child and adolescent development (10 hours)

B. Adolescent sexual development (10 hours)

C. General subject area regarding juveniles who commit sexual offenses. The training areas are listed in Section 4.100 (C) of these Standards.

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.

4.720 Abel Assessment Examiner

4.721 An Abel Assessment examiner shall be listed as a treatment provider under these Standards, hold a baccalaureate degree from a four year college or university and demonstrate that he or she has been trained and licensed as a site to utilize the instrument.

4.722 Continued Placement on the Provider List -- Abel Assessment Examiner

Abel Assessment examiners must apply for placement on the Provider List every three (3) years by the date provided by the Board. This 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 Assessment examiners.

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

4.800 Application for Listing Guidelines

4.810 Providers and programs who are subject to these Standards must submit a completed "Intent to Make Application" form (Appendix H) by September 30, 2002, so that a provisional list of providers can be issued by December 31, 2002.

This edition (July, 2002) is the first publication in the state of Colorado setting forth Standards and Guidelines of practice for the evaluation, assessment, treatment and management of juveniles who have committed sexual offenses.

Each applicant will be reviewed by the SOMB Application and Review Committee comprised of Board members and professionals in the field of juvenile sexual offending.

It is incumbent upon the professional or program to demonstrate that they have been substantially engaged in the provision of evaluation, and/or treatment services or as a program for at least five (5) years prior to the effective date of these Standards.

Such a demonstration may include, but is not limited to:

- A. Documentation of referrals from probation, parole, community corrections and/or the state or county Department of Human Services, or the Department of Corrections, for the evaluation, treatment or placement of juveniles who commit sexual offenses.
- B. Documentation of employment records as a sex offense specific juvenile evaluator, treatment provider or placement facility.
- C. Documentation of the number of juveniles who have committed sexual offenses treated during the past five (5) years.
- D. Documentation of the percent of the provider, evaluator or program's practice which is specific to juveniles who commit sexual offenses.

- E. **Other written documentation that establishes with reasonable certainty that the individual or program has been substantially engaged in the provision of evaluation, treatment and management of juveniles who have committed sexual offenses.**

4.811 Exemption Clause

Notwithstanding the above Standards, the Department of Public Safety and the Sex Offender Management Board may also choose, on a one-time basis within one (1) year of the effective date of these Standards, to waive the underlying credential of licensure or academic degree above a baccalaureate for those individuals without these credentials who can demonstrate that they:

- A. **Have been providing evaluation or treatment services to juveniles who have committed sexual offenses under juvenile justice/social service jurisdiction on a regular and ongoing basis within the past five (5) years**
- B. **Have lifetime experience of at least two thousand (2000) hours of experience specifically in the area of evaluation or treatment and management of juveniles who have committed sexual offenses**
- C. **Have supervision from a professional who has experience with juveniles**
- D. **Meet all other qualifications for full operating level treatment providers and evaluators.**

Discussion: The purpose of this Standard is to acknowledge those few sex offense specific evaluators, treatment providers and programs in Colorado who are very experienced in the provision of services, but who do not meet the licensure or post-graduate academic requirement of these Standards, by allowing them to substitute one thousand (1000) additional hours of experience in the area of juvenile sex offense specific evaluation, treatment and management for the licensing or academic credential if they have continuously provided sex offense specific services for at least the past five (5) years.

4.812 Compliance Clause

Individuals and programs currently providing juveniles with sex offense specific treatment who do not meet one or more of the qualifications under these Standards have a period of time to come into compliance not to exceed one year from the effective date of these Standards. It is incumbent upon the provider or program to complete a request for listing under the Compliance Clause and describe their plan to come into compliance.

5.000

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

5.100 After an adjudication or a deferred adjudication has been entered, and a referral to probation, parole, or out-of-home placement has been made, the supervising officer/agent (or DHS case manager in the absence of an officer/agent) shall convene a multidisciplinary team to manage the juvenile during the term of supervision.^{30,31,32} The members of the team may change as the treatment and supervision plan evolves.

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

Multidisciplinary Team Functions

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

Supervision and behavioral monitoring are the collaborative and cooperative responsibilities of the multidisciplinary team. The team may include the parent/caregiver, supervising officer/agent, treatment provider, human services caseworker, polygraph examiner, other clinical professionals, school personnel and guardian ad litem.

Parents shall be advised of the multidisciplinary team's expectations including the requirements of informed supervision. Parents and caregivers are recognized as having an integral role in the juvenile's development and, ultimately, community-based stability. The team may also include extended family members, law enforcement, church leaders, peers, victim therapists, victims, coaches and employers.

³⁰ Association for the Treatment of Sexual Abusers (2000). Position on the Effective Legal Management of Juvenile Sexual Offenders. Beaverton, OR: Association for the Treatment of Sexual Abusers.

³¹ The National Task Force on Juvenile Sexual Offending (1993) as cited in Hunter, J.A., & Figueredo, A.J. (1999). Factors Associated with Treatment Compliance in a Population of Juvenile Sexual Offenders. Sexual Abuse: A Journal of Research and Treatment, 11(1).

³² McGrath, R.J., Cumming, G., Holt, J. (2002). Collaboration Among Sex Offender Treatment Providers and Probation and Parole Officers: The Beliefs and Behaviors of Treatment Providers. Sexual Abuse: A Journal of Research and Treatment, 14(1).

Discussion: Parental involvement with the multidisciplinary team is strongly encouraged throughout the supervision and care continuum.³³ Families provide invaluable information about the juvenile's environment and are in most cases the central support system of the juvenile. Family involvement is required in treatment per these Standards in Section 3.140 .

5.110 Each multidisciplinary team, shall at a minimum consist of:

- A. The supervising officer/agent**
- B. Department of Human Services caseworker, if assigned**
- C. The juvenile's caregiver in any out-of-home placement**
- D. The treatment provider**
- E. The polygraph examiner, when utilized**
- F. Victim representation (Section 8.000)**

Each team is formed around a particular juvenile and is flexible enough to include any individual necessary to ensure the best approach to managing and treating the juvenile.

The multidisciplinary team members perform separate and distinct functions relative to their agency affiliations. Maintaining the integrity of the team and the specified relationship with the juvenile are crucial to the success of the team. Therefore, team members shall not perform more than one role for an individual juvenile.

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

5.120 The multidisciplinary team shall be convened and coordinated by the supervising officer/agent, or DHS caseworker, in the absence of a supervising officer/agent, who shall facilitate team decision making regarding:

- A. The members of the team beyond required membership, and members' attendance at any given meeting.**
- B. The frequency of multidisciplinary team meetings which shall occur quarterly at a minimum.**
- C. The content and goals of the meetings, with input from the team members.**
- D. The type(s) of information required to be released.**
- E. The designation of the custodian of the complete case record (supervising officer/agent, beyond their agency affiliation record keeping requirements), for data gathering purposes as required in section 16-11.7-103, C.R.S.**

³³ Bischof, G.P., Stith, S.M., Whitney, M.L. (1995). Family Environments of Adolescent Sex Offenders and Other Juvenile Delinquents. *Adolescence*, 30(117).

- 5.121 Case files shall be maintained in accordance with the policies of each agency involved. The intervention action specific to each agency shall be highlighted (or otherwise identified to stand out from the body of the file) in the complete case record including action/follow-up in treatment plans, safety plans, relapse prevention plans and any other appropriate notations.
- 5.130 Decisions concerning the management and/or treatment of juveniles who have committed sexual offenses shall give precedence to victim protection and community safety while considering the developmental level and best interests of the juvenile.

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

5.140 The multidisciplinary team shall demonstrate the following operational norms:

- A. There is an ongoing, completely open flow of information among the mandatory members of the team, and, as appropriate, among other members.
- B. Team members fulfill their assigned responsibilities in the management of the juvenile.

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

- C. Team members are committed to the team approach and settle among themselves conflicts and differences of opinion that might make them less effective in presenting a unified response.
- D. Team members shall seek assistance through supervision with conflicts or alignment issues that occur.
- E. Because these Standards apply to adjudicated juveniles, the final authority regarding community safety and supervision rests with the supervising officer/agent or DHS caseworker (in the absence of a supervising officer/agent). The supervising officer has final authority in all decisions regarding conditions set by the court or parole board and regarding court orders in the delinquency action. Placement recommendations are to be made by the multidisciplinary team, however community placements are the responsibility of the Department of Human Services and are generally decided by the court.

Situations may arise, including emergencies, that require a multidisciplinary team member to make an independent decision in order to protect victims and/or community safety. Independent decisions should be the exception rather than the rule. These decisions must be reviewed as soon as possible with the multidisciplinary team.

- F. A record of all decisions made shall be entered into the case file and considered part of the complete case record.**

Discussion: Supervising officers/agents may at times be placed in the position of taking a case back to court or to the parole board for a ruling on a specific issue that could not be resolved by the multidisciplinary team. The multidisciplinary team should be mindful of the level of decision-making that would require court or parole board intervention and seek remedy only after inner-team solutions have been deemed unattainable by the team members. Supervising officers/agents are encouraged to work diligently within the framework of the multidisciplinary team before seeking action from the court/parole board.

Multidisciplinary team members may provide reports to the court/parole board as a team with dissenting opinions in the absence of team consensus to recommend modification or revocation of probation or parole. Copies of such reports should be forwarded to the pertinent multidisciplinary team members.

- 5.141 The supervising officer/agent shall include dissenting opinions of the multidisciplinary team members in such reports.**

5.200 Responsibilities of the Supervising Officer/Agent

The supervising officer/agent is the coordinator of the multidisciplinary team.

The primary responsibility of the supervising officer/agent is to protect the victim and community by ensuring the juvenile is in compliance with the conditions of community supervision.

Team members shall share behavioral observations with the supervising officer/agent relevant to the juvenile's current functioning and information regarding cooperation/compliance with the conditions of community supervision and safety plans. Confirmation by the supervising officer/agent that the juvenile is receiving required supervision and support from the multidisciplinary team and parents/caregivers is paramount for victim and community safety.

In addition to working closely with the multidisciplinary team, the supervising officer's approach must include working closely with parents, alternative caregivers, school staff and victim services.

- 5.201 The supervising officer/agent, or DHS case worker if no officer/agent is currently involved, shall refer all juveniles to whom these Standards apply for evaluation, assessment and treatment only to providers listed with the Sex Offender Management Board (section 16-11.7-106, C.R.S.).**

- 5.202 The supervising officer/agent shall ensure that the juvenile and the parent/guardian have signed a waiver of confidentiality to obtain all relevant information required for the evaluation, assessment, treatment and management of the juvenile. The waiver/release must authorize the release of information to and from the mandatory members of the multidisciplinary team. Such information shall include, but is not limited to:**

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

2. Medical, psychiatric and psychological reports
3. School records
4. Presentence investigation report(s)
5. Child abuse investigation report(s).

Relevant information may also be received from and released to professionals working with the victim(s) of the juvenile's offense(s). The privacy associated with victims' records must be respected. Such information may be needed by the team to make decisions about contact and/or reunification, to correct empathy deficits and to resolve discrepancies in differing accounts of the offense and/or relationship.

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

- 5.203 The supervising officer/agent shall notify juveniles who have committed sexual offenses and their parent/caregiver that they must register with local law enforcement in accordance with section 18-3-412.5, C.R.S. The supervising officer/agent shall verify that registration has taken place.
- 5.204 Parental responsibility terms and conditions shall be presented to the respondents in a juvenile justice case and the expectations, including but not limited to, participation in treatment and informed supervision shall be explained by the supervising officer/agent.

The supervising officer/agent shall follow the Initial Caregiver--Juvenile Supervision Plan outlined in Appendix A2 of these Standards.

- 5.205 The supervising officer/agent shall explain to juveniles who have committed a sexual offense and are transferred to Colorado through the Interstate Compact Agreement that they must agree to participate in sex offense specific treatment and they must comply with the additional conditions of supervision, which are contained in these Standards.
- 5.206 The supervising officer/agent shall require written safety plans developed by the multidisciplinary team as a precondition for decisions regarding activities not covered by the treatment plan. The supervising officer/agent shall refer to the treatment and safety plans in monitoring the juvenile's behaviors.

Discussion: While it is the responsibility of the Office of the District Attorney to inform the school of the charges against the juvenile upon adjudication, it is the responsibility of the supervising officer/agent to clarify and implement the safety plan in the school setting.

- 5.207 The supervising officer/agent may utilize polygraph testing for behavioral monitoring. When polygraph testing is used, the supervising officer/agent shall make decisions guided by these Standards in Sections 2.000, 3.000 and 7.000.
- 5.208 The supervising officer/agent in concert with the multidisciplinary team members shall require disclosure to certain third parties regarding the nature and extent of the juvenile's sexual offending and/or abusive behavior. This disclosure includes conditions of community supervision as part of the safety plan when the third party may be a potential victim, or the

multidisciplinary team deems it necessary for community safety. The multidisciplinary team shall specify the extent of information to be disclosed.

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

- 5.209 The supervising officer/agent shall work within the multidisciplinary team to discuss and approve changes in treatment providers and/or placements.**
- 5.210 The supervising officer/agent shall ensure supervision levels and behavioral monitoring that meet risk level and the individual needs of the juvenile.**
- 5.211 The supervising officer/agent shall obtain written progress reports from treatment providers indicating current status and progress with treatment goals.**
- 5.212 The supervising officer/agent shall discuss any plans for contact between the juvenile and the victim or potential victim(s) with the multidisciplinary team, the victim's therapist/advocate and the parents/guardians of the juvenile.**
- 5.213 The supervising officer/agent shall develop the supervision plan on the basis of the individualized evaluation, ongoing assessments, reports of current behavioral observations by educators and caregivers and information from the treatment provider.**
- 5.214 The supervising officer/agent shall confer with the multidisciplinary team (if still convened) prior to requesting early termination of supervision. Early termination may be possible in rare cases, but only after successful completion of treatment and fulfillment of court requirements.**
- 5.215 Juveniles who have committed sexual offenses should not be placed in, or allowed to have positions of authority over, or responsibility for other children. Supervision shall always include restrictions that preclude babysitting or other positions of authority with younger children. These restrictions are rarely modified and should be modified only after extensive review by the team and approval by the court (if court approval is required).**
- 5.216 The supervising officer/agent shall seek a means of continued court ordered supervision, i.e. extension or revocation and re-granting of probation/supervision for a juvenile who has been otherwise compliant but has not achieved his/her treatment goals by an approaching supervision expiration date.**

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

- 5.217 The supervising officer/agent should not allow a juvenile who has been unsuccessfully discharged from a treatment program to enter another program unless the multidisciplinary team has modified the treatment plan to meet the needs of the juvenile.**

Documentation shall address: the reasons and underlying issues for unsuccessful discharge, and the rationale for a revised plan. A notation shall be entered describing whether or not the level of care is the same, or more or less intensive, than that in the previous program. The treatment plan must follow the juvenile from one placement and program to another. A juvenile's termination from treatment should not be based solely on the family's unwillingness to support the goals of treatment.

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

5.218 Supervising officer/agents assessing or supervising juveniles who have committed a sexual offense should successfully complete training programs specific to this population. Such training includes, but is not limited to the following:

- Prevalence of sexual assault
- Risk and re-offense
- Offender characteristics
- Differences and similarities between adults and juveniles who commit sexual offenses
- Evaluation/assessment of juveniles
- Current research
- Informed Supervision: Community management, containment
- Interviewing skills
- Victim issues
- Sex offense specific treatment
- Qualifications and expectations of evaluators and treatment providers
- Relapse prevention
- Objective measurement tools
- Determining progress/outcome planning
- Denial
- Special needs populations
- Cultural, ethnic and gender awareness
- Family dynamics and interventions
- Developmental theory
- Trauma Theory: Secondary and vicarious trauma
- Impact: Professionals' experience of secondary trauma
- Role of the multidisciplinary team.

Twenty four (24) of the required forty (40) hours of annual training for probation officers should be in sex offense specific related areas.

It is also desirable for agency supervisors of officers/agents managing juveniles to complete training as outlined above.

Discussion: It is considered best practice for a supervising officer/agent to have training specific to juveniles who have committed sexual offenses before receiving the caseload. Community safety may be jeopardized if a supervising officer/agent is under-trained and unaware of potential risks posed by the juvenile.

5.300 Responsibilities of Treatment Providers

5.310 The treatment provider is a required member of the multidisciplinary team. The provider shall establish a cooperative professional relationship with the supervising officer/agent of each juvenile and with other relevant supervising agencies. The responsibilities include but may not be limited to:

- A.** The provider shall participate in multidisciplinary team meetings.
- B.** The provider is responsible for conducting treatment in compliance with these Standards.
- C.** The provider shall immediately report to the supervising officer/agent all violations of the provider/client contract, including those related to specific conditions of probation, parole, community corrections, or out-of-home placement.
- D.** The provider shall report to the supervising officer/agent any reduction in frequency or duration of contacts or any alteration in treatment modality that constitutes a change in a juvenile's treatment plan. Any permanent reduction in duration or frequency of contacts or permanent alteration in treatment modality shall be determined on an individual case basis by the provider and the multidisciplinary team.
- E.** On a monthly basis, the provider shall submit to the supervising officer/agent progress reports documenting at a minimum a juvenile's attendance, participation in treatment, changes in risk factors, changes in the treatment plan, and treatment progress.
- F.** If a revocation of probation or parole is filed by the supervising officer/agent, the provider shall furnish, when requested by the supervising officer/agent, written information regarding the juvenile's treatment progress. The information shall include: changes in the treatment plan; dates of attendance; treatment activities; the juvenile's relative progress and compliance in treatment; and any other material relevant to the court or parole board at hearing. The treatment provider shall be willing to testify if requested.
- G.** The provider shall discuss with the supervising officer/agent, the victim's therapist, caseworker, custodial parent, foster parent and/or guardian ad litem specific plans for any and all contact of the juvenile with the victim(s) and plans for clarification and family reunification.
- H.** The provider shall make recommendations to the supervising officer/agent regarding selections of informed supervisors for a juvenile's contact with children, if such contact is allowed.
- I.** The provider shall assess the juvenile's ongoing level of risk to ensure containment and make recommendations for corrective or legal actions that are developmentally appropriate.
- J.** The provider shall make recommendations to the multidisciplinary team regarding a juvenile's level of community access with specific focus on schools, extra-

curricular activities, recreation activities (including organized sports), employment or volunteer work, and access to children, siblings or potential victims.

- K. The provider shall share case information with collateral parties as needed. The provider shall advocate for developmentally appropriate evaluations, assessments, treatment and interventions.

5.400 Responsibilities of the Polygraph Examiner

- 5.410** The polygraph examiner shall participate as a member of the multidisciplinary team when requested by the team established for each juvenile who has committed a sexual offense.

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

- 5.420** The polygraph examiner shall provide information to the team regarding the juvenile's level of risk upon completion of the polygraph. The polygraph examiner shall provide written reports within two (2) weeks from the testing date to the multidisciplinary team.

- 5.430** The polygraph examiner shall report significant risk behavior or re-offense information to the multidisciplinary team within 48 hours of receipt of this information.

- 5.440** Attendance at multidisciplinary team meetings shall be on an as needed basis. At the discretion of the multidisciplinary team, the polygraph examiner may be required to attend only those meetings preceding and/or following a juvenile's polygraph examination.

- 5.450** The polygraph examiner shall only perform polygraph testing on juveniles who meet the criteria listed in Section 7.000 of these Standards.

- 5.460** The polygraph examiner shall obtain informed consent of the parent/legal guardian and the informed assent of the juvenile (Section 7.130).

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

- 5.470** The polygraph examiner must have training in the areas of juvenile sex offense specific treatment, developmental issues, risk and re-offense, interviewing skills specific to juveniles, victim issues, contraindications of polygraph testing, and special populations.

5.500 Responsibilities of the Department of Human Services

- 5.510** In cases when the Department of Human Services is involved:

- A. The caseworker shall assess the home situation to determine victim safety and the juvenile's risk level. A written safety and supervision plan shall be developed with the family and implemented if the juvenile remains in the home. Informed Supervision must be in place (Appendices A, A1, A2).

- B. The caseworker shall establish a multidisciplinary team if one is not in place and work cooperatively with the team regarding placement decisions.**

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

- C. The caseworker shall assess out-of-home placement needs. If placement is indicated the juvenile should be placed in care where the providers are trained in the special needs of juveniles who commit sexual offenses and the providers are willing to comply with the Standards under Section 5.700.**

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

- D. On a monthly basis the caseworker shall monitor treatment, safety and supervision plans (in accordance with Volumes 7 and 8 of the Colorado Department of Human Services Rules and Regulations).**

- E. The caseworker shall recommend and monitor cooperation and participation by the juvenile's family in treatment.**

- F. The caseworker shall make recommendations to the court about the treatment plan to maintain consistency between any parallel dependency and neglect, and delinquency court proceedings.**

- G. Caseworkers shall attend multidisciplinary team meetings.**

- H. Training for DHS staff should include, but not be limited to, the core caseworker training and a minimum of twenty four (24) hours ANNUALLY of the training outlined in Section 5.218 of these Standards.**

- I. The caseworker shall include the sex-offense specific treatment plan in the DHS service plan.**

- J. The caseworker shall not allow contact between the juvenile and the victim(s), siblings or potential victims unless and until there is an established safety and supervision plan or agreement established by the multidisciplinary team.**

5.600 Responsibilities of the Division of Youth Corrections

- 5.610 The Division of Youth Corrections shall comply with Section 2.000 of these Standards and section 19-2-922, C.R.S. Juveniles who have been committed to the Division of Youth Corrections (DYC) due to committing a sexual offense shall undergo a sex offense specific evaluation at the designated assessment center. If the juvenile has had a previous sex offense specific evaluation, that evaluation shall be reviewed and updated during the assessment process.**

- 5.620** Treatment providers within DYC and programs or facilities contracting with DYC to provide sex offense specific treatment shall comply with these Standards as described in Section 3.000. Providers must meet the qualifications described in Section 4.000 of these Standards.
- 5.630** DYC treatment providers and client managers/parole officers shall utilize the multidisciplinary team (MDT) as outlined in Sections 4.000 and 5.000 of these Standards. Client managers/parole officers shall comply with the intent of these Standards and the Guidelines in section 19-2-1003, C.R.S.
- 5.640** All juveniles who are committed to DYC due to a sexual offense and who are not on parole status, shall be approved by the appropriate Community Review Board (section 19-2-210, C.R.S.) prior to community placement. The multidisciplinary team shall make recommendations for placement in accordance with section 19-2-403, C.R.S.
- 5.650** Committed juveniles shall be referred to the Juvenile Parole Board (section 19-2-1002, C.R.S.) when recommended by the multidisciplinary team or when the juvenile has completed his/her commitment and is eligible for mandatory parole. When appropriate the multidisciplinary team shall recommend to suspend, modify or revoke the juvenile's parole. The juvenile's client manager/parole officer shall comply with these Standards and sections 19-2-1003 and 19-2-209, C.R.S.
- 5.660** When it is recommended by the multidisciplinary team that a juvenile who has been committed to DYC for a sexual offense be considered for continued placement after commitment with the Department of Human Services, the client manager/parole officer shall contact the appropriate county department of social/human services (section 19-2-921, C.R.S.) and arrange a staffing with all interested parties.
- 5.670** A discharge summary shall be completed on all juveniles who have been committed to DYC for a sexual offense who will be released directly to the community without a period of community placement or parole. The summary shall provide the juvenile's institutional adjustment, modus operandi and risk of re-offending. The discharge summary and Notice to Register as a Sexual Offender (section 18-3-412.5, C.R.S.) shall be forwarded to appropriate law enforcement units.
- 5.700** Responsibilities of the Informed Supervisor and Therapeutic Care Provider
- 5.710** Different levels of care have been identified which are primarily dependent upon the residential status of the juvenile and the role of the care providers involved. All juveniles shall have an informed supervisor. Some juveniles will also have therapeutic care providers.

Anyone providing supervision for a juvenile who has committed a sexual offense shall meet the following three (3) criteria in addition to any other requirements.

The Informed Supervisor or Therapeutic Care Provider:

- A.** Is not currently under the jurisdiction of any court or criminal justice agency for a matter that the multidisciplinary team determines could impact his/her capacity to safely serve as an Informed Supervisor or Therapeutic Care Provider
- B.** He/she has no prior conviction for unlawful sexual behavior, child abuse, neglect, or domestic violence

- C. If ever accused of unlawful sexual behavior, child abuse, or domestic violence, he/she presents information requested by the multidisciplinary team so that the multidisciplinary team may assess current impact on his/her capacity to serve as an Informed Supervisor or Therapeutic Care Provider.

5.711 Informed Supervisor

The primary care provider of a juvenile who has committed a sexual offense has a responsibility to provide informed supervision. Informed supervisors are defined as primary care providers, parents (if not directly involved in the treatment process), advocates, mentors, kin, spiritual leaders, teachers, work managers, coaches and others as identified by the multidisciplinary team. It is the responsibility of the multidisciplinary team to educate, inform and evaluate potential informed supervisors regarding their role specific to sexual offense issues.

The Informed Supervisor Protocol (Appendix A) shall be initiated by the supervising officer/agent and shall be followed within the protocol timelines.

Safety plans shall be utilized to assist in defining an informed supervisor's role. The expectations of the multidisciplinary team regarding informed supervisors' responsibilities must be determined and agreed upon before implementation.

An informed supervisor is an adult, approved by the multidisciplinary team, who:

- A. Is aware of the juvenile's history of sexual offending behaviors
- B. Does not allow contact with the victim(s) unless and until approved by the multidisciplinary team
- C. Directly observes and monitors contact between the juvenile, victim(s), siblings and other potential victims as defined by the multidisciplinary team
- D. Does not deny or minimize the juvenile's responsibility for, or seriousness of sexual offending
- E. Is aware of the laws relevant to juvenile sexual offending behavior
- F. Can define all types of abusive behaviors and can recognize abusive behaviors in daily functioning
- G. Is aware of the dynamic patterns (cycle) associated with abusive behaviors and is able to recognize such patterns in daily functioning
- H. Understands the conditions of community supervision and treatment
- I. Can design, implement and monitor safety plans for daily activities
- J. Is able to hold the juvenile accountable for his/her behavior
- K. Has the skills to intervene in and interrupt high risk patterns
- L. Communicates with the multidisciplinary team regarding observations of the juvenile's daily functioning.

Discussion: The Board recognizes there is a learning process for informed supervisors. Non-compliance by an informed supervisor should not be used as the sole reason for terminating a juvenile from treatment, placement, or to raise the level of care. If non-compliance by an informed supervisor interferes with the juvenile's progress in sex offense specific treatment there will need to be a recommendation to revise the level of involvement of the informed supervisor.

5.712 Therapeutic Care Provider

Therapeutic care providers provide corrective care and guidance beyond what is normally expected of a parent and informed supervisor to assist the juvenile in addressing special needs or developmental deficits that impede successful functioning. Therapeutic care providers are responsible for implementing interventions to address treatment goals. Standards for therapeutic care providers apply to care in both in-, and out-of-home living settings. Parents may provide such care only if they are active participants in the treatment process.

Therapeutic care providers are informed supervisors. Therapeutic care providers are line staff, counselors, foster parents, group home or CPA parents, RTC, RCCF, DYC, day treatment and home-based service providers.

Note: The therapeutic care provider is not usually the treatment provider. If there is a dual role, the treatment provider must adhere to the treatment provider Standards and qualifications as outlined in Section 4.000.

Therapeutic care providers are responsible for providing informed supervision. In addition to the responsibilities described in 5.711, therapeutic care providers shall:

- A. Not allow contact with the victim(s) unless and until approved by the multidisciplinary team
- B. Monitor contact between the juvenile, victim(s), siblings and other potential victims when approved by the multidisciplinary team
- C. Provide for the physical and psychological safety in the living environment and community for the juvenile
- D. Participate in containment planning and adhere to informed supervision guidelines
- E. Be involved in case management decisions as a primary member, or as requested by the multidisciplinary team
- F. Support multidisciplinary team decisions, and implement specific goals identified in the treatment plan
- G. Be educated on sexual offense dynamics and provide relevant information about the juvenile to the multidisciplinary team
- H. Respond to changes in risk factors and report observations to the multidisciplinary team
- I. Implement behavior management techniques and provide consequences and interventions to address negative choices
- J. Provide learning opportunities to interrupt behaviors that include, but are not limited to, elements of the offense cycle
- K. Provide opportunities for the juvenile to interact with positive male and female, adult and peer role models
- L. Provide activities that promote positive relaxation, recreation and play
- M. Make arrangements for, ensure transportation to and monitor attendance at all of the juvenile's appointments
- N. Share information about special needs, patterns, successful behavior management strategies and information with the multidisciplinary team.

5.713 Therapeutic care providers shall implement a continuum of care that includes intervention, nurturing, supervision and monitoring which supports the multidisciplinary team's goals and direction.

5.800 Responsibilities of Schools/School Districts

- 5.810** If the juvenile is enrolled in a school, the school/school district should designate a representative from the school or school district to participate as a member of the multidisciplinary team. The representative may be the resource officer, social worker, counselor, vice principal or other professional.
- 5.820** Schools/School districts are responsible for the training of school representatives on the multidisciplinary team regarding juveniles who commit sexual offenses.
- 5.830** The responsibilities of the school representative on the multidisciplinary team may include, but are not limited to:
- A.** Communicating with the multidisciplinary team regarding the juvenile’s school attendance, grades, activities, compliance with supervision conditions and any concerns about observed high-risk behaviors
 - B.** Assisting in the development of the supervision plan
 - C.** Providing informed supervision and support to the juvenile while in school
 - D.** Developing a supervision safety plan considering the needs of the victim(s) (if in the same school) and potential victims
 - E.** Attending multidisciplinary team meetings as requested
 - F.** Participating in the development of transition plans for juveniles who are transitioning between different levels of care and/or different school settings.

5.900 Responsibilities of Court Appointed Legal Representatives

Guardian ad litem (GAL)

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

- 5.910** Best practice duties and responsibilities of the guardian ad litem representing either the juvenile who has committed a sexual offense or an underage victim shall include:
- A.** When a guardian ad litem is regularly representing children in cases involving juveniles who have committed sexual offenses the attorney should have specific training in the areas of evaluation, intervention, treatment and child development.
 - B.** The Office of the Child’s Representative should assist the guardian ad litem in receiving juvenile sex offense specific training by either coordinating with the other agencies and creating access to this specific area of training or by incorporating this education into their own training curriculum. The Office of Child’s Representative shall offer child development training to anyone serving as a guardian ad litem.
 - C.** In cases where the guardian ad litem is involved, the GAL should be included as part of the multidisciplinary team and attend all the team meetings. The guardian

ad litem should advocate for elements of the treatment plan that are in accordance with these Standards when it is in the best interest of his or her child/client.

- D. The guardian ad litem should consult with the multidisciplinary team prior to taking a position and making recommendations in any legal action regarding contact or visitation with the victim(s) or potential victim(s). The multidisciplinary team and guardian ad litem must always keep in mind that after receiving information from the team, the guardian ad litem is ethically obligated as required by the Colorado Rules of Professional Conduct to zealously represent his or her client and make a recommendation that serves his or her client's best interest.
- E. When sex offense specific treatment is in the best interest of the client, the guardian ad litem should zealously advocate for timely evaluations and treatment which should commence as soon as possible after initiation of the court process.

Court Appointed Special Advocate (CASA)

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

- A. The CASA shall complete training specific to that of Informed Supervision.
- B. If the CASA is assigned to the juvenile who committed a sexual offense, the CASA must participate as a member of the multidisciplinary team as requested by the team.
- C. The CASA should communicate to the court elements of the treatment plan that are congruent with the Standards.
- D. The CASA must consult with the multidisciplinary team prior to making any recommendations regarding visitation/contact between the juvenile and the victim(s).
- E. The CASA will not participate or initiate any visitation/contact between the victim(s) and the juvenile who has committed a sexual offense unless and until approved by the multidisciplinary team.

6.000

ADDITIONAL CONDITIONS OF COMMUNITY SUPERVISION

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

In the interest of victim and public safety, it is recommended that numbers 6, 7, 8, 9 and 10 be implemented as pre-trial release conditions.

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

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

1. If you have been adjudicated of any sexual offense involving sexual penetration as defined in section 18-3-412, C.R.S.; you shall submit to a blood test for the human immunodeficiency virus (HIV), which can cause immune deficiency syndrome, pursuant to section 18-3-415, C.R.S.
2. You shall comply with the sex offender registration law requirements pursuant to section 18-3-412.5, C.R.S.
3. **Genetic Marker Testing:** You shall submit to a blood test to determine genetic markers (DNA) in accordance with section 19-2-925.5, C.R.S. and shall pay a fee to the Sex Offender Identification Fund for said testing (applies to offenses committed on or after July 1, 2001).
4. You shall attend and actively participate in sex offense specific evaluation and treatment at a program approved by the supervising officer/agent in consultation with the multidisciplinary team. You will abide by the rules of the treatment program and successfully complete the program to the satisfaction of the supervising officer/agent in consultation with the multidisciplinary team.
5. You shall submit, at your own expense, to any program for psychological or physiological assessment at the direction of the supervising officer/agent, in consultation with the treatment provider and/or multidisciplinary team. This may include the polygraph, Abel Assessment, and/or plethysmograph testing to assist in treatment planning and case monitoring.

- 6. You shall have no contact with the victim(s) including letters, electronic communication, by telephone or communication through another person except under circumstances approved in advance by the supervising officer/agent in consultation with the multidisciplinary team. You shall not enter onto the premises, travel past or loiter near where the victim(s) resides unless authorized in advance by the supervising officer/agent in consultation with the multidisciplinary team.**
- 7. You shall not have contact with children three or more years younger than yourself, or potential victims unless and until approved in advance and in writing by the supervising officer/agent in consultation with the multidisciplinary team.**
- 8. If you have contact (even incidental/accidental) with other children from whom you are restricted, it is your responsibility to immediately remove yourself from the situation in a safe and responsible manner. You must notify your supervising officer/agent and your treatment provider immediately.**
- 9. Before you may return to or attend the same school as the victim(s), victim input must be obtained by the multidisciplinary team describing the victim's perspective on your presence in the school. If you are allowed to enroll in the same school as the victim(s), prior to return a safety plan must be completed, it must be ready to implement and approved by the multidisciplinary team.**
- 10. You may not enter into a position of trust or authority with any child or potential victim. Any employment or volunteer work must be approved in advance and a safety plan shall be designed specific to the setting by the supervising officer/agent in consultation with the treatment provider and/or the multidisciplinary team.**
- 11. You shall not possess or view any pornographic, X-rated or inappropriate sexually arousing material and you will not go to or loiter in areas where pornographic materials are sold, rented or distributed. This includes but is not limited to phone sex lines, computer generated pornography and cable stations which show nudity or sexually explicit material.**
- 12. You and/or your parent/guardian will be financially responsible for all examinations, evaluations and treatment unless other arrangements have been made through your supervising officer/agent in consultation with treatment provider.**
- 13. You shall not change treatment programs without prior approval by your supervising officer/agent in consultation with the multidisciplinary team. In the event that you refuse to attend treatment you must submit your refusal in writing to your supervising officer/agent and the members of the multidisciplinary team.**

14. You shall sign waivers of confidentiality to allow the supervising officer/agent to communicate with other professionals involved in your supervision and treatment, and to allow all professionals involved to communicate with each other. This will include a release of information to the therapist of the victim(s).
15. You shall not go on over-night visits away from your home without prior approval of your supervising officer/agent in consultation with the multidisciplinary team. Overnight visits may be approved only after the development of a safety plan with the appropriate multidisciplinary team members. The safety plan must be approved by your parent/caregiver and notice made to the parent/caregiver at the overnight location who must become an informed supervisor.
16. You shall not be allowed to subscribe to or use any internet service provider by modem, LAN, DSL or any other avenue and you shall not be allowed to use another person's internet or use the internet through any commercial means unless and until approved by the supervising officer/agent in consultation with the multidisciplinary team. You may not participate in chat rooms. A safety plan with a supervision component must be in place prior to access. These conditions include material(s) downloaded to disks, CD's, hand-held computer organizers, or any other electronic device(s) or duplicating machines.
17. You shall not use long-range vision enhancing or tunnel focusing devices unless a safety plan is approved and in place through the supervising officer/agent in consultation with the multidisciplinary team. These devices include binoculars, telescopes, spotting scopes, hollow pipes and any other focusing device.
18. You shall not use or possess video or photography equipment or participate in the use of this equipment unless and until a written safety plan is in place and approved by the supervising officer/agent in consultation with the multidisciplinary team.
19. If you are considering becoming involved in a relationship with any person who is a parent/guardian or is responsible for the supervision of children, you are required to advise your supervising officer/agent immediately. Your supervising officer/agent in consultation with the multidisciplinary team, will determine/limit the extent of your involvement in this relationship based on issues related to victim access and/or your history of sexually offending behaviors.
20. You shall not hitchhike or pick up hitchhikers. You shall not provide rides for any person unless and until it has been approved by the supervising officer/agent in consultation with the multidisciplinary team in advance and in writing in your safety plan.

21. **When applicable, you understand that your relationships and dating may be completely or partially restricted until the multidisciplinary team determines that you have exhibited the ability to maintain yourself in a consistently safe manner. You understand that you are required to inform at minimum, the supervising officer/agent and treatment provider of your relationships and/or dating activities on an ongoing and timely basis.**

You also understand that the multidisciplinary team may require further disclosure to any potential sexual partner of the nature and extent of your sexual offending behavior history prior to any sexual contact occurring.

7.000

POLYGRAPH EXAMINATION OF JUVENILES WHO HAVE COMMITTED SEXUAL OFFENSES

7.100 The multidisciplinary team shall refer for polygraph examination those juveniles who meet the following criteria:

- A.** Chronological age of 14 or older, and a minimum functional age-equivalency of 12 years
 - 1.** Twelve (12) and thirteen (13) year olds may be referred for polygraph examination when the multidisciplinary team determines that the information and results would be clinically useful. There must be a determination of a minimum functional age-equivalency of 12 years, and the juvenile must meet other criteria for suitability for polygraph testing as defined in this Section.
 - 2.** Standardized psychometric testing shall be employed when there is doubt about a juvenile's level of functioning.
- B.** Capacity for abstract thinking
- C.** Capacity for insight
- D.** Capacity to understand right from wrong
- E.** Ability to tell truth from lies
- F.** Ability to anticipate rewards and consequences for behavior
- G.** Consistent orientation to date, time, place.

7.110 At the time of testing the polygraph examiner shall make the final determination of suitability for polygraph examination and shall not conduct polygraph examinations with juveniles when clear indicators exist that results would be invalid.

7.111 The multidisciplinary team shall determine and document in case files the rationale for and type of polygraph testing used, frequency of testing and the use of the results in treatment, behavioral monitoring and supervision.

7.120 The multidisciplinary team shall not refer juveniles for polygraph testing when any of the following are present:

- A.** Diagnosis of psychotic condition per the DSM IV-TR
- B.** Lack of contact with reality
- C.** DSM IV-TR Axis I severity specifier of "severe" for any diagnosis
- D.** DSM IV-TR Axis V Current – Global Assessment of Functioning score indicative of serious or profound functional difficulties (i.e., GAF score less than 50)
- E.** Presence of acute pain or illness
- F.** Presence of acute distress

- G. Recent medication changes**
- H. Mean Age Equivalency (MAE) or Standard Age Score (SAS) is below 12 years (per standardized psychometric testing)**
- I. Clear indicators exist that results would be invalid.**

- 7.121 Exceptions to the requirement to use polygraph testing shall be made by a majority of the multidisciplinary team in consultation with the polygraph examiner. The reasons for the exception shall be documented in the juvenile's file. If the exception(s) change, documentation is required regarding referral for or continued deferment from polygraph examination.**
- 7.130 No juvenile shall be referred for polygraph examination without the full, informed consent of the parent/legal guardian and the informed assent of the juvenile. The potential consequences of compliance or non-compliance with the procedure should be fully explained including legal consequences.**
- 7.140 Before commencing any polygraph examination with any juvenile who has committed a sexual offense, the polygraph examiner shall document that each juvenile, at each examination, has been provided a thorough explanation of the polygraph examination process and the potential relevance of the procedure to the juvenile's treatment and/or supervision. Review and documentation of informed assent will include information regarding the juvenile's right to terminate the examination at any time and to speak with his/her attorney if desired.**
- 7.150 As per standardized polygraph examination procedure, polygraph examiners shall be required to explain during the pre-test interview the polygraph instrumentation including causes of psychophysiological responses recorded during testing.**
- 7.160 Polygraph testing shall be used as an adjunct tool, it does not replace other forms of monitoring. Information and results obtained from polygraph examinations should never be used in isolation when making treatment or supervision decisions.**
- 7.161 Information and results obtained through polygraph examination shall be considered, but shall not become the sole basis for decisions regarding transition, progress, and completion of treatment. Polygraph test findings for juveniles should be reported as "significant reactions," "no significant reactions," or as "inconclusive." Such findings become a focus area for treatment and supervision. The findings of polygraph tests, as well as the juvenile's compliance or refusal to comply with request for polygraph testing, should not be used as the sole source in making treatment and supervision decisions.**
- 7.162 The multidisciplinary team shall respond to polygraph testing results in order to maintain the efficacy of the tool for maximum therapeutic benefit. Multidisciplinary team responses shall be in the form of sanctions, additional restrictions, rewards, or follow-up through the treatment and safety plans commensurate with the information obtained in the results.**

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

A. Sexual History polygraph examination:

- 1. The multidisciplinary team shall refer juveniles determined to be suitable for polygraph examination according to the criteria defined in Section 7.100 for sexual history polygraph examination. When employed, the sexual history polygraph examination should be initiated within 3-9 months following the onset of treatment to allow for sufficient preparation and follow-up on the information and results**
- 2. When necessary, the multidisciplinary team may accelerate or delay referral for sexual history polygraph examination, and the reasons for this decision must be documented in the juvenile's clinical and supervision records**
- 3. The multidisciplinary team shall assure that juveniles referred for sexual history polygraph examination possess sufficient understanding of laws and definition regarding abusive and/or illegal sexual behavior**
- 4. Test questions shall focus on issues that are clinically relevant to risk assessment, treatment issues and transition planning**
- 5. Care shall be given to minimize the focus on detail that may be sexually arousing**

B. Maintenance/monitoring polygraph examination:

- 1. The multidisciplinary team shall refer juveniles determined to be suitable for polygraph examination according to criteria defined in section 7.100 for maintenance/monitoring polygraph examination prior to transition to less restrictive placement settings in the community.**
- 2. When indicated in accordance with suitability criteria, the multidisciplinary team shall refer juveniles for maintenance/monitoring polygraph examination approximately 2-4 months prior to transition from one supervision level to another.**

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

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

C. Specific Issue polygraph examination:

- 1. The multidisciplinary team shall, at its discretion, refer juveniles determined to be suitable for polygraph examination according to criteria defined in Section 7.100 for specific issue polygraph examination.**
- 2. Specific issue polygraph examination shall be employed under the following conditions:**
 - a. Substantial denial of offense**
 - b. Significant discrepancy between the account of the juvenile who committed a sexual offense and the victims description of the offense**
 - c. To explore specific allegations or concerns**
 - d. Prior to victim clarification per Section 8.000 of these Standards.**

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

- A. Polygraph examiners shall employ a modern computerized or late model (1980's or later), electronically enhanced, polygraph instrument capable of simultaneously recording the individual's respiratory patterns, cardiovascular functions, electrodermal response, and metered chart/test time.**
- B. Polygraph examiners shall employ a standardized comparison question technique that is generally accepted within the polygraph examination profession, in addition to a peak of tension and/or sensitivity/calibration test when appropriate.**
- C. Polygraph examiners shall develop and review with the examinee, examination questions that are consistent with the examinee's level of maturity, development and understanding. Polygraph examination questions shall adhere to the following requirements:**
 - 1. Be simple, direct and as short as possible**
 - 2. Exclude legal terminology or treatment jargon that allow for rationalization**
 - 3. Exclude mental state or motivation terminology**
 - 4. Provide clear and simple meaning and interpretation**
 - 5. Contain reference to only one issue**
 - 6. Never presuppose knowledge on the part of the examiner**
 - 7. Use language that is easily understood by the examinee (all terms should be fully reviewed and explained to the examinee)**
 - 8. Be easily answered "yes" or "no"**
 - 9. Use language that is behaviorally descriptive**
 - 10. Avoid the use of any emotionally laden terminology.**
- D. Each examination shall be a minimum of 90 minutes in length, beginning when the examinee enters the examination room and ending when the examinee departs after examination.**

- E. Polygraph examiners shall record each examination in its entirety. While audio and video recording is preferable, audio recording alone will suffice when video recording is not practical.**
- F. Polygraph examiners shall submit a written report within two (2) weeks of the examination that will be factual and descriptive of the information and results of each examination. Written reports are intended for treatment and supervision purposes only, and shall be submitted to the supervising officer/agent, caseworker and treatment provider. Each report shall include information regarding:**
- 1. The date of examination**
 - 2. Beginning and ending time**
 - 3. Name of person requesting examination**
 - 4. Name of examinee**
 - 5. Birth date of examinee**
 - 6. Type of court supervision**
 - 7. Reason for examination**
 - 8. Date of last clinical polygraph examination**
 - 9. Examination questions and answers**
 - 10. Any additional information deemed pertinent by the examiner**
 - 11. Reasons for inability to complete the examination**
 - 12. Post-test phases of the examination**
 - 13. Test results.**
- G. Polygraph examiners shall score the examination data in accordance with physiological criterion that are generally accepted within the science of polygraphy as correlated with deception. In addition, a computerized scoring algorithm may be used, however the examiner must render the final decision with consideration for all the data obtained during the examination.**
- H. Polygraph examiners shall employ quality control processes as recommended by the American Polygraph Association and generally accepted practice within the polygraph profession.**

8.000

VICTIMS AND POTENTIAL VICTIMS: CLARIFICATION, CONTACT AND REUNIFICATION

8.100 Victim Clarification

The victim clarification process is designed to primarily benefit the victim. Through the process the juvenile who has committed a sexual offense clarifies that the victim has no responsibility for the juvenile's behavior. The specific questions posed to the juvenile or topics to be addressed must be clearly defined and the goals and purpose of such communication must be clear to all involved. Issues addressed include the damage done to the victim, family and/or secondary victim(s).

Clarification is a lengthy process that occurs over time usually beginning with the juvenile's reduction of denial and ability to accurately self-disclose about the offending behavior. Following written work, clarification may then progress to verbal contact prior to or in lieu of face-to-face contact. 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.

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

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

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

8.110 Victim clarification procedures must be approved by the multidisciplinary team and specifically include the victim's therapist or an advocate. The multidisciplinary team shall use the following criteria:

- A.** The victim(s) requests clarification and the victim's therapist or advocate concurs that the victim(s) would benefit from clarification
- B.** Parents/guardians of the victim(s) (if a minor) and the juvenile offender are informed of and give approval for the clarification process
- C.** The juvenile evidences empathic regard through consistent behavioral accountability including an improved understanding of: the victim's perspective; the victim's feelings; and the impact of the juvenile's offending behavior
- D.** Any significant difference between the juvenile's statements, the victim's statements and corroborating information about the offense/abuse has been resolved to the

satisfaction of the multidisciplinary team. The juvenile is able to acknowledge the victim's statements without minimizing, blaming or justifying

- E. The juvenile shall be required to have a specific issue polygraph prior to clarification if he/she meets the suitability criteria in Section 7.000 of these Standards
- F. The juvenile is prepared to answer questions and is able to make a clear statement of accountability, and give reasons for victim selection to remove guilt and perceived responsibility from the victim
- G. The juvenile is able to demonstrate the ability to manage abusive or deviant sexual interest/arousal specific to the victim
- H. The juvenile evidences decreased risk by demonstrating changes listed in Section 3.151 (B) which are supported by polygraph testing, when utilized
- I. Any sexual impulses are at a manageable level and the juvenile can utilize cognitive and behavioral interventions to interrupt deviant fantasies as determined by continued assessment.

8.200 Contact

Contact includes verbal or non-verbal communication which may be indirect or direct, between a juvenile and victim(s). Contact is first initiated through the clarification process. Following commencement of the clarification process and upon agreement of the multidisciplinary team, contact may progress to supervised contact with an informed supervisor outside of a therapeutic setting.

8.210 The multidisciplinary team shall:

- A. Collaborate with the victim's therapist or advocate, guardian, custodial parent, foster parent and/or guardian ad litem, in making decisions regarding communication, visits and reunification in accordance with court directives.
- B. Support the victim's wishes regarding contact with the juvenile to the extent that it is consistent with the victim's safety and well-being.

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

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

- 1. An informed supervisor has been approved by the multidisciplinary team. If the supervisor is not known to the victim, then the victim's therapist, advocate or caregiver must be present in the case of a child. This adult must meet the requirements of an informed supervisor as outlined in Section 5.700 of these Standards**
- 2. The juvenile is willing to plan for contact, to develop and utilize a safety plan for all contact and to accept and cooperate with supervision**
- 3. The juvenile is willing to accept limits on contact by family members and the victim, puts the victim's needs first and respects the victim's boundaries and need for privacy**
- 4. The juvenile is willing to cooperate with family or third party disclosure related to risk as directed by the multidisciplinary team.**

Discussion: It is generally preferred that clarification take place prior to contact. In rare instances, the multidisciplinary team may approve contact prior to clarification when therapeutically indicated for the victim's benefit. The victim's therapist or an informed supervisor must be present.

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

- 1. The safety plan must have a mechanism in place to inform the multidisciplinary team and specifically the supervising officer/agent of concerns or rule violations during contact**
- 2. Victim's and potential victim's emotional and physical safety shall be assessed on a continuing basis and contact shall be terminated immediately if any aspect of safety is jeopardized.**

8.300 Family Reunification

8.310 The multidisciplinary team shall make recommendations regarding reunification. Family reunification shall never take precedence over the safety of any victim. If reunification is indicated, after careful consideration of all the potential risks, the multidisciplinary team shall closely monitor the process. Even when indicated, family reunification can be a long-term process that involves risk and must be approached with great deliberation.

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

8.320 Reunification may only be considered when clarification has been accomplished and:

- A. The multidisciplinary team has determined that the juvenile has made significant progress toward goals and outcomes as outlined in Section 3.150**
- B. The multidisciplinary team has determined the victim has the abilities to set age appropriate boundaries and limits, and ask for help**
- C. The multidisciplinary team has determined the parents/guardians have demonstrated the ability to provide informed supervision (Section 5.700) and demonstrate evidence of:**
 - 1. The ability to initiate consistent communication with the victim regarding the victim's safety**
 - 2. The family believes the abuse occurred, has received support and education, and accepts that potential exists for future abuse or offending**
 - 3. The family has established a relapse prevention plan that extends into aftercare and includes evidence of a comprehensive understanding of the offending behavior(s) and implementation of safety plans.**

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

Appendix A INFORMED SUPERVISION PROTOCOL

Informed supervisors of juveniles who have committed sexual offenses shall be identified by the supervising officer/agent or DHS caseworker in the absence of a probation officer, at the onset of involvement with any agency that is required to comply with these Standards.

ALL JUVENILES WHO HAVE COMMITTED SEXUAL OFFENSES SHALL HAVE INFORMED SUPERVISION (5.700).

The primary care provider of a juvenile who has committed a sexual offense has the responsibility to provide informed supervision. Informed supervisors are defined as primary care providers, parents (if not directly involved in the treatment process), advocates, mentors, kin, spiritual leaders, teachers, work managers, coaches and others as identified by the multidisciplinary team. It is the responsibility of the multidisciplinary team to educate, inform and evaluate potential informed supervisors regarding their role specific to sexual offense issues.

The informed supervisor who is the primary care provider must be made aware of all relevant information, but at a minimum: 1) The nature and extent (as is possible) of the alleged or known sexual offending behavior of the juvenile; 2) immediate risk factors; 3) if being supervised through the juvenile justice system, the terms and conditions of supervision, prior to the juvenile residing with the informed supervisor; and, 4) the requirement to develop a Caregiver--Juvenile Supervision Plan (as identified in Appendix A2).

These four factors shall be completed and documented by the supervising officer/agent within the first 24 hours of community or residential placement. The supervising officer/agent and informed supervisor shall sign the informed supervision agreement (Appendix A1). In residential settings, the residential supervisor shall sign the agreement in addition to the supervising officer/agent.

Anyone providing informed supervision for a juvenile who has committed a sexual offense shall meet the following three (3) criteria in addition to any other requirements. The informed supervisor:

1. Is not currently under the jurisdiction of any court or criminal justice agency for a matter that the multidisciplinary team determines could impact his/her capacity to safely serve as an informed supervisor
2. Has no prior conviction for unlawful sexual behavior, child abuse or neglect, or domestic violence
3. If ever accused of unlawful sexual behavior, child abuse, or domestic violence, presents information requested by the multidisciplinary team so that the multidisciplinary team may assess his/her capacity to serve as an informed supervisor.

A designated member of the multidisciplinary team shall meet with the primary care provider within the first five (5) days of community or residential supervision to further educate the informed supervisor on the elements and requirements of informed supervision and to build the Caregiver--Juvenile Supervision Plan to fit the needs of the juvenile to the extent that they have been identified at the time of placement.

The elements of informed supervision are listed in Section 5.711 of these Standards.

Discussion: Informed supervision is an ongoing process and will change as the dynamic needs of the juvenile change. The multidisciplinary team and the informed supervisor will need to work closely and cooperatively to respond to these needs. Responses must be documented in the case file and reflected in treatment and safety plans per these Standards.

**Appendix A1
INFORMED SUPERVISION AGREEMENT**

Juvenile: _____

Respondent: _____

Relationship of Respondent: _____

Identified Informed Supervisor: _____

Relationship of Informed Supervisor to Juvenile: _____

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

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

- 2) **Immediate risk factors**
Notes: _____

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

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

Informed Supervisor	Date	Supervising Officer/DHS caseworker	Date
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Appointment date to develop the initial Caregiver--Juvenile Supervision Plan _____

(See Back)

The Informed Supervision Protocol requirements for the FIRST 5 DAYS of placement have been met through the initial development of the Caregiver--Juvenile Supervision Plan.
The plan as outlined in Appendix A2 is attached:

YES / NO

Notes:

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

Appendix A2 INFORMED SUPERVISION INITIAL CAREGIVER--JUVENILE SUPERVISION PLAN

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

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

Immediately upon receipt of a juvenile who has committed a sexual offense into the juvenile justice or DHS system, the supervising officer/agent shall complete the Informed Supervision Agreement (Appendix A1).

The Informed Supervision Agreement (Appendix A-1) is to be placed in the juvenile's complete case record. This informed supervision agreement is meant to be used at intake and is the minimum foundation of the expected level of informed supervision.

INITIAL CAREGIVER—JUVENILE SUPERVISION PLAN

The required elements of informed supervision are outlined in Section 5.700 of these Standards. The following eight (8) items constitute the basis for the initial Caregiver--Juvenile Supervision Plan.

1. The parent/guardian or caregiver is responsible for supervision of the juvenile 24 hours per day, 7 days per week, including sleeping hours. The parent/guardian or caregiver must be aware of the juvenile's whereabouts and activities at all times including common daily activities such as: collecting mail; placing the trash out; bathing or presence in another room. Informed supervision must be provided while riding in vehicles.
2. The parent/guardian or caregiver must be responsible for line-of-sight supervision of the juvenile whenever the juvenile is around children or potential victims.
3. The parent/guardian or caregiver must make arrangements for another informed supervisor to be present when the parent/guardian or caregiver is not available.
4. The parent/guardian or caregiver must make arrangements for informed supervision when the juvenile is in the community, in school or involved in activities where exposure to other children may occur.
5. The parent/guardian or caregiver must inform the school counselor, social worker or school liaison of the juvenile's potential risk and develop a safety plan with the school.
6. The parent/guardian or caregiver must make arrangements for and participate in sex offense specific evaluations, assessments and treatment with the juvenile.
7. The parent/guardian or caregiver must be involved with the multidisciplinary team to ensure safety and to enhance treatment progress.
8. The parent/guardian or caregiver must recognize the potential risk posed by a juvenile who has committed a sexual offense. The parent/guardian or caregiver must make necessary adjustments to ensure maximum safety and supervision. The parent/guardian or caregiver may need to install motion detectors, cameras, alarms, or other security devices.

(OVER)

The supervising officer/agent and/or DHS caseworker must document their action(s) in the following areas:

- 1. Review Informed Supervision Protocol with the informed supervisor, parent/guardian or caregiver and the juvenile who has committed a sexual offense.**
- 2. Upon initial placement, including emergency or respite care, the DHS caseworker must assess the residence for environmental considerations and safeguards including sleeping arrangements or play areas.**
- 3. Set an appointment to complete informed supervision requirements within the required time frames.**
- 4. Set regular appointments between named parties including time and place.**

Appendix B THERAPEUTIC CARE PROTOCOL

Therapeutic care providers shall provide all aspects of informed supervision and shall comply with Standard 3.160. A therapeutic care provider shall be aware of and be able to implement the conditions of the Informed Supervision Protocol (Appendix A) and shall be a signatory on the initial Caregiver--Juvenile Supervision Plan (Appendix A2).

When a caregiver is identified as a therapeutic care provider by the multidisciplinary team, the supervising officer/agent or the DHS caseworker shall review Section 5.712 with the therapeutic care provider within the first 5 days of placement.

An initial therapeutic care plan shall be developed conjointly between the therapeutic care provider and the multidisciplinary team.

All signature forms of Informed Supervision (Appendices A, A1, A2) apply to therapeutic care and shall be completed within the prescribed timelines.

Appendix C

POLYGRAPH EXAMINATION

Excerpted and adapted from the Ethical Standards and Principles for the Management of Sexual Abusers (1997), and Practice Standards and Guidelines (2001), the Association for the Treatment of Sexual Abusers.

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

A. Types of Polygraph Examinations

1. Sexual History Examination

The sexual history examination is a thorough examination of the juvenile's sexual history. When employed, the sexual history polygraph examination should be initiated within 3-9 months following the onset of treatment to allow for sufficient preparation and follow-up on the information and results.

Due to the diverse response from various jurisdictions of the criminal justice system, clinicians should be aware of the general implications and local judicial policies regarding newly reported crimes and self incrimination when requiring clients to undergo sexual history polygraph examinations.

2. Specific Issue Examination

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

3. Maintenance/Monitoring Examination

The maintenance examination is a periodic examination of a juvenile's compliance with treatment and/or probation/parole restrictions. This examination serves to identify and deter high risk behaviors. Monitoring or maintenance polygraph examinations are usually implemented every four to six months, but can be done more frequently on those juveniles who present as high risk.

The examinations further assist the service providers in tailoring more effective intervention strategies.

B. Polygraph Examination Recording Guidelines

All polygraph examinations will be appropriately recorded for diagnostic and documentation purposes.

Recording channels/components required for polygraph examinations have been outlined by the American Polygraph Association which requires that:

- 1. Respiration patterns made by pneumograph component(s)--at least one respiration component will record the thoracic (upper chest) respiration and/or abdominal (lower stomach) respiration pattern.**
- 2. One of the chart tracings will record the Skin Conductance Response (SCR) also commonly referred to as Galvanic Skin Response (GSR), which reflects relative changes in the conductivity/resistance of very small amounts of current by the epidermal tissue.**

3. A cardiograph tracing will be utilized to record changes in the pulse rate, pulse amplitude, and changes in the relative blood pressure.
4. To effectively evaluate the polygraph tracings collected during any polygraph examination it is necessary to obtain easily readable trace recordings. Tracings that are either too large or too small or that have extraneous responses to outside stimuli are difficult to evaluate.
5. Chart tracings consistently less than one-half inch in amplitude in the pneumograph and/or cardiograph tracings, without sufficient documented explanation of physiological cause, may be considered insufficient for analysis purposes.

C. Polygraph Instrument Calibration

Standardized Chart Markings recognized and used within the polygraph profession will be employed to annotate all calibration and examination charts.

Each polygraph instrument will be calibrated on a regular basis to ensure the instrument is functioning properly. The examiner shall maintain true and accurate records of such calibration. The records of these calibrations should be maintained by the examiner for three years.

If the instrument remains stationary, all analog polygraph instruments will be calibrated at least once each week.

If the instrument was moved subsequent to its last calibration procedure, each analog instrument will be calibrated prior to being used.

Digital polygraph instruments will be calibrated according to factory specifications and the manufacturer's recommendations.

D. Recommended Frequency of Polygraph Examinations

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

To safeguard against the possibility of client habituation and familiarization between the examiner and the subject, it is recommended that the polygraph examiner not conduct more than three separate examinations per year on the same client.

A re-examination to resolve a previously failed examination, or where no clear opinion was formed as to the subject's truthfulness, would not be considered a separate examination.

In order to allow sufficient time for the pre-test, in-test and post-test phases of the examination, most tests will require at least 90 minutes. In many cases, it should be anticipated that the examination session will take longer to complete.

E. Polygraph Testing Techniques and Procedures

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

To be an approved examination format, the examination procedure must include appropriately designed relevant questions, appropriately designed control questions for diagnostic purposes, and appropriately designed irrelevant questions as applicable to that defined and standardized procedure.

A standardized examination technique or procedure is defined as:

- 1) A technique or procedure which has achieved a published, scientific database sufficient to support and demonstrate validity and reliability from the application and use of that specific polygraph technique.
- 2) A technique or procedure that is evaluated according to the published methods for that specific procedure and provides for numerical scoring and quantification of the chart data.
- 3) A technique or procedure that has not been modified without the support of published validity and reliability studies for that particular modification.
- 4) A technique or procedure that has been taught as part of the formal course work at a basic polygraph school accredited by the American Polygraph Association.

Recommended procedures include:

- 1) Standardized and published Zone Comparison Techniques (ZCT)
- 2) Standardized and published Control Question Techniques (CQT)
- 3) Other standardized and published procedures that meet the guidelines and requirements described above.

Utilizing these procedures ensures maximum validity and reliability of diagnostic opinions and ensures that opinions rendered are defensible in court.

F. Stimulation/Acquaintance Test

The Stimulation/Acquaintance Test is used to demonstrate that the psychological set of the client and the client's reaction capabilities are established for diagnostic purposes.

This test is a recognized procedure utilized in conjunction with professional examination formats and may be a part of the polygraph examination.

G. Number of Relevant Questions

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

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

H. Single-Issue and Mixed Issue Examinations

Available scientific research has indicated that mixing issues during an examination can significantly reduce the ability to form valid and reliable opinions.

The importance of psychological set, satiation, adrenaline exhaustion and other principles forming the foundation of the polygraph science must be maintained.

I. Relevant Question Construction

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

- 1) Be as simple, direct and short as possible.

- 2) **Not include legal terminology (i.e., sexual assault, homicide, incest, etc.) as this terminology allows for client rationalization and utilization of other defense mechanisms.**
- 3) **Ensure the meaning of each question is clear, not allow for multiple interpretations and not be accusatory in nature.**
- 4) **Never presuppose knowledge.**
- 5) **Contain reference to only one element of the issue under investigation.**
- 6) **Use language easily understood by the client.**
- 7) **Be easily answerable yes or no.**
- 8) **To avoid the use of any emotionally laden terminology (i.e., rape, molest, murder, etc.)**

Appendix C-1 (July, 2003) Responding to Polygraph Results

The purpose of this appendix is to assist multidisciplinary teams in their use of polygraph testing with juveniles who have committed sexual offenses. Though several sections address polygraph use throughout these Standards, questions from the field have arisen regarding practical application and implementation. This appendix is not intended to revise existing Standards, but rather to provide guidance to multidisciplinary teams who evaluate, treat, manage and supervise this population.

Representing a cross-section of mandatory members of any multidisciplinary team (Section 5.110) the Sex Offender Management Board committee developed this appendix soon after the first publication of these Standards. Thoughtful consideration of comments and concerns from a variety of consumers provided the framework for the committee's approach.

The outcome is a best practice-based document that answers frequently asked questions, provides guidance regarding testing preparation, and outlines the process multidisciplinary teams should undergo when making decisions about the use of polygraph testing and the results of examinations.

Preparation for Polygraph Testing

Adequate preparation for polygraph examination has been found to contribute to improvements in the quality and quantity of information obtained from the polygraph, and to the accuracy of polygraph results. Structured preparation guidelines will serve to assure that juveniles are provided necessary guidance in preparing for polygraph examination, variability in preparation procedures will be determined by the multidisciplinary team (MDT). The MDT should provide the youth with guidance and structure sufficient to identify and organize the information pertaining to the polygraph test. All written materials should be provided to the examiner prior to or at the time of the examination.

Following are the three types of polygraph examination as listed in these Standards, and the minimal requirements for preparation by the juvenile:

1. Sexual history polygraph examination

Minimal preparation requirements by the juvenile:

- Is able to define types of abusive and unlawful sexual behavior (sibling, family member, lack of consent, lack of equality, some form of coercive pressure)
- Identification of victims of past abusive sexual behaviors and specific types of unlawful sexual contact are clear
- Demonstrates an adequate conceptual vocabulary regarding the test issues
- Written preparation materials completed by the juvenile should be provided to the examiner prior to or at the time of the examination.

Examination areas may include:

- Sexual offenses
- Sexual behavior patterns
- Consensual sexual contacts
- Masturbation issues
- Pornography issues
- Grooming, silencing, and maintenance behaviors
- Household boundaries

The MDT should assist the youth in preparing for sexual history polygraph testing by ensuring that the youth can define and identify abusive and/or unlawful sexual behaviors. In addition, the MDT should ensure that the youth possess and demonstrates an adequate conceptual vocabulary regarding the issues under investigation (i.e., pornography, masturbation, sexual contact, force, threats, coercion, relatives, consent, etc.)

Discussion: The MDT and/or polygraph examiner may elect to limit the time of reference of disclosure -- during the preparation, pre-test, and in-test phase of the examination -- to more recent history of sexual offense behaviors (i.e., since age 10, or since a memorable event marker). This may be particularly important for those youths whose early childhood experiences include severe chaos or abuse, or highly sexualized behaviors at young ages.

2. Maintenance/monitoring polygraph examination

Minimal preparation requirements by the juvenile:

- Is able to define of abusive and unlawful sexual behavior (sibling, family member, lack of consent, lack of equality, some form of coercive pressure)
- Demonstrates an adequate conceptual vocabulary regarding the test issues
- Written preparation materials completed by the juvenile should be provided to the examiner prior to or at the time of the examination.

Examination areas may include:

- Re-offense/lapse/relapse behaviors
- Sexual contacts
- Contacts with minors and/or vulnerable persons
- Masturbation issues
- Pornography issues
- Grooming, silencing, and maintenance behaviors
- Recent criminal behaviors
- Compliance issues
- Household boundaries
- School boundaries

3. Specific issue polygraph examination

Minimal preparation requirements by the juvenile

- Is able to define types of abusive and unlawful sexual behavior (sibling, family member, lack of consent, lack of equality, some form of coercive pressure)
- Demonstrates an adequate conceptual vocabulary regarding the test issues
- Conceptual understanding of the nature and time-frame of the issue, allegation, or inconsistency under investigation
- Written preparation materials completed by the juvenile should be provided to the examiner prior to or at the time of the examination
- Examiner should be provided the police/investigation reports, presentence investigation (PSI), and/or victim's statement prior to the examination date

Examination areas may include:

- Any history of involvement in the issue under investigation (absent of any allegation or reason to suspect involvement)
- Specific issues regarding the allegation and/or discrepancies under investigation
- Determine the presence or absence of other unreported behaviors

The MDT will seek to assist youths in preparation for polygraph testing in a manner that is least likely to induce or increase the youth's sexual arousal to deviant sexual themes and stimuli.

Preparation materials, as recommended in this appendix, should assist the juvenile in identifying all relevant sexual behaviors involving abusive or unlawful conduct toward others in addition to the juvenile's history of involvement in other sexual behaviors indicative of sexual preoccupation, sexual deviancy, and risk for sexual recidivism.

It is not mandatory that all treatment providers utilize the same polygraph preparation materials, and some variability in methods is expected in response to the demands of specific sub-groups within the population of juveniles who have committed sexual offenses. Programs that utilize alternative preparation materials to those recommended in this appendix should ensure that their materials address a similar range of clinical and risk predictive issues, and remain sensitive to juveniles' needs for the development of healthy/normative sexual identities.

Responding to Polygraph Outcomes

Polygraph examinations are administered for the following purposes:

- To gain information relevant to the determination of risk level and/or progress in treatment
- To deter problem behavior and encourage compliance and healthy/safe behavioral adjustment
- To verify an individual's honesty with the members of, and compliance with, the requirements of the multidisciplinary team (MDT).

Three types of polygraph examinations are utilized with juveniles who have sexually offended, and the target issues vary accordingly:

- 1) the juvenile's history of involvement in sexual offense behaviors and sexual behaviors (sexual history polygraph examination)
- 2) examination of a juvenile's behavior and/or compliance with rules and condition of supervision during a designated time period under supervision and/or while in treatment (maintenance/monitoring examination)
- 3) investigation of a single or specific issue of concern (i.e., drug or alcohol use, the nature and extent of the juvenile's offenses against an individual, etc.)

The MDT is required to consider all sources of information when making decisions regarding a juvenile's progress in treatment, transition to less restrictive levels of care, and successful completion of treatment. When a polygraph examination is utilized as a source of information, the MDT should remain aware of the following considerations: 1) the nature and purpose of the polygraph test; 2) the information and results obtained from the polygraph test; and 3) the implications of the test results in the individual's treatment and management plan.

The MDT should formulate its response to the information and results from the polygraph test in a manner that is consistent with the objectives of the examination (i.e., community safety needs, individual treatment needs). The MDT should consider the following in formulating its response:

1. Nature and purpose of the polygraph examination

- Detection of information relevant to risk assessment and treatment planning
- Verification of compliance with supervision and/or treatment requirements
- Deterrence of problem behaviors

Discussion: Polygraph examination outcomes may lead to increased or decreased activity restrictions and/or changes in supervision or treatment requirements.

2. Polygraph outcomes

- Admissions/disclosures
- Timeliness of admissions and disclosures (i.e., preparation, pre-test, post-test)
- Scored test results
- Juvenile's response to the polygraph process and/or results (including efforts to resolve remaining inconsistencies)

Discussion: The MDT's response to polygraph examination outcomes may vary according to the timeliness of any admissions or disclosures. Juveniles who make 11th hour admissions prior to or during a polygraph examination may be demonstrating a more reluctant attitude toward the treatment and supervision process compared with those who report behaviors in a more timely manner. However, any effort to disclose behavioral issues and/or resolve inconsistencies may be an indicator of progress.

3. Case management context (to be considered when responding to polygraph examination outcomes)

- Individual's diagnostic/developmental profile
- Length of court supervision (remaining supervision period)
- Progress in sex offense specific treatment
- History of behavioral compliance
- Quality and level of supervision in the individual's environment
- Involvement in community based activities (family, work, school, recreation)

Discussion: When a youth discloses information that changes his/her assessed risk level -- regardless of the test outcome-- the MDT may elect to intensify treatment and supervision requirements. This information may accelerate or delay plans for transition or access to activities in the community. In the event of inevitable transitions, the MDT may elect to delay maintenance/monitoring examinations to a time following the transition to deter problem behavior and support the youth's behavioral adjustment in the new setting.

Questions and Answers
Regarding Polygraph Testing of Juveniles Who have Committed Sexual Offenses

1. **Who makes the referral for a polygraph examination?**

Standard 7.100 states that the MDT makes the referral for a polygraph examination. Polygraph referrals should not be made by an individual member of the MDT without the involvement of the other members.

2. **Is it permissible to inform the juvenile's family and/or attorney of the questions or issues to be addressed during the examination?**

The juvenile's family members and/or attorney may be informed of the general areas of inquiry that will be investigated during the examination. The questions asked will be individualized and language and vocabulary may be infinitely variable. The juvenile should not be informed of the exact questions prior to the examination. Such information may limit the individual's willingness to discuss other important issues that may interfere with the examination and would not contribute to favorable test outcomes. The MDT determines question target areas, and the exact language of the test questions will be developed during the examination.

3. **What are the areas of inquiry during a maintenance polygraph examination?**

The pre-test interview is conducted to determine the extent of the individual's reported activities within the areas of concern as determined by the MDT. The pre-test interview is conducted in a manner to build a suitable testing rapport between the juvenile and the examiner, stabilize issues that could interfere with the examination results, and assure the examinee is able to focus on the test issues in a clear and accurate manner. Areas of inquiry may include sexual contacts, sexual behaviors, contact(s) with children or vulnerable persons, masturbation issues, compliance issues and issues related to overall honesty and integrity with significant persons involved in the youth's life.

4. **How does the sexual history polygraph contribute to risk assessment?**

Risk assessment assumes both quantitative (i.e., how high is an individual's risk level) and qualitative dimensions (i.e., what are specific risk factors that must be monitored and managed). Polygraph testing can provide additional information to both dimensions of risk assessment.

However, the polygraph test itself is not a measurement of an individual's risk level. Because the polygraph test contains only a limited number of questions, not all of these issues will be addressed during all polygraph examinations. The members of the MDT will identify the issues most salient to the accurate assessment of each individual referred for sexual history polygraph testing.

5. **What are the areas of inquiry during a sexual history polygraph examination?**

Areas of investigation during sexual history polygraphs may include sexual offenses, consensual sexual contacts, sexual victimization issues, sexual deviancy/preoccupation and general questions relevant to an individual's level of honesty and integrity.

6. What are the requirements for a completed or resolved sexual history polygraph?

Sexual history polygraph examinations should include, but may not be limited to, questions about sexual contact without consent (i.e., force, threats, coercion, and manipulation), sexual contact involving younger family members or relatives, and sexual contact with persons four (4) or more years younger than oneself.

Questions may also address sexual behavior patterns and sexual offenses against persons who were asleep or unconscious at the time (i.e., drugs or alcohol), or other vulnerable persons. The MDT or examiner may elect to limit the pre-test or in-test questions to the time period since a certain age (i.e., age 10 or other age) or another memorable event or time marker. In accordance with standardized procedure, polygraph examinations may also include questions relevant to an individual's overall level of honesty and integrity.

7. Is there a required or standardized method of preparation for a polygraph examination?

While some preparation for polygraph examination is important, exact methods of preparation may vary across individuals and treatment groups, and may be population dependent. Not enough is known to dictate the specific methods of preparation that will most likely lead to satisfactory test outcomes across varying populations of youths in treatment. Multidisciplinary team members are encouraged to develop preparation materials relevant to the needs of each individual and treatment program. Materials developed by local treatment providers and polygraph examiners have been found useful with some individuals.

In general, the quality and degree of organization of the information contained within each individual's history is the most important factor concerning preparation for polygraph examination.

Care should be taken to minimize exposure to deviancy when assisting youths preparing for polygraph testing.

8. Should the juvenile include in his/her sexual offense history those persons with whom s/he has had contact, yet the juvenile has not defined as a victim?

It may be useful to discuss issues of uncertainty with the examiner. However, it is generally the responsibility of the treatment provider to assist the youth in learning to define and identify his/ her abusive and/or unlawful sexual behavior toward others. These issues should be resolved in treatment before the polygraph examination, which is then conducted to examine the veracity of the juvenile's reports.

9. What should the MDT do when the youth is unsure about the use of force, or threat of force during an offense?

These questions should be resolved in treatment prior to the polygraph examination. The MDT should consider whether the youth possesses the capacity to clearly recall if s/he had engaged in forceful or threatening behavior and should be prepared to document any mental health or developmental issues that preclude this awareness.

10. Under what circumstance might a specific issue polygraph be considered for the first polygraph?

A specific issue polygraph, regarding the referral offense, should be considered for a youth's first polygraph examination in cases in which there is a substantial discrepancy between the victim's and the offender's account of the offense, or when a discrepancy serves as a barrier to effective participation and progress in treatment. Investigation of current community safety concerns should take precedence over polygraph examination of the referral offense or sexual history.

11. How should the MDT respond to repeated unresolved polygraphs?

In the case of repeated unresolved polygraphs, the MDT, including the polygraph examiner, should meet to review the case to determine the extent of information already obtained, identify impeding clinical or historical variables, and formulate a hypothesis about possible reasons for the youth's unresolved polygraph results. The MDT should determine whether further polygraph testing is warranted, and should identify target issues for any future polygraph tests. There may be cases in which continued investigation of sexual history is not useful; however, there may be value of maintenance/monitoring polygraphs in order to identify ongoing risk issues and deter problem behavior.

There may be times when continued testing may not be useful. In general, evaluating and adjusting the focus and breadth of the questions during the examination, and paying careful attention to question formulation may resolve repeated unresolved polygraphs.

12. Does the extent of a juvenile's sexual history affect his/her testability?

An extensive sexual history does not preclude a person from passing a polygraph examination. Generally speaking, the greatest factors affecting an individual's ability to resolve polygraph examination questions are the individual's willingness to accurately and clearly identify and describe his/her history of involvement in the behaviors under investigation. Some youths may have trouble clearly delineating their history of involvement in sexual behavior that began at early ages. The MDT should assist the youth to suitably prepare for the polygraph examination, and may elect to limit the scope of the sexual history polygraph to sexual behavior since age 10 or other memorable time marker after which the youth may be able to recall the extent of his/her involvement in sexual activities.

13. Are there circumstances when we should administer polygraphs prior to sentencing?

Polygraph examinations conducted prior to sentencing may not meet the requirements of these Standards. The MDT may wish to have these examinations reviewed by another qualified examiner before accepting them.

Most polygraph examinations prior to sentencing will be specific issue tests (i.e., regarding the allegation or accusation), or monitoring/maintenance polygraphs regarding an individual's behavior while participating in treatment. Polygraph examinations conducted prior to sentencing will fall under the purview of these Standards only when a youth has been referred to sex offense specific treatment (i.e., by social services, pretrial supervision, diversion programs, etc.) In general, non-adjudicated youths should not be referred for sexual history polygraph testing, unless a protective order has been established to preclude prosecution in response to disclosure.

14. **Are there circumstances when the MDT should decide not to refer a juvenile for a polygraph examination?**

The MDT should not refer a juvenile for polygraph testing when he or she does not meet the referral criteria defined in these Standards.

15. **May the juvenile and family have access to the polygraph examination report and/or recording?**

While conducted in support of the treatment process, the polygraph examination is not a psychometric assessment. The polygraph examination is an investigative examination, and polygraph examiners who conduct examinations on juveniles who have committed sexual offenses do so as members of the MDT. Communication of the information and results from the polygraph examination is intended to serve the needs of the professional members of the MDT in assessing an individual's risk level, progress in treatment, and compliance and honesty regarding behavioral expectations. Therefore, information and results from the polygraph examination should be communicated only to the professional members of the MDT as specified on the polygraph authorization and release form.

To preserve the objectivity and integrity of the examiner's role on the MDT, and to prevent the influence of family or third-party influence on the examiner, polygraph examiners should refrain from providing information and results directly to the juvenile and/or family members following the completion of the post-test portion of the examination. Information and results from the polygraph examination should be reviewed with the youth and family in a therapeutic setting with a professional member of the MDT. The examiner should only discuss polygraph information and results with the juvenile and/or family members in the context of MDT functions (i.e., staffing or telephone conference).

When polygraph examinations are incorporated into a youth's treatment file, the youth and family may access those reports under certain conditions. The examiners, and related agency, are the only persons authorized to disseminate the examination report, and then only to individuals and agencies named on the authorization and release form. Professionals in various service delivery systems and organizations may be subject to different regulations regarding the redistribution or re-release of information and reports generated or developed outside their own agency. Members of the MDT should familiarize themselves with the regulations that pertain to their profession, agency and/or organization.

Like the polygraph examination report, all recorded materials pertaining to a polygraph examination are subject to the authorization and release form, and may only be released to the professional members of the MDT. Members of the MDT must become familiar with agency and professional regulations pertaining to the redistribution of such materials. Due to the sensitive nature of the information discussed during polygraph examinations, parents and family members who wish to review an examination recording should do so only in the context of a supportive therapeutic setting.

16. **May a youth's family make the referral for a polygraph examination to be conducted independently of the MDT?**

Polygraph examinations conducted without the involvement and referral from the MDT may not meet the requirements of these Standards.

17. Should the polygraph report be released to the court as a part of the probation or department of human services progress report?

Materials submitted to the court may become a matter of public record, and polygraph examination reports may contain sensitive information. Supervising officers and caseworkers should not attach a copy of the polygraph results to presentence investigations or other reports to the court. Instead, supervising officers and caseworkers should summarize the information from the polygraph in their reports to the court.

18. Can a question about the extent of sexual abuse against a known victim be asked in the context of a sexual history polygraph regarding unknown victims?

This practice is not recommended. Sexual history polygraph examinations are conducted to determine the range and scope of an individual's sexually abusive behavior for the purpose of identifying victims, risk assessment, and treatment planning. Testing the limits of a juvenile's sexually abusive behavior against a particular victim should be the focus of a specific issue polygraph.

19. What is the best way to use the polygraph to verify the absence of concerns of sexual abuse against other younger siblings or vulnerable individuals?

In the presence of a specific allegation or reason to suspect abuse against a particular individual, a specific issue polygraph regarding the allegation is warranted. In the absence of an allegation or reason to suspect abuse against a single younger sibling or individual, a specific issue examination regarding general types of sexual contact with that individual is recommended. In the absence of allegations or reasons to suspect abuse against multiple younger siblings or vulnerable individuals, the test would be structured as a partial sexual history polygraph regarding younger siblings, family members, or vulnerable individuals. These questions may also be resolved in the context of a sexual history polygraph.

20. Is it acceptable to conduct polygraph examinations on multiple issues?

Questions within the scope of a sex history polygraph may contain multiple related issues (i.e., questions about different types of sexual offense behavior, victim selection behaviors, sexual behavior issues). Similarly, questions within a maintenance polygraph may address multiple issues related to re-offenses, sexual contacts, sexual behavior issues, and rule compliance while in treatment and/or under supervision. Specific issue polygraphs may contain multiple questions regarding the specific allegations under investigation.

To reduce the likelihood of erroneous test results in the event that a youth shows significant responses to any individual question on a mixed issue test, the examiner may not render any opinion regarding the absence of significant responses to other questions. To reduce the likelihood of false negative results, the examiner must report the presence or absence of significant reactions to individual questions and may not render any opinion regarding a youth's responses to individual questions that fail to meet the criterion thresholds.

As with other forms of testing and evaluation, addressing a broader range of questions within a single examination may lead to an increased likelihood of unresolved examination results. The polygraph examiner should consult with the other members of the MDT to determine the type and purpose of the test, and the scope of the test questions.

21. Are polygraph examiners mandatory child abuse reporters? Who is responsible for reporting previously unreported victims?

Polygraph examiners are not mandatory child abuse reporters by statute; this includes polygraph examiners with clinical training. However, polygraph examiners who conduct examinations under these Standards are required to report all pertinent information about sexual offenses, sexual contacts, and risk indicative behaviors to the other members of the MDT. All members of the MDT who are mandatory child abuse reporters are responsible for assuring the timely and accurate reporting of child abuse to the appropriate authorities.

22. How does the MDT decide what type of polygraph examination to administer?

To aid in the development of an accurate sense of empathy for victims, youths who present with significant discrepancies in their reports of the abuse compared to their victim's reports may be asked to undergo a specific issue polygraph examination regarding a particular offense. It is not advisable to defer this work until the end of treatment. Maintenance polygraph testing may be requested any time there are concerns about an individual's recent or current behavior, and should be used as a transition support tool (i.e., to assess behavioral readiness for transition and/or to deter and detect the onset of problem behavior after transition).

Polygraph examination of juveniles who have committed sexual offenses is required for juveniles who meet the testing criteria. It is an adjunct tool for treatment providers, supervision officers, and case workers to support the youths' progress in the treatment, safety in the community, and to access more accurate information regarding an individual's risk level and honesty. There is no requirement that various types of polygraph testing be completed in any particular order. Instead, the MDT should assess the safety, placement stability and progress of each youth and decide which type of polygraph examination best suits the objectives of safety and progress at any given time.

23. Should youths be asked polygraph questions regarding their own victimization?

Except in rare circumstances, an individual's history of victimization should not be subject to polygraph testing. Some youths may report their victimization history when reviewing their offense history. It is acceptable for examiners to inquire about a youth's victimization history during the pre-test interview as such information may assist some youths in fully disclosing their sexual history and may lead to an improved test outcome. Care should be taken to avoid causing unnecessary distress when investigating any individual's history of victimization.

24. Should youths be given sexual history disclosure materials to work on at home or in their rooms?

Youths may become aroused to their own history of sexual offense behaviors and history of involvement in sexual behavior patterns. To minimize the likelihood of reinforcing sexual arousal to deviant themes, disclosure work should be done in the context of individual or group therapy. When youths are requested to complete disclosure work independently, they should be instructed to stop at any point they become sexually aroused, and to report any arousal issues to their treatment provider.

25. How does the MDT determine the target questions for various types of post-conviction (post-adjudication) polygraphs?

While all polygraph examinations may include questions relevant to an individual's overall honesty and integrity, sexual history polygraph examinations will likely focus on the unlawful sexual contact issues of greatest likelihood for each individual.

Questions on maintenance/monitoring polygraphs will generally address issues regarding recidivistic offending behavior patterns, any issues of observed deviancy or concern, and other issues salient to an individual's behavior and honesty in treatment. Specific issue polygraphs will address the specific allegations under investigation, any discrepancies in the offender's and victim's statements, and the extent or frequency of abuse.

26. May questions about intent be included in the scope of a polygraph examination?

Questions about state of mind or body may be most useful when formulated in reference to behaviorally descriptive events or activities.

27. How does the polygraph contribute to recommendations surrounding a juvenile's status on probation or in treatment, transition plan, registration requirements and/or expungement following the completion of treatment and probation?

Polygraph examination results can aid in the formulation of the MDT's recommendations surrounding these decisions, though the results and information from the polygraph should never become the sole basis of such decisions. The MDT must make recommendations and decisions with careful consideration of all information relevant to an individual's risk profile, progress in treatment, and available resources.

The lack of available resources should not dictate a recommendation for services that would be less than adequate. Results and information can contribute to these decisions by providing additional information to the MDT regarding the accuracy and integrity of an individual's engagement in treatment, and compliance with supervision and treatment program rules.

Verification of an individual's honesty and non-involvement in problem behaviors during the entire period of time following adjudication, or other reasonable period of time, would provide the most expedient contribution to these recommendations and decisions.

28. May a youth's therapist, parents, or attorney participate in or observe the polygraph examination?

Except during circumstances in which an individual is unable to communicate effectively without the aid of an interpreter, no one is permitted in the examination room except the juvenile and the examiner. Members of the MDT may observe the examination through a video monitor, or review the recording at a later time. In order to minimize distraction and outside influence, no interaction may occur between the youth and any member of the MDT once the polygraph pre-test interview has begun.

Due to the sensitive nature of the information discussed during the polygraph examination, family members should not be allowed to observe the examination as it occurs. Information from the polygraph examination should be reviewed with family members in a supportive therapeutic setting.

The juvenile's attorney is generally not involved in post-conviction (post-adjudication) polygraph examination and ongoing treatment and management of the juvenile. An attorney may elect to observe an examination that is conducted at the attorney's request, however these examinations may not meet the requirements of these Standards.

Glossary of Terminology

The terminology contained in this appendix applies to polygraph examination and related subject matter. Terms and concepts used and defined in this glossary may not have the same meaning outside of sex offense specific services.

Terms with an asterisk* notation are direct quotes from: Krapohl, D. and Sturm, S., (2002). Terminology Reference for the Science of Psychophysiological Detection of Deception. Polygraph, 2002, 31 (3).

Some of the following terms use language commonly applied to adult testing, i.e. conviction, parole, prison, etc. When these terms are encountered, please consider the language used in juvenile settings such as adjudicated, supervision, DYC/commitment, etc.

The remaining terms have been defined by the Juvenile Standards Polygraph Committee of the Sex Offender Management Board that was comprised of a cross-section of professionals in the field.

Coercion

Exploitation of authority, use of pressure through actions such as bribes, threats, or intimidation to gain cooperation or compliance. Also includes threats of loss of relationship, esteem, or privilege, or threats of punishment inflicted by a parent. While coercion is inclusive of force and threats, it is useful to differentiate physical forms of force, or threat of force/harm from other forms of coercion.

Disclosure examination*

See sexual history examination.

Examination*

The entirety of the PPD process, including pretest, test and posttest elements, from onset to completion.

Note: PPD refers to Psychophysiological Detection of Deception

Frame of reference

Conceptual issue in post-conviction polygraph examination referring to the purpose of the examination, i.e. sexual history, maintenance/monitoring polygraph, or offense specific polygraph. Distinct from other specific issue examinations in which a specific accusation or allegation includes an identified victim, date, time, location, and behavioral description.

Incapacitated

Asleep or unconscious from drugs and/or alcohol, or other medical condition. May include persons who are stuporous or unaware due to general or overall functional impairments.

Instant offense examination*

A form of post-conviction sex offender testing, conducted when a subject is in denial of the offense or of some significant element of the offense for which he or she was convicted, and is often used to break down the denial barrier. This is also an examination that can be given when a new allegation has been made while the subject is on probation or parole. The polygraph is used to determine whether the allegations are true. Also called a specific issue examination. See: Cooley-Towel, Pasini-Hill, & Patrick (2000); Dutton, (2000); English, Pullen, & Jones (1996); Heil, Almeyer, McCullar, & McKee (2000).

Masturbation

Purposeful stimulation of one's own genitals through the use of hands or other objects.

Monitoring examination*

A form of post-conviction sex offender testing (PCSOT) that is requested by a probation or parole officer to ensure compliance with the conditions of the offender's release from prison; i.e., alcohol or drug issues, computer violations contact with children, etc. See: Cooley-Towel, Pasini-Hill, & Patrick (2000); Dutton (2000); English, Pullen, & Jones (1996); Heil, Ahlmeier, McCullar, & McKee (2000).

Note: This type of examination applies to juveniles and would be used similarly to that described above. For the best guidance see Standard 7.170 (B).

No deception indicated (NDI)

In conventional PDD, NDI signifies that (1) the polygraph test recordings are stable and interpretable, and (2) the evaluation criteria used by the examiner led him/her to conclude that the examinee was not being deceptive regarding answers to the question(s) during the examination. NDI and DI (deception indicated) decision options are generally used in specific issue testing and correspond to NSPR (no significant physiological responses) and NSR (no significant physiological responses/no significant reactions) in post-adjudication polygraph testing of juveniles who have committed sexual offenses.

No opinion*

Alternate form of an inconclusive call, especially in the Federal Government. Sometimes used to denote an incomplete call in other sectors.

No significant physiological responses (NSPR/NSR)

Accepted language in decision options in polygraph examination procedures developed by the Department of Defense, and is equivalent to the NDI (no deception indicated) decision option in general use.

Objectifying behaviors

Looking at others as sexual objects with little or no regard for their personhood, feelings or the offender's impact on them. May also include attempts to look inside people's clothing in an attempt to see their sexual organs.

Discussion (labels vs. description): Attempts to account for the nature and extent of sexual offenses against a victim are inherently limited by language-based definitions of individual words, terms and concepts. Over-reliance on individual words or labels to convey an adequate description of events invites argument and dissention about the exact meaning of individual words or labels. It is preferable to provide event-related information in descriptive detail that does not depend on the connotative, denotative, or stipulated definitions of individual words. Such an approach more adequately conveys the events and their potential impact on the individuals involved.

Physical Force

Grabbing, holding, pulling, tugging, pushing down or restraining a victim. Using one's strength or size to overpower a victim's resistance, attempts to escape or attempts to stop or end an offense. Using any physical object to restrain a victim, block escape, or overcome resistance.

Polygram*

Complete graphical recording of physiological data from a polygraph test, with the required annotations. Usually called a *polygraph chart*.

Polygraph*

By definition, an instrument that simultaneously records two or more channels of data. The term now most commonly signifies the instrument and techniques used in the psychophysiological detection of deception, though polygraphs are also used in research in other sciences. In PDD the polygraph traditionally records physiologic activity with four sensors: blood pressure cuff, electrodermal sensors, and two respiration sensors. Some instruments also record *finger pulse amplitude* using a photoplethysmograph.

Post-conviction sex offender testing (PCSOT)

Specialized application of polygraphy that aids in the management of persons who have been convicted of or adjudicated for sexual offenses, and who have been released into the community, though sometimes employed as part of treatment for persons in secured settings. There are four primary types of post-conviction sex offender testing: referral/instant offense examination, sexual history/disclosure examination, maintenance/monitoring examination, and specific issue examination.

Note: Please see Standard 7.100 for clear guidance on the use of these types of polygraph examinations with juveniles who have committed sexual offenses.

Posttest*

Final portion of a polygraph examination. The posttest could include a debriefing of an examinee who passed the examination, or an interview or interrogation of an examinee who failed the examination. The posttest may or may not be a part of any given polygraph technique, and plays no part in the formulation of the results in any polygraph technique.

Note: Section 7.161 describes the language to use regarding the reporting of results. These Standards are not recommending the use of “passed” or “failed” when reporting examination outcomes.

Pretest interview*

The earliest portion of the PDD examination process during which the examinee and examiner discuss the test, test procedure, examinee’s medical history, and the details of the test issues. During the pretest interview, in some techniques, the examiner will make behavioral assessments of the examinee to help determine the PDD outcome. The pretest interview also serves to prepare the examinee for testing. The length of the pretest interview ranges from 30 minutes to 2 hours or longer, depending on the complexity of the case, examiner-examinee interactions, and testing technique. All PDD techniques use pretest interviews.

Psychophysiological detection of deception (PDD)*

Common scientific term to denote the use of the polygraph to diagnose deception.

Relatives/family members

Persons who are related by blood, marriage or adoption, including parents, grandparents, step-siblings, aunts, uncles, cousins, nieces, nephews.

Sexual contact

Rubbing or touching another person’s sexual organs (i.e., breasts/chest area, buttocks, vagina, penis) either bare (under clothing) or over clothing if done for the purpose of evoking sexual arousal or sexual gratification of oneself or the other person. Sexual contact may also include causing or allowing another person to touch one’s own sexual organs either over or under the clothing, if done for the purpose of sexual arousal or gratification. The term *physical sexual contact* is used interchangeably and may be used to improve some individuals’ abilities to provide clear and unequivocal answers to polygraph questions.

Discussion: Behavior is typically not defined by an individual’s motive. It is worth noting that there are other motivations, besides sexual arousal, for touching the sexual organs of another person (i.e., anger, aggression, retaliation, changing diapers, bathing).

Sexual history examination*

A form of post conviction sex offender testing (PCSOT) which entails an in-depth look at the entire life cycle of an offender and his or her sexual behaviors up to the date of criminal conviction. Sometimes referred to as a *disclosure examination*. See: Cooley-Towel, Pasini-Hill, & Patrick (2000); Dutton, (2000); English, Pullen, & Jones (1996); Heil, Ahlmeyer, McCullar, & McKee (2000).

Note: Please see Section 7.170 for guidance with juveniles who have committed sexual offenses.

Sexually stimulating materials and/or pornography

These may include:

- Erotica - swimsuit calendars, lingerie or underwear advertisements, non-pornographic magazines
- Pornography - nudity in pornographic magazines, movies or websites
- Sexually aggressive pornography - sexual materials depicting violence or force
- Sexually explicit pornography - material depicting sexual acts

Significant physiological responses (SPR/SR)

Accepted language in decision options in polygraph examination procedures developed by the Department of Defense, and is equivalent to the DI (deception indicated) decision option in general use.

The practice of reporting polygraph examination results as SPR/SR or NSPR/NSR is favored out of consideration of the theoretical, technical, and clinical complexities surrounding the use of polygraphy with juveniles who have committed sexual offenses.

Specific issue polygraph examination*

A single issue PDD examination, almost always administered in conjunction with a criminal investigation, and usually addresses a single issue. Sometimes called a *specific* by PDD practitioners to differentiate from pre-employment or periodic testing.

Threats of harm or force

Threats of any bodily harm or injury. Threats to use a weapon, including displaying or brandishing a weapon, or brandishing one's fists. Displays of anger may constitute a threat against a victim, who may perceive the need to cooperate in order to avoid further harm.

Time of reference

Conceptual issue in post-conviction polygraph examination structure that addresses a specific time period of reference (i.e., prior to the date of conviction or adjudication for sexual history polygraph, and a segment of time following the date of conviction or adjudication for maintenance/monitoring polygraph examinations).

Vulnerable person(s)

Any person who is substantially younger (i.e., 4 or more years younger), mentally or medically impaired, or physically handicapped. May include any person (including an older person) who is unable to defend him/herself or unable to access assistance to prevent assault/abuse.

Appendix D

PLETHYSMOGRAPH EXAMINATION

Excerpted and adapted from the Ethical Standards and Principles for the Management of Sexual Abusers, the Association for the Treatment of Sexual Abusers (1997).

The purpose of the phallometric assessment is to provide objective data regarding sexual arousal. It may also promote self-disclosure and reduce minimization and denial of sexual offenses. Additionally, it can assist in monitoring changes in sexual arousal patterns which have been modified by treatment.

A. USES

Physiological assessment can be used to identify the need to reduce and control deviant sexual arousal.

B. LIMITATIONS

Phallometric assessment data should not be used as a sole measure to predict risk of engaging in deviant sexual behavior.

Failure to develop significant responses to deviant sexual themes cannot be used to demonstrate innocence of a specific allegation of sexually deviant behavior.

Development of significant arousal to deviant themes cannot be used to demonstrate guilt of a specific allegation of sexually deviant behavior.

It is inappropriate to use erection responses to determine or make statements about whether or not someone has engaged in a specific sexual behavior or whether someone fits the “profile of a sexual abuser.”

Extreme caution should be used in interpreting erection responses to non-standardized sets of stimuli.

C. JUVENILES

Use of phallometric assessment with pre-pubertal youth is not recommended.

Phallometry should only be used with juveniles younger than 14 years of age when the clinician needs more information than is currently available via other, more traditional sources.

For individuals under the age of 14, or for those who may not have attained the maturational level associated with puberty, clinicians should seek interdisciplinary or institutional review of the physiological procedures.

The relationship between phallometric arousal and clinical characteristics appears weaker in an adolescent population than in an adult population. Caution should be used in interpreting adolescent data in a manner parallel to that of adult data.

Adolescents appear more fluid in their sexual interests and patterns of behavior than adults and may not show as high a degree of correspondence between measured arousal patterns and reported offense histories.

D. DEVELOPMENTALLY 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.

E. PRELIMINARY PROCEDURES

The examiner should gather supportive information, such as marital and family history, criminal history, present life situation, legal status, sexual history, mental health contacts, and the reason for referral.

It is the responsibility of the examiner to screen the client for contamination factors, such as drug use, medication, last sexual activity, emotional state, physical impairment, etc.

Prior to the examination, the examiner should take steps to ensure that the examination will not be interrupted.

No client with an active sexually transmittable disease or parasite should be tested. The client should sign a disclaimer of any knowledge of a current sexually transmitted disease.

F. LEGAL CONCERNS/INFORMED CONSENT

Consent forms regarding the penile plethysmograph procedure should be read, signed and dated by the client.

Discussion: The Standards in this document require informed assent.

When plethysmography is used with persons under the age of 15, this procedure should be reviewed by a community or institutional advisory group.

Release forms allowing for both the receipt and dissemination of information should be obtained.

Raw data forms must provide information for retrieval of specific stimulus materials that were used in the assessment.

G. LAB EQUIPMENT

Plethysmograph equipment should provide either continuous chart paper readout or, with computerized equipment, a printed readout of response levels to each stimulus.

Equipment should be used as designed. See users' documents.

An arm chair or lounge chair with cleanable surface must be provided. A reclining lounge chair is preferable.

A disposable cover on the chair seat and on the arms of chair is required for each client.

Mercury-in-rubber, Indium-gallium, or Barlow gauges may be used and each gauge must be tested and calibrated before each use. Documentation of gauge calibrations should be provided.

A calibration device or cone is required in ½ cm increments with a minimal range of 6 cm.

Security devices must ensure client's privacy, but must also include emergency entrance and exit with the safety of the client in mind.

Slide projector for visual material should be capable of projecting images spanning a 35 degree visual angle.

An intercom system should be used to provide communication between client and examiner.

Clinician must have a protocol for fitting gauges, trouble-shooting equipment, breakdowns, and malfunctions.

Plethysmograph equipment should be used as designed, according to the user documents.

The penile plethysmograph should be isolated from AC with a DC converter.

H. LAB SETTING AND CLIENT SPACE REQUIREMENTS

Client space must be separated from the clinician's work area by at least an opaque partition that is a minimum of 7 feet high, to ensure client's privacy. A stationary wall is preferred to maintain maximum privacy.

Client space is recommended to be approximately 7 feet by 8 feet in dimension. The minimal requirement for this space is 4 feet by 6 feet.

An intercom system must be used when the client is in a stationary enclosure.

A constant room temperature must be maintained between 76-80 degrees Fahrenheit.

The client room should have adequate ventilation; adjustable lighting is desirable.

Sound-deadening measures should be used in order to ensure that the client's space is as sound-proof as possible.

Security measures must be provided for the laboratory and stimulus material.

It is recommended that a system be devised for the examiner to be able to determine when and if the client is attending to the stimuli being presented.

The door separating the client room from the examiner's work area should have an inside lock that the client can control.

I. CALIBRATION PROCESS

The strain gauge must be stretched adequately to obtain continuous variation. The mercury gauge requires 20% (slightly stretched on the cone) of its full scale. The Barlow gauge also requires moderate stretching.

The stretched gauge is then placed on a cone allowing measurement of at least $\frac{1}{2}$ centimeter increments. The gauge is moved down the cylinder until 3 cm of stretch is obtained (6 steps). This should be considered 100%, and sensitivity is then set on the plethysmograph.

The steps are then checked for linearity (each step on the cone equals proportionate steps on the plethysmograph). If a variation of greater than 25% occurs between steps, the process should be repeated. If a 25% or greater variation remains, discard the gauge and repeat the process.

If linearity cannot be obtained with multiple gauges, the plethysmograph is not functioning properly.

If the first or last step of the calibration procedure yields 25% or greater variation, the gauge was not fitted properly to the circumference device, or the gauge is faulty.

After the gauge is fitted to the client and adequate time has elapsed for detumescence, the sensitivity should be set at the "0" point.

At the completion of the assessment process, if the client achieved a full erection, then that level of change becomes 100%.

The penile plethysmograph should be calibrated.

Prior to each assessment, gauges should be calibrated over a minimum of six steps using an accurate calibration device.

Care should be exercised to avoid rolling the gauge while placing on the calibration cone.

J. FITTING THE PENILE TRANSDUCER

Placement of the gauge should be at midshaft of the penis.

Client should place gauge on his own penis.

Examiner should assure that wiring has some slack next to the transducer or clinical error may result. Clothing should not touch penis or transducer.

Recording of full penile tumescence should be obtained whenever possible. The examiner should ensure that sufficient arousal has been recorded to accurately interpret data. When data is to be interpreted as a percentage of full erection, it is important to request the client to achieve full erection.

The client should be instructed to exercise care to avoid rolling the gauge while placing it on his penis.

Proper fit can be determined by:

- (1) Setting the plethysmograph at zero before the client places the gauge on his penis.
- (2) Ensuring the gauge has stretched at least 20% after being placed on the penis.
- (3) Ensuring the gauge has not stretched more than 40%.

If the gauge has stretched more than 40%, the gauge is too small. If the gauge has stretched less than 20%, the gauge is too big.

After proper fit has been determined, the plethysmograph is reset to zero.

K. STIMULUS MATERIAL

The examiner will have available a range of sexual stimulus material depicting various Tanner Stages of development for both males and females, including culturally diverse subject material. Stimulus materials should also be available to differentiate between consenting, coercive, forcible, sadistic and aggressive themes with both adults and children.

Visual Stimuli:

Efforts should be made to use new technology which does not make use of human subjects.

Visual stimuli should be devoid of distracting stimuli.

Multiple stimulus presentations should be used for each Tanner stage.

Both sexes should be represented.

Stimulus duration should be consistent with research that has demonstrated validity.

The examiner should be satisfied detumescence has occurred and at least thirty seconds have elapsed before presenting new stimulus.

Audio Stimuli:

Audio stimuli should be sufficient to clearly differentiate minors from adults.

Stimuli should clearly differentiate consenting, coercive, forcible, sadistic and aggressive sexual themes.

Every effort should be made to use standardized stimuli reflecting the client's deviant sexual behavior.

Multiple stimuli presentations representing various normal and deviant sexual activity should be available.

L. DOCUMENTING ASSESSMENT DATA

Physiological assessments should be interpreted only in conjunction with a comprehensive psychological examination.

Written reports may include:

- (1) A description of the method for collecting data.
- (2) The range of physiological responses exhibited by client.

- (3) Any indication of suppression or falsification.**
- (4) An indication of the validity of the data and validity controls used.**
- (5) The types of stimulus materials used.**
- (6) Summary of highest arousal in each category.**
- (7) Client emotional state.**
- (8) Level of client cooperation.**
- (9) Interpretation of data.**

Any confounding physical or emotional inhibitors to sexual arousal.

M. DISINFECTANT PROCEDURES

Gauges will be disinfected prior to use, utilizing an accepted liquid immersion method or other accepted laboratory disinfection procedures.

A disposable covering will be used for protection over the chair seat and arms of the chair.

Client will place gauge in receptacle after use of the gauge and before leaving the testing room. Client will also dispose of protective coverings before leaving testing room.

Clinician should use disposable gloves and anti-bacterial soap after contact with gauges. Any items or articles that have been in contact with the client should also be disinfected.

Appendix E

DENIAL

There has been a limited amount of research conducted on denial specific to juveniles who commit sexual offenses. Although it remains unclear as to whether juvenile denial is associated with sexual recidivism (Weinrott , 1998; Kahn & Chambers, 1991), the research that has been conducted with juveniles who commit sexual offenses and engage in denial conclude that accountability is necessary for a positive treatment outcome (Hunter & Figueredo, 1999; Barbaree & Cortini, 1993) and that the treatment of denial should preclude sex offense specific treatment (Becker & Hunter, 1997; Barbaree & Cortini, 1993).

Barbaree & Cortini (1993) created a typology of denial and minimization that is applicable to both adults and juveniles:

Denial of the facts:

- Denial of any interaction with the victim**
- Denial the interaction with the victim was sexual**
- Denial the interaction with the victim was offensive**

Minimization:

Of responsibility

- Victim was to blame**
- External attributions (alcohol, was provoked)**
- Irresponsible internal attributions (past victimization, sex drive)**

Of extent of previous offensive behavior

- Frequency**
- Number of previous victims**
- Force Used**
- Intrusiveness**

Of harm

- Victim won't suffer long-term effects**
- No consequences were suffered by the victim**
- Benefits out-weigh the harm done to the victim**

Salter (1988) also created a classification system of denial among juvenile offenders:

- A. Admission with Justification**
- B. Denial of Behavior**
 - 1. Physical Denial With or Without Family Denial**
 - 2. Psychological Denial**
 - 3. Minimization of the Extent of the Behavior**
- C. Denial of the Seriousness of the Behavior and Need for Treatment**
- D. Denial of Responsibility for Behaviors**
- E. Full Admission with Responsibility and Guilt**

French (1988) outlined common denial strategies among adolescent offenders:

Common Denial Strategies:

- A. Adolescent denies having committed the offense and offers alternative stories and explanations as to the circumstances of the offense.**

- B. Adolescent emphatically denies that he had anything to do with the offense, while offering no alternative explanations as to the origin of the accusations.
- C. Adolescent avoids the important facts through excessive elaboration on related but insignificant aspects of the offense.
- D. Adolescent takes an offensive stance toward the interviewer by means of verbal attack (accuses the interviewer of lying and attempts to expose weaknesses in the interviewer).
- E. Adolescent withdraws from the interview by refusing to discuss anything with the interviewer.
- F. Adolescent uses "I don't remember" as his response to confrontation.

Barbaree, H.E. & Cortini, F.A. (1993). Treatment of the juvenile sex offender within the criminal justice and mental health systems. In H.E. Barbaree, W.L. Marshall, & S.M. Hudson (Eds.), The Juvenile Sex Offender (pp. 243-263). New York: Guilford Press.

Becker, J.V., & Hunter, J.A. (1997). Understanding and treating child and adolescent sexual offenders. In T.H. Ollendick & R.J. Prinz (Eds.), Advances in Clinical Child Psychology: Vol. 19. (pp. 177-197). New York: Plenum Press.

French, D. (1988). Distortion and Lying as Defense Processes in the Adolescent Child Molester. Journal of Offender Counseling, Services, & Rehabilitation, Vol. 13(1) 27-37.

Hunter, Jr., J.A., & Figueredo, A.J. (1999) Factors associated with treatment compliance in a population of juvenile sexual offenders. Sexual Abuse: A Journal of Research and Treatment, 11, (1), 49-67.

Kahn, T.J., & Chambers, H.J. (1991). Assessing reoffense risk with juvenile sexual offenders. Child Welfare, 70, 333-345.

Salter, A. (1988). Treating Child Sex Offenders and Victims: A Practical Guide. Beverly Hills: Sage Publications.

Weinrott, M. (1998). Recidivism among juvenile sex offenders: Are favorable outcomes only favorable when therapy matters? Handout from Empirically-based treatment interventions for juvenile sex offenders. Presentation sponsored by the Child Abuse Action Network and the State Forensic Service, Augusta, ME.

Appendix F

SPECIAL POPULATIONS

Excerpted and adapted from the Ethical Standards and Principles for the Management of Sexual Abusers, the Association for the Treatment of Sexual Abusers (1997).

There is a growing awareness of the importance of designing and implementing specific treatment programs sensitive to diverse populations. Many of the evaluation and treatment procedures currently being used have been developed by the majority culture and do not reflect awareness or sensitivity to differences within minority populations. It is incumbent upon the service providers in this field to modify and adapt the generally accepted treatment techniques, standards and principles to those special populations that they serve.

- A. Where differences of age, gender, race, ethnicity, national origin, religion, sexual orientation, disability, language or socioeconomic status significantly differ from the service provider's experience and/or orientation, it is imperative that the treatment provider obtain the training and/or supervision necessary to ensure the adequacy of the services provided.
- B. If it is not feasible to obtain training and/or supervision to adequately provide services to a special clientele, referral to a service provider who does possess the necessary knowledge and skills is required.
- C. Emphasis should be placed on the development of specific programs and treatment plans that address the sexually abusive/offending behavior within the context of the minority group culture.
- D. Service providers must acknowledge and educate themselves about their own ethnic, cultural, racial and/or professional biases and assumptions.
- E. Special care and attention should be given to the environment in which the juvenile will spend most of his or her time, both during and following treatment intervention.

Appendix G

SEX OFFENDER MANAGEMENT BOARD ADMINISTRATIVE POLICIES

Revised for Juvenile Standards publication, July, 2002.

- A. Individuals on the Provider List who work for or with a juvenile sex offense specific treatment program shall notify the Board in writing if they leave the program and continue to provide 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 their change in employment.
- B. 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.
- C. 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 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.
- D. 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 these 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.
- E. 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 remediated by additional information.
- F. Any applicant who is denied placement on the Provider List will be supplied with a letter from the Application Review Committee outlining the reasons for the denial and notifying them of their right to an appeal to the Board in its entirety.
- G. Any provider who is denied placement on or removed from the Provider List shall not provide any services in Colorado to juveniles who have committed sexual offenses without written permission from the Board.

Unless written permission from the Board has been attained, no listed provider shall use any provider denied placement on, or removed from the Provider List, for services in Colorado for juveniles who have committed sexual offenses.

H. 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 45 minutes long: 15 minutes for a verbal presentation by the complainant; 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.

I. When a complaint is made to the Sex Offender Management Board about a listed or unlisted treatment provider, evaluator, plethysmograph or Abel Assessment examiner or polygraph examiner, 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 for 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 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 Evaluation, Assessment, Treatment and Supervision of Juveniles Who Have Committed Sexual Offenses to the person identified in the complaint for informational purposes.

Complaints appropriate for Sex Offender Management Board intervention are those complaints against juvenile sex offense specific treatment providers, evaluators, plethysmograph examiners and polygraph examiners who are listed on the Provider List when the complainant alleges 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 his/her 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 Application Review Committee may:
 - a. Request more information from the complainant
 - b. Request a response from the identified provider
 - c. Initiate and carry out, or cause to be carried out, an investigation of the complaint, either directly or through staff, investigators or consultants
 - d. Hold a hearing before the committee requesting both parties to appear.

The Application Review Committee 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 Application Review Committee 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 Committee may recommend changes in the provider's services, additional training or supervision. The letter of admonition and the provider's response to the Committee'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 Committee'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.
- J. 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 party requesting the appeal 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 the complainant; 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 Board will notify both parties of its decision in writing.**
- 6. The decision of the Board will be final in the appeal process.**

Appendix H

DENIAL OF PLACEMENT ON PROVIDER LIST

The Board reserves the right to deny placement on the Provider List to any applicant applying to be listed as a treatment provider, evaluator, polygraph examiner or plethysmograph examiner, Abel Assessment examiner or program under these Standards.

Reasons for denial include, but are not limited to:

- A. The Board determines that the applicant does not demonstrate the qualifications required by these Standards**
- B. The Board determines that the applicant is not in compliance with the standards of practice outlined in these Standards**
- C. The applicant fails to provide the necessary materials for application as outlined in the application materials and the administrative policies and procedures**
- D. The applicant has been convicted of or received a deferred judgment for any criminal offense**
- E. The applicant has been found to engage in unethical behavior by any licensing or certifying body or has had a license or certification revoked, canceled, suspended or been placed on probationary status by any professional oversight body**
- F. The applicant is addicted to or dependent on alcohol or any habit forming drug as defined in section 12-22-102, C.R.S., or is a habitual user of any controlled substance as defined in section 12-22-303, C.R.S.**
- G. The applicant has a physical or mental disability which renders the applicant unable to treat clients with reasonable skill and safety or which may endanger the health or safety of persons under the individual's care**
- H. The Board determines that the results of the background investigation, the references given or any other aspect of the application process are unsatisfactory.**

Appendix I SYNOPSIS OF SUPPORTING RESEARCH

The Colorado Sex Offender Management Board has worked diligently to promote research based Standards and Guidelines. Following is a listing and synopsis of the research or published articles cited as footnotes in these Standards.

The authors' terminology regarding juveniles who commit sexual offenses is used in each synopsis for consistency with the citation.

Introduction

Judith Becker (1998) conducted a thorough review of recent empirical research on the characteristics and treatment of juvenile sex offenders. Her findings revealed a lack of longitudinal data available to support the speculation that if adolescents commit a sexual offense, they will continue offending into adulthood. In addition, she cautions against the notion of juveniles needing monitoring for the rest of their lives if they have committed a sexually inappropriate behavior. Similarly, Becker and Hunter (1997) provided recidivism rates from several studies of juvenile sexual offenders who have received treatment:

Kahn and Chambers' (1991) 20 month follow-up study on 221 juvenile sex offenders treated in 10 programs had a sexual recidivism rate of 7.5% with an overall recidivism rate of (both sexual and nonsexual) 44.8%.

Schram, Milloy, and Rowe (1991) conducted an extended follow-up study with Kahn and Chambers' sample, of which 197 participated, and found 12.2% having been arrested for a sex offense and a 10% conviction rate.

Bremer (1992) reported recidivism rates of residentially treated juvenile sex offenders with a follow-up period ranging from several months to six years. Eleven percent re-offended sexually, 6% were convicted for nonsexual offenses.

Becker (1990) provided 2-years of follow-up data on 80 juvenile sex offenders who were treated on an outpatient basis and found 8% had sexually re-offended.

Guiding Principles 2,3

In 1998, Kim English concluded a multi-faceted 2-year study (English, Pullen, & Jones, 1996) that involved surveys of probation and parole supervisors; extensive literature review on victim trauma and sex offender treatment; a systemic document review of materials ranging from agency memoranda and protocols to legislation and administrative orders; and field research in the area of community management of sex offenders. The findings suggested a sex offender containment approach that consisted of five components; one of which focused on community safety. Within this component, English concluded, "The effects of sexual assault on victims are often brutal and long-lasting...Psychological recovery from the assault is often prolonged for victims of these types of assaults." For those reasons, the community safety component valued and supported the need for a victim-oriented philosophy (as well as a public safety approach) for the containment and treatment of sex offenders.

Guiding Principle 12

Hagan and Gust-Brey (2000) followed the transition of 50 12-19 year-old perpetrators of sexual assault against children upon their return to the community after successfully completing a sex offender treatment program. The goals of their study were to determine the risk they presented for sexual and other re-offending. Ten years later, 86% of the adolescent perpetrators had been involved in another crime. Only 20% re-offended sexually, while 60% re-offended non-sexually.

Guiding Principle 12, 20

In 1996, M. Weinrott conducted a critical review of studies on juvenile sexual aggression. In his review of recidivism studies, he concluded that most males who sexually abuse younger children do not re-offend sexually (at least during the 5-10 years following apprehension). He also stated that juvenile sex offenders are more likely to come to the attention of police for nonsexual offenses.

Guiding Principle 14

Ageton and her colleagues (as cited in Prentky, et al., 2000) developed a theoretical model for adolescent sexual offenders that included strain measures, bonding to conventional social order, integration into a delinquent peer group, and a variety of variables aimed at sexual assault. Of these variables, four correctly classified 77% of the juveniles that re-offended sexually—involvement with delinquent peers, crimes against persons, attitudes towards rape and sex assault, and family normlessness. Further discriminant analysis revealed that involvement with delinquent peers correctly classified 76% of the cases.

Guiding Principle 14

Bagley and Shewchuk-Dann (1991) (as cited in Righthand and Welch, 2001) conducted a comparison study of juvenile sex offenders and other juvenile offenders in two residential treatment centers. They found sexually assaultive juveniles typically come from families that evidence severe pathology, including child maltreatment, and that the parents had higher levels of marital stress. They also found that the parents of the sexually assaultive group had more mental health problems that required intervention and the fathers had greater rates of alcohol abuse. Miner, Siekert, and Ackland (1997) (as cited in Righthand and Welch, 2001) described the juvenile sex offenders in their sample as, “coming from chaotic family environments. Nearly 60% of the biological fathers had substance abuse histories and 28% had criminal histories. Biological mothers, when compared to fathers, were less likely to have substance abuse histories or criminal histories. The mothers, however, were more likely than the fathers to have a history of psychiatric treatment.” Smith and Israel (1987) (as cited in Righthand and Welch, 2001) found that some parents of juveniles who sexually assaulted their siblings “were physically and/or emotionally inaccessible and distant.”

Guiding Principle 20

Worling (2000) collected recidivism data from a National Database for 148 adolescent sex offenders (ages 12-19 years) who were assessed at the SAFE-T program. The treatment group was made up of 58 offenders who participated in at least 12 months of specialized treatment (group, family, and individual treatment) and the comparison group consisted of 90 adolescents who received only an assessment, refused treatment, or dropped-out prior to a 12 month period. The follow-up period ranged from 2–10 years. He found the sexual assault recidivism rate for the comparison group (18%) was 72% higher than the recidivism rate for the treatment group (5%). For nonviolent offenses, the comparison group was 59% higher than the treatment group.

Section 1.600

Marshall (1999) reported, “Although formal assessments of the offenders are essential, it is also crucial to have available information from external sources (police reports, victim statements, and possibly court records) so that the interviewer may challenge the offender’s report. We have found that offenders typically represent themselves in an exculpatory manner and that many outright deny they ever committed an offense (Marshall, 1994). Without the external information, we would have little basis to challenge the offender’s account, and as a consequence, we would come to inaccurate conclusions.”

Section 2.100

Quinsey, Harris, Rice, and Cormier (1998) reported on numerous studies on clinical judgment in regard to prediction of violence. His overall conclusion to these studies was that “clinical intuition, experience, and training at least as traditionally conceived are not helpful in either prediction or treatment delivery. Although discouraging, this conclusion is not nihilistic. Training, in the sense of knowing the empirical literature and relevant scientific and statistical techniques, must improve the selection of appropriate treatments, treatment program planning, and evaluation.”

Section 3.120

Borduin, Henggeler, Blaske, Stein (1990) compared the efficacy of multisystemic therapy (MST) and individual therapy in an outpatient treatment setting for 16 male adolescent sexual offenders. Multisystemic treatment targeted characteristics of the adolescent offender and his family and peer relations that have been linked with sexual offending. Specifically, it looked at cognitive processes, family relations, peer relations, and school performance. Individual therapy provided counseling that focused on personal, family, and academic issues. The MST group had recidivism rates of 12.5% for sexual offenses and 25% for nonsexual offenses. The Individual Therapy group had significantly higher recidivism rates: 75% for sexual offenses and 50% for nonsexual offenses.

Section 3.120

Marshall and Barbaree (1990) looked at outcome evaluations of several cognitive-behavioral programs for the treatment of sexual offenders. These programs are comprehensive in terms of the range of problems addressed in treatment, from social-skills training to reducing deviant interests and increasing appropriate sexual desires. One of the studies reviewed had a comparison group of traditional psychotherapy. This study of incarcerated sex offenders who received a behavioral program was found to be far more effective than a more traditional psychotherapy program in meeting the within-treatment goals (Marshall & Williams, 1975). They went on to say, “The behavioral program achieved its goals in changing various features of these offenders, whereas psychotherapy did not.” In addition, Marshall and Barbaree concluded that most cognitive-behavioral programs combine individual therapy components with group therapy components. They presented rationale for group therapies led by co-therapists (both male and female): 1) individual therapy is costly and sometimes inefficient in that what needs to be learned is better presented to groups of patients by more than one therapist, 2) having both a male and female therapist can offer different views on sexual offending, 3) modeling by two therapists of egalitarian male/female relationships can facilitate change in attitude, and 4) other group members can provide insight into fellow offenders’ problems on the basis of personal experience, which the therapist does not possess.

Section 3.140

Miner and Crimmins (1997) conducted a study with 78 youths in sex offender treatment programs in Minnesota. Two comparison groups were also used, using data from the third nationwide survey of the longitudinal sample of the NYS (National Youth Surevey). The two comparison groups were comprised of violent youth with no behaviors considered to be a sex offense, and non-delinquent youth. Some of the findings from this study suggested that sex offenders hold negative attitudes toward delinquent behavior, more so than non-delinquent youth, and are “more normless in their beliefs about family interactions than either of the other groups.” In addition, sex offenders were more likely to be isolated from peers and families than non-delinquent youth and violent youth. Overall, the study supported a social control theory of sex offending, independent from other forms of juvenile delinquency. The primary difference in this sample was the isolation from both peers and their families for the sex offender group. Because of this finding, Miner and Crimmins concluded that breaking the process of social isolation may have some impact on the development of sexually inappropriate behavior. Using group therapy, social-cognitive intervention strategies, and family interventions would help to achieve these goals.

Section 3.140

Sirles, Araji, and Bosek (1997) conducted an overview of numerous programs and practices used by therapists who are working with sexually abusive children and their families. Although most of the programs reviewed haven’t been tested empirically, their overview identified theories used to guide programs as well as goals for intervention. As a result, a list of 10 factors were suggested as an aid in program development and treatment planning:

1. The treatment of preadolescent sexual aggression requires a comprehensive knowledge of biopsychosocial theories of sexuality and aggression to guide in the development of intervention models.
2. A treatment model should incorporate theories of child development, sexual abuse, trauma, reciprocal cycles of abuse, learning, relapse prevention, and systems theories.
3. The treatment should incorporate cognitive and behavioral interventions that place responsibility for behavior with the child and address sexual aggression as a learned behavior that is changeable.
4. Family systems theory and therapy need to be integrated into treatment models to address dysfunctional family dynamics.
5. Group, peer, or pair therapy are useful methods for working with sexually aggressive youth. Children are best managed and treated in developmentally divided age groups.
6. Treatment that is individually tailored and offense specific offers the greatest likelihood for success.
7. Treatment goals should target eliminating sexually abusive and aggressive behavior, increasing behavior controls, and developing competencies for coping with precursors to sexual aggression.
8. When appropriate, treatment needs to address the history of sexual abuse of the perpetrator—that is, victimization issues.
9. Parental groups are an effective means for teaching parents the skills necessary to prevent further aggression and abuse by themselves and their children.
10. When needed, referrals should be made to specialized programs, agencies, or therapists to facilitate as comprehensive a treatment approach as local services allow.

Section 3.140

Bernet and Dulcan (1999) also conducted an overview of the currently available psychosocial and biological treatment of children and adolescents who are sexually abusive of others, along with the literature available. Again, most of these treatment types haven't been tested empirically, however, they were able to conclude that, "group therapy with juvenile sex offenders provides a context in which the sexual abuser is unable to easily minimize, deny, or rationalize his or her sexual behaviors. Peer group therapy, as the medium for therapeutic interventions, is used in a number of different ways depending on the setting, group membership, severity of the sexual offenses, group goals and objectives, whether the groups are open or closed, and the length of the group experience." They also found through their research that family therapy may be most useful in cases of incest. Furthermore, "Family therapy facilitates the learning of new ways of communicating and building a support system which will help interrupt the abuse cycle and ultimately be supportive to the offender's capacity for regulating and modulating aggressive sexual behavior." Bernet and Dulcan found that individual therapy is usually used in conjunction with other treatment approaches.

Section 3.151

Hanson and Harris (1998 – 2001) conducted a study of dynamic risk factors that involved retrospective comparisons of 208 sexual offenders who had recidivated while on community supervision and 201 offenders who had not recidivated. The study has several findings, some of which include: the recidivists viewed themselves as little risk for committing new sexual offenses and took few precautions to avoid high risk situations; were more likely to engage in socially deviant sexual activities; showed little remorse or concern for their victims; had a generally chaotic, antisocial lifestyle, resisted personal change, and held strongly antisocial attitudes; had poorer self-management strategies; had poor social support; and had an increase in anger and subjective distress.

Section 3.151

Cortoni & Marshall (2001) studied sexual activity functions as a coping strategy for sexual offenders among 89 incarcerated offenders, 59 of whom were sexual offenders. Sexual offenders reported using sexual activities (both consenting and non-consenting) as a coping strategy for stressful and problematic situations at a higher rate than non-sexual offenders. When compared to non-sex offenders, sex offenders evidenced a sexual preoccupation during adolescence, which was related to the use of sex as a coping strategy.

Section 3.540

Becker and Hunter (1997) discussed the treatment of adolescent sex offenders in their article, "Understanding and Treating Child Adolescent Sexual Offenders." Because of the numerous reasons juveniles may deny their behavior (shame, embarrassment, fear of consequences), they stated the first step in treatment for the juvenile should include having the juvenile accept responsibility for his or her behavior. Educating the juvenile about what treatment can offer, such as learning how to develop and sustain healthy relationships with peers, may help persuade them to discuss problem areas. Also, juveniles placed in group treatment with other juveniles who have accepted responsibility for their behavior gives them both an opportunity to see that they're not alone and allows the "admitters" of the group to relate to the "deniers"—that they were once in that place.

Section 3.540

In Ryan and Lane's book, Juvenile Sexual Offending, Lane writes about juvenile sex offenders in denial. She reported that if a youth is in denial or not taking responsibility for a sexually abusive behavior, he or she will not benefit from offense-specific treatment, nor will he or she be able to manage his or her sexually abusive behavior patterns. Therefore, efforts should be made to first address his or her denial and ascertain what type of treatment setting would be most appropriate.

Section 3.540

Kahn and Chambers (1991) conducted a two-year study of juvenile sexual offenders who received both community and institution based treatment. Recidivism data was collected over a 20-month follow-up period. Of their findings, one of a few variables found to have a significant relationship to sexual re-offending was blaming the victim. Offenders who blamed their victim and used verbal threats had somewhat higher sexual recidivism rates than those who did not. A surprising find was that of the eight adolescents who denied their sexual offenses, none re-offended sexually during the follow-up period. Kahn and Chambers stated that there could be several explanations for that finding, but it is worth further exploration and study.

Section 3.540

In The Juvenile Sex Offender (Barbaree, Marshall, Hudson, 1993), Barbaree and Cortoni address the issue of denial and minimization among juvenile sex offenders. They stated that an offender in denial will not be able to progress in treatment. In addition, denial and minimization need to be reduced in order for the offender to develop victim empathy, which is necessary to work toward change in his or her behavior. Therefore, they suggested addressing denial and victim empathy as a first stage in treatment.

Section 3.610

Langstrom and Grann (2000) analyzed risk factors for 46 young sex offenders from 1988 – 1995. Sixty-five percent of this sample re-offended (20% re-offended sexually). Risk factors they found to be associated with elevated risk of sexual re-offending for this sample include early onset of sexually abusive behavior, male victim choice, more than one victim, and poor social skills.

Introduction,
Section 5.100

The Association for the Treatment of Sexual Abusers, an international organization with a membership of over 2000 professionals committed to the prevention of sexual assault through effective management of sex offenders, adopted a position paper on the effective management of juvenile sexual offenders in March of 2000. This paper states that there is little evidence to support the assumption that most juvenile sexual offenders are destined to become adult sexual offenders. The reasoning for this, as stated in the paper, is the significantly lower frequency of more extreme forms of sexual aggression, fantasy, and compulsivity among juveniles than among adults which suggests that many juveniles have sexual behavior problems that may be more amenable to treatment. They go on to say that recent studies suggest that many juveniles who sexually abuse will cease this behavior by the time they reach adulthood, especially if provided with specialized treatment and supervision. Research also states that juvenile offenders may be more responsive to treatment because of their emerging development. In addition, ATSA believes that effective public policy requires the balancing of criminal justice sanctions, to enhance public safety and to punish criminal acts, with providing interventions to juveniles who are amenable to treatment.

Section 5.100

The National Task Force on Juvenile Sexual Offending (1993) as cited in Hunter and Figueredo's (1999) paper on the factors associated with treatment compliance of juvenile sexual offenders states that the interface between mental health and criminal justice systems is necessary for a sound public health policy in regard to juvenile sexual offenders.

Section 5.100

McGrath, Cumming, and Holt (2002) conducted a study with treatment providers, probation officers, and parole officers about their collaboration in the treatment and supervision of sex offenders. One hundred and ninety treatment programs throughout the nation completed a survey questionnaire that asked about program size and approach; age, gender, education, and professional affiliation; type, frequency, and value of different methods of communication their program had with probation officers; and a rating of several scenarios of communication between treatment providers and probation officers commonly used throughout the US. Treatment provider and probation officer communication was shown to be valued, common, and frequent. Over 87% described open communication as essential for effectively managing this population in the community.

Section 5.100

Bischof, Stith, and Whitney (1995) studied the family environments of adolescent sex offenders and other juvenile delinquents. The Family Environment Scale (FES) Form-R was completed by 105 adolescent males in various outpatient and residential programs. Thirty-nine were sex offenders, 25 were violent non-sex offenders, and 41 were non-violent, non-sex offenders. Although a nondelinquent control group was not used in this study, FES has been normed to the general population and those norms were used as comparison scores. No differences were found among the delinquent groups, however, several differences were evidenced among the delinquent groups when compared to the normative scores. The delinquent groups considered their families to be less cohesive, less expressive, and having a lower level of independence when compared with the non-delinquent group scores. These findings suggest that the families of adolescent sexual offenders are similar to those of violent and nonviolent juvenile delinquents in most ways assessed by the FES. Therefore, family interventions which have been demonstrated effective with juvenile delinquents in general are likely to be helpful with juvenile sex offenders as well.

INDEX

a

Abel Assessment, see objective measures, 8, 34, 50, 52, 53, 55, 56, 77, 95, 137
aftercare, 8, 11, 26, 39, 43, 44, 46, 47
assessment, 1, 5, 6, 8, 11, 12, 13, 16, 20, 21, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 41, 43, 45, 46, 47, 48, 50, 51, 52, 55, 56, 57, 62, 63, 64, 68, 70, 73, 75, 76, 77, 79, 82, 84, 85, 87, 88, 95, 99, 101, 106, 113, 121, 122, 124, 125, 132, 140, 141

c

caregivers, 11, 18
caseworker, 12, 20, 26, 29, 79, 80, 81, 82, 86, 87, 88, 95, 103, 109, 111, 112, 113, 114, 115
case manager, 79
clarification, 39, 40, 43, 56, 57, 80, 86, 102, 105, 106, 107, 108
coercion, 4, 20, 29
community safety, 1, 3, 5, 8, 16, 26, 46, 81, 82, 84, 139
community supervision, 6, 8, 12, 14, 21, 22, 44, 82, 83, 90, 95, 143
complete case record, 12
confidentiality, 44
contact, 12, 13, 30, 31, 32, 33, 34, 35, 36, 49, 105, 106
continuum of care, 12, 23, 67

d

deferred adjudications, 1, 19, 37
denial, 35, 48, 68, 76, 85, 127
Department of Corrections, 37, 46, 77
Department of Human Services, 1, 12, 37, 46, 65, 77, 80, 81, 87, 878, 89
discharge. see release.
Division of Probation Services, 95
Division of Youth Corrections (DYC), 18, 64, 88, 89, 91, 136

e

evaluation, 1, 4, 5, 6, 13, 16, 18, 19, 20, 21, 22, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 43, 44, 45, 47, 48, 49, 50, 55, 56, 57, 59, 60, 62,

63, 64, 65, 76, 77, 78, 79, 82, 84, 85, 88, 92, 95, 129, 132, 136

evaluation and assessment, 25

evaluator, 21, 22, 26, 27, 28, 29, 48, 58, 59, 61, 62, 63, 77, 132, 137

g

general topic areas, 57

guardian ad litem, 92, 93

i

informed supervision, 14, 109, 111, 113

informed supervisor, 65, 89, 90, 91, 97, 106, 107, 109, 111, 112, 113, 114

m

monitoring, 1, 5, 26, 51, 52, 70, 73, 79, 83, 84, 91, 95, 99, 100, 101, 121

multidisciplinary team, 2, 3, 4, 5, 11, 12, 15, 26, 37, 38, 39, 40, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 59, 60, 62, 64, 65, 66, 68, 69, 70, 72, 73, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 95, 96, 97, 98, 99, 100, 101, 102, 105, 106, 107, 108, 109, 113, 115

o

objective measures of sexual arousal or interest, see Abel Assessment and plethysmograph 50

out-of-home placement, 1, 20, 37, 79, 80, 86, 88

p

parent, 7, 13, 14, 21, 28, 29, 39, 44, 45, 46, 51, 79, 82, 83, 86, 87, 91, 96, 97, 100, 106, 113, 114

parent/guardian, 14, 28, 29, 44, 45, 46, 51, 82, 83, 96, 97, 113, 114

parole, 1, 12, 17, 26, 37, 44, 46, 77, 79, 86, 95, 117

plethysmograph, see objective measures. 50, 51, 52, 55, 74, 75, 76, 95, 122, 123, 124, 125, 132, 137

polygraph, 34, 35, 56, 58, 68, 70, 71, 73, 80, 87, 100, 102, 103, 117, 118, 119

presentence investigation (PSI), 19, 20, 21, 22, 26, 79, 83

pre-trial, 26

probation, 19, 26, 37, 97

probation officers, 19

programs, 38, 55, 64

programs that provide out-of-home and day treatment, 64

r

relapse prevention, 8, 9, 16, 27, 38, 39, 41, 44, 46, 47, 81, 108

release, 26. see termination

reunification, 39, 57, 83, 86, 106, 107, 108

risk assessment, 5, 16, 19, 56

risk factors, 8, 13, 17, 25, 41, 47, 86, 91, 109, 111, 143, 144

s

schools/school districts, 92

sex offense specific evaluation, 20

sex offense specific training, 2, 16, 19, 37, 38, 41, 43, 49, 55, 56, 59, 85, 92

supervising officer/agent, 47, 79, 80, 81, 82, 83, 84, 85, 86, 90, 95, 96, 97, 98, 103, 107, 109, 113, 114, 115

t

termination, 26, 47. see release.

therapeutic care, 18, 115

therapeutic care provider, 89, 90, 91, 112, 115

treatment plan, 21, 58

treatment provider, 37, 44, 45, 50, 55, 59, 73, 77, 86, 89

u

underlying factual basis, 1,19,37

v

victim impact statement, 19, 21, 36

victim(s), 7, 20, 29, 36, 40, 47, 49, 57, 58, 60, 81, 83, 86, 88, 90, 91, 92, 93, 96, 97, 105, 106