The Juvenile Standards Implementation Assessment Project

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Executive Summary:

The Juvenile Standards Implementation Assessment Project was initiated to gather information regarding the status of implementation of the *Standards and Guidelines For The Evaluation, Assessment, Treatment and Supervision of Juveniles Who Have Committed Sexual Offenses* (Juvenile Standards) in Colorado. A grant, funded by the United States Department of Justice, Office of Justice Programs, Bureau of Justice Assistance, supported the provision of assistance to 11 judicial districts in Colorado to conduct a formal, structured assessment process of the eight areas of the Juvenile Standards. The information gathered was used to identify patterns regarding the extent to which the Juvenile Standards have been implemented as well as the challenges and barriers to full implementation of the Juvenile Standards in Colorado. The findings are promising in many aspects, but also raise concerns regarding systemic issues that affect the full implementation of the Juvenile Standards.

Respondents within the 11 participating judicial districts reported that they had implemented the majority of the Juvenile Standards prior to the July 1, 2006 target date for full implementation. Areas of strengths that were identified include: pre-sentence investigations are being completed by appropriately trained probation officers; probation is providing offense specific training to officers and supervisors; offense specific assessments and treatment services are being provided by Sex Offender Management Board (Board) approved providers; Multidisciplinary teams (MDT's) are typically being convened and functioning with the appropriate personnel; special terms and conditions are being utilized by probation and parole; polygraphs are typically being used appropriately; and MDT's are addressing clarification and reunification issues.

The project also identified needs in the following areas: documentation and information sharing; timely and adequate training for various stakeholders; individualization of treatment services to meet developmental needs; and victim issues regarding training, contact and representation on MDT's. Additionally, participants in the project identified challenges and barriers that were best described as "systemic issues." These "systemic issues" are categorized as: resource constraints; limited specialized treatment capacities; continuum of services barriers; and less than optimal collaboration. The nature and scope of these challenges have a number of implications that may warrant attention at the broader policy level, as they have the potential to impact the implementation of the Juvenile Standards and the overall management of juveniles who have committed sex offenses.

BACKGROUND

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 (Board) to develop and prescribe a standardized set of procedures for the evaluation, assessment, treatment and supervision of juveniles who have committed a sexual offense. The legislative mandate to the Board was to develop and implement methods of intervention for juveniles who have committed sexual offenses that have as a priority the physical and psychological safety of victims and potential victims.

The scope of the mandate is broad, requiring that the Board develop and implement guidelines and standards for a system of programs to be utilized with juveniles who have

committed sexual offenses 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.

Subsequently, the Board created the *Standards and Guidelines for the Evaluation, Assessment, Treatment and Supervision of Juveniles Who Have Committed Sexual Offenses* (Juvenile Standards), which were first published in 2002 and then revised in July 2003. Although not specifically outlined in the provisions of the statute, 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.

When the Juvenile Standards were first published, the Board requested that agencies and treatment providers "do what you can within existing resources." The ***Board ultimately established July 1, 2006*** as the target date by which the Juvenile Standards should be fully implemented statewide.

JUVENILE STANDARDS IMPLEMENTATION PROJECT

The Juvenile Standards Implementation Project is funded by a federal grant from the United States Department of Justice, Office of Justice Programs, Bureau of Justice Assistance (BJA) and is staffed by the Sex Offender Management Unit in the Division of Criminal Justice (DCJ). The Advisory Group for the project includes representatives from the Sex Offender Management Board (Board), a technical advisor from the Center for Sex Offender Management (CSOM), the Division of Criminal Justice, State Judicial Office Division of Probation Services, the 8th Judicial Probation Department, and other community agencies. Core members of the Advisory Group worked with the technical advisor from CSOM to identify key stakeholders, finalize the composition of the Advisory Group, establish a formal mission, and clarify specific goals and objectives to guide the project.

The mission of the project is to promote the full implementation of the *Standards and Guidelines for the Evaluation, Assessment, Treatment and Supervision of Juveniles Who Have Committed Sexual Offenses* (Juvenile Standards) through identifying barriers and

creating strategies to address those barriers, as well as identifying strengths and assets which can serve as models. Additionally, this project provided an opportunity for individuals and agencies to network with other teams from across the state and to share their experiences regarding the implementation of the Juvenile Standards with the Board.

Originally, the Advisory Group proposed to work with stakeholders in each Colorado judicial district to inventory and assess current practices relative to the implementation of the Juvenile Standards. The Advisory Group also planned initially to work with each judicial district to develop and prioritize approaches to improve current practice, prepare an implementation plan, share solutions across jurisdictions, and provide limited resources to assist each of the 22 judicial districts and the Division of Youth Corrections with implementing these plans.

To facilitate a structured assessment process, the Advisory Group developed an assessment tool based directly on the Juvenile Standards. This tool was designed to identify the extent to which the Juvenile Standards were implemented in each of the participating districts and any barriers to implementation. The data gathered from the assessment can assist the participating districts with developing action plans to promote the overall goal of full implementation of the Juvenile Standards.

Ultimately, in order to accommodate the resource and logistical issues of managing the project on a statewide level, the Advisory Group made the determination to reduce the size of the project by one half. The opportunity to participate in the project was announced statewide, and interested districts were asked to submit a letter of interest in response to the solicitation. Eleven judicial districts volunteered to participate and all were included in the project. The original staffing plan for the project (four regional contracted site coordinators) was then modified to use grant-designated positions at the Division of Criminal Justice. A half-time coordinator was hired in May 2005 to manage four judicial districts and the full time coordinator in July 2005 to manage seven judicial districts. When the half-time site coordinator left the project in November of 2005, the full time coordinator assumed responsibility for all eleven judicial districts given the immediacy of data collection timeframes.

METHODOLOGY AND SAMPLE

Participating districts and teams

Eleven judicial districts from across the state submitted letters of interest to participate in the assessment project. These districts (1st, 4th, 5th, 6th, 9th, 11th, 14th, 17th, 18th, 20th, and 21st) represented both urban and rural areas. It is important to note that some of the judicial districts are comprised of multiple counties and, in some cases, span large geographical areas. Consequently, the agencies and individuals participating in any given judicial district were not always reflective of all of the agencies and communities in that particular judicial district.

Various stakeholders in districts participated in the assessment process, including representatives from Probation Departments, Department of Human Services, school districts, treatment providers, victim advocates, judges and magistrates, district attorneys, Division of Youth Corrections and community based youth service agencies. The composition of teams in each participating judicial district was quite varied for a number of reasons. Some of the judicial districts had pre-existing multidisciplinary teams in place and had been working together locally for several years on issues related to juveniles who sexually offend. Others were in the initial stages of creating collaborative

teams and struggling with eliciting the involvement of a wider base of stakeholders in their communities. The site coordinators assisted these teams with the process of developing and/or strengthening their collaborative teams. It is fair to say that in the judicial districts that were newer to the process, the driving energy was typically the efforts of a small number of dedicated people who acknowledge and value the importance of providing supervision, management and treatment services to juveniles who have committed sexual offenses and are actively seeking knowledge and support to be effective in this endeavor.

Initially, the site coordinators conducted on-site visits with each of the judicial districts to further explain the project and initiate preliminary discussions regarding perceived strengths, challenges, barriers, and needs within the district. In addition, a full-day orientation workshop was conducted on September 19, 2005, in Frisco, Colorado, for all of the participating judicial districts. Seventy-one people representing all of the eleven judicial districts attended the workshop, which was presented by the Advisory Group. The workshop provided an overview of the project, a presentation on effective collaboration for criminal justice teams, group activities to begin to consider their current status with respect to the implementation of the Juvenile Standards in their respective districts, and an overview of the assessment tool. The assessment tool was provided to the judicial districts immediately following the orientation workshop.

Approaches to the assessment process

Throughout the course of the project, site visits for the assessment process were scheduled with each participating judicial districts based on the availability of their groups to meet. Some teams were able to schedule all day reviews and others could only meet for brief periods of several hours at a time over a period of several months with members of the groups working on the assessment in between meetings. This aspect was very site specific and determined by the individuals in the groups and the time allowable for their involvement in the project. The site coordinator consulted with the districts individually to determine the manner by which they would conduct the assessment. Their approaches varied depending on the parties involved, policies and philosophies regarding confidentiality and information sharing, and in some cases, logistical issues. Participating districts were encouraged to have a multidisciplinary team composition so that the process had more objectivity, and to promote more thorough discussions of cross-disciplinary issues. Some of the teams organized themselves into subcommittees, while others chose to conduct the assessment as a larger team. Some of the smaller communities had very small populations of juveniles on which to base their system wide assessment, while other districts has large numbers of juveniles and therefore selected representative samples of cases to review. Case sampling and reviews were primarily dictated by what the teams believed was most feasible on a site-specific basis. Teams varied in the extent to which they were task- or process-focused, and ways in which they reviewed their local practices, philosophies, and information sharing. The DCJ site coordinator was present at most of the sites to facilitate the assessment processes and team discussions, and assisted with answering the questions regarding the assessment tool when necessary.

Assessment instrument (see Appendix C)

A total of 98 questions were developed for the assessment tool, reflecting the following areas of the Juvenile Standards: Pre Sentence Investigations; Evaluation and Assessment; Standards of Practice for Treatment Providers; Qualifications of Providers, Evaluators and Programs; Establishment of Multidisciplinary Teams; Additional Conditions of Community Supervision; Polygraph Examination; and Victims and Potential Victims: Clarification, Contact and Reunification.

The format of the assessment tool allowed districts to respond to each of the questions using a 5-point response set:
1 = Always (100% of the time);
2 = Typically (~75% of the time);
3 = Sometimes (~50% of the time);
4 = Generally Not (~25% of the time); or
5 = Never.

When a site stated they did not always or typically follow the standard, they were expected to answer the following three questions:

1. What are the barriers preventing this from always or typically happening?
2. What does the community/agency/etc. need to allow this to always or typically happen?
3. What is the community's agency's/etc. current practice regarding this issue?

FINDINGS

It is important to note that the data generated in this report is limited to the 11 judicial districts that participated in the assessment project, and reflects only the perspectives of the participating individuals and agencies within those districts, and in some cases does not include all of the counties in a particular judicial district. While this data is believed to highlight trends in the participating judicial districts, it is important to note that the data cannot be used to make generalized statements reflecting the status of implementation across the state. The assessment process was not designed as a formal research project, performance audit, or quality assurance evaluation. Rather, it was designed as an information-gathering process in order to identify potential patterns and trends related to the implementation of the Juvenile Standards in a range of jurisdictions throughout the state.

The data that follows is presented in two formats that reflect data from the aggregate of all 11 participating judicial districts. Separate from this report, each judicial district has received their respective data compared to the aggregate. The first set, the frequency graphs, represent the percentage of responses in each of the five categories (ranging from always to never) for a particular item on the assessment. Appendix A includes "stacked graphs" that give a visual indication of the site-by-site comparisons without identifying the districts specifically.

Overall, respondents within the 11 participating judicial districts reported implementing the majority of the Juvenile Standards prior to the July 1, 2006, target date. Overall, eighty percent (80%) of the standards were listed as *Always - Typically* being implemented. Eleven percent (11%) of the standards were listed as *Typically – Sometimes* being implemented and nine percent (9%) of the standards were listed as *Sometimes – Generally Not* being implemented. However, there was variability in the

range of scores across participating districts, as well as within and across substantive areas in each participating district. (The stacked graphs in Appendix A illustrate the trend of scores over each question for all of the participating sites).

Section 1: Presentence Investigations of Juveniles Who Have Committed Sexual Offenses

Strengths

Participants reported that several of the standards in Section 1 of the Juvenile Standards are being implemented, including the following:

- Pre-Sentence Investigations (PSI) are conducted routinely with both juveniles adjudicated for a sexual offense or those adjudicated for a non-sexual offense, if the instant offense has an underlying factual basis of unlawful sexual behavior;

- Those who conduct a PSI have received the recommended training; and

- PSI's make recommendations concerning the juvenile's amenability to treatment and suitability for community supervision.

Gaps and Barriers

A number of gaps and associated barriers were identified with respect to the implementation of Section 1 of the Juvenile Standards, including the following:

- Standard 1.4: PSI include: sexual offending and abuse patterns, grooming and victim selection; type of threat, use of coercion; sexual and non-sexual assaultiveness pattern or history; financial status; leisure/recreation – activities and affiliations; inter/intra-personal skills; assets and coping abilities; disabilities (developmental, etc.); emotional/personal problems; initial case plan; placement recommendations and availability in Colorado; potential impact of each sentencing option on the victim(s); restorative/reparative options.

  ➢*Many of the participants reported that the Psychosexual Evaluation report included this information that was then incorporated into the PSI report.*

➢ *It was reported that sometimes some of this information may not be shared with judges and magistrates due to issues of the cost or lack of placement resources.*
➢*It was reported that this information is already in the Psychosexual Evaluation and is not duplicated and often the youth may already be in placement given the time frames of the PSI process. Consequently placement recommendations may not be included in the PSI reports.*
➢ *It was reported that most typically the County Department of Human or Social Services would make placement recommendations to the court as they are the placing agency and have the requisite information as part of their placement evaluation process.*

Section 1: Presentence Investigations of Juveniles Who Have Committed Sexual Offenses (continued)

- Standard 1.41: When out-of-home placement is being considered, PSI include: list of recommended placements; list of monthly cost of each recommended placement; if a change in legal custody is being recommended, other alternatives explored and the reasons for rejection & particular placements that were explored, rejected and the reasons for rejection; assessment of the juvenile's physical health, developmental status, family history, social history; treatment plan includes: goals to be achieved by the placement, services to be provided and by when, intensity of services, duration of services, identification of services which can only be provided in a residential setting, recommended duration of the placement; required fee charged to the parent pursuant to C.R.S.

  ➢*It was reported that sometimes probation will defer to the Mental Health Sex Offense Specific Evaluation (Psychosexual Evaluation) and to the recommendations of the County Department of Human or Social Services rather than re-create that information independently.*
  ➢*Some participants described a "role conflict" between probation officers and County social or human service workers over the placement and case decisions. This was further explained as sometimes occurring from differences of opinion regarding community safety issues or potentially driven by differing agency mandates and expectations.*
  ➢ *A comment was made questioning the appropriateness of a PSI writer to make decisions "on their own" when often the decisions are made by the MDT after sentencing and placement has occurred.*
  ➢*Barriers to fully implementing this were described as including: a lack of available resources; limited resources; and efforts to keep kids in their homes.*

- Are the issues related to victims or potential victims addressed in relation to the recommendations made in the PSI?

  ➢ *Participants reported that often there was little or no contact with victims and that is was important to have them participate in clarification and reunification through treatment if reunification was a goal. It was also reported that there might be little communication or coordination with victim therapists to facilitate addressing victim issues.*

➢ *Comments were made that recommendations were sometimes very generic and needed to be more individualized by the PSI writers.*

- Standard 1.7: At the time of the PSI or intake interview, the juveniles and families/guardians receive the complete waiver of confidentiality.

  ➢ *It was reported that some families refuse to take the documents when provided or they may refuse to sign waivers.*
  ➢ *Some families and guardians will do a release of information but not a full waiver and court orders are required.*

Section 1 - Implications

The Pre-Sentence Investigation (PSI) is utilized to inform and make recommendations to the court regarding the disposition of a specific case. The accuracy and completeness of the PSI is essential for providing the court with the information necessary to make appropriate and effective dispositions. It is encouraging that PSIs are being done as frequently as reported and by individuals with training specific to sexual offending behaviors who make recommendations regarding the juvenile's amenability for treatment and supervision.

One implication from the findings is that there is a high potential for role confusion and insufficient coordination regarding collection of data and information required in the PSI reports. The findings indicate that PSI writers may be tasked with providing information that is either duplicative or possibly unavailable to them at the time of the report. In many instances the PSI writer may be reliant on information that is provided by other parties such as evaluators or human/social service agencies (examples: placement information, educational evaluations and treatment plans) although reporting the information is the requirement of the PSI writer. Additionally, there is a concern raised regarding the PSI writer having to make recommendations without the benefit of input from the full MDT during the presentence process. This situation may inadvertently put undue emphasis on solely the input of the PSI writer without incorporating the collective knowledge and experience and perspective of a MDT, which is often gained in the months following the PSI. In such circumstances, the exclusion of such input might adversely impact court dispositions and potentially public and victim safety. On a policy level, it would be beneficial to review and modify the current expectations and practices regarding the PSI process with the intent of reducing redundancy, improving efficiency and clarifying the roles and responsibilities of different agencies in the information gathering and coordination process. On the local level there is much to be gained by MDT's by taking the time to communicate with each other in regards to specific strengths, needs and barriers in their PSI process of their jurisdiction and to engage in creating solutions and formal agreements for more effective communication and coordination in response to identified barriers and challenges related to timely and complete information gathering.

Developing a comprehensive, accurate PSI is a very labor-intensive process. Inadequate fiscal resources limit the ability of PSI writers to spend the requisite time necessary to fully investigate, gather information and develop high quality PSI reports. In such circumstances, the PSI report quality may suffer from time restraints imposed by management or workload demands. Increased time pressure on PSI writers can lend towards generalizing reports in order to be more expedient. Less than comprehensive information can adversely impact court dispositions and potentially public and victim

safety as well. In addition, treatment and supervision efforts may be negatively impacted if services are not crafted to meet the individual juvenile's needs, motivation and personal resources. The provision of adequate fiscal resources to allow for the optimum quality of PSI reports falls into the realm of policy makers and agency management personnel. It is suggested that the resource requirements for comprehensive PSI reports be evaluated and funding provided to adequately address the resource needs that are identified.

Section 1 - Implications (continued)

The rights and needs of victims are deemed paramount in the Juvenile Standards. It is common that some victims may choose to not engage in the process and their wishes must be respected and supported. When families are not fully informed of their rights, responsibilities and options, they may make decisions that are counter-productive to the overall well being of their children and the community. All victims should have the opportunity to engage in the sharing of information to assist them in their healing and empowerment with regards to the person/s who have offended against them. The PSI writer plays a crucial role in gathering the information in the early stages of a case with regard to identifying the appropriate victim representatives and sharing relevant information. In some jurisdictions is has been reported that often there may not be victim impact statements provided by the victim advocates or information that is received is more accurately described as the details of the offense rather than the impact to the victim. When this occurs, it may be incumbent on the PSI writers to be more assertive in their procurement of relevant and complete information so that the MDT does not operate in a vacuum with regards to the victims of sexual offenses. It is recommended that jurisdictions engage in evaluation of their current practices so they may develop more effective methods of information sharing and engaging victims representatives. This would include formalizing agreements and processes for insuring that relevant information is received in a timely fashion from the agencies involved.

Pre-Sentence Investigations are crucial in the formulation of the plan for both the supervision and treatment of juveniles who have committed sexual offenses. Public and victim safety are paramount and supervision must be developed in a manner that is commensurate with the risk determined for each specific juvenile. Currently probation officers in Colorado utilize the O' Brien Protective Factors and the Colorado Young Offender-Level of Service Inventory (CYO-LSI) to determine treatment and supervision levels for juveniles who have committed sexual offenses. Unfortunately, offense specific risk assessment tools for juveniles who have committed sexual offenses that are currently available are limited in scope and capability. This fact complicates the ability to determine the risk of sexual offending that a particular individual juvenile presents to the community and victims. New tools for juvenile risk assessment are being developed and researched for validity and reliability. Probation officers could benefit from training specific to new sex offense specific risk assessment instruments as they become available.

The Juvenile Standards include the promotion of health as an important aspect of decreasing risk for sexual offending. The Juvenile Standards (Sec 1.400) indicate that PSI reports should include "assets and coping abilities" where applicable. While the information available to the PSI writer at the time of their investigation may be limited, it is strongly encouraged that diligent efforts be made to identify any strengths and resources that a juvenile possesses. This information can be transmitted to the MDT for further exploration and determination of how to incorporate this material into the ongoing supervision and treatment of juveniles who have committed sexual offenses.

Section 2: Evaluation and Ongoing Assessment of Juveniles Who Have Committed Sexual Offenses

- Offense specific evaluations of juveniles who have committed sexual offenses were reported as being conducted most of the time within the participating judicial districts;

- Offense specific evaluations assessed overall risk to the community; provided documentation regarding the protection for victims and potential victims; assessed the juvenile's strengths, risks, and deficits; identified and documented treatment and developmental needs; determined amenability for treatment; identified individual differences, potential barriers to treatment, static and dynamic risk factors; made recommendations for the management and supervision of the juvenile; and provided information which can help identify the type and intensity of community based treatment, or the need for a more restrictive setting;

- Generally, the evaluations made recommendations regarding intervention based on levels of risk and needs rather than on resources currently available. If this was not the case, this information was documented;

- Ongoing needs assessments were conducted and documented; and

- Evaluation methodologies included examination of juvenile justice information and/or DHS reports; details of the offense, including harm done to the victim; examination of collateral information regarding the juvenile's history of sexual offending and/or abusive behavior; a sex offense specific risk assessment protocol; use of multiple assessment instruments; structured clinical interviews including sexual history; integration of information from collateral sources; and standardize psychological testing if clinically indicated.

Gaps and Barriers

- 2.21: Evaluations and assessments are conducted prior to release/termination from treatment.

  ➢*This issue was at times confusing because of varying interpretations of the terms "evaluations and assessments." It was reported that the MDT's review cases and assess progress and compliance and make their recommendations regarding release or termination, but no formal evaluation instrument is done.*
  ➢ *Cost of formal evaluations is an issue affecting whether or not these were done as part of the release/termination process.*

Section 2: Evaluation and Ongoing Assessment of Juveniles Who Have Committed Sexual Offenses (continued)

- 2.21: Evaluations and assessments are conducted during follow-up/monitoring post-treatment release.

  ➢ *This was considered to be optional since treatment and supervision often terminate concurrently and clients are not subject to on-going follow up or monitoring.*
  ➢*Follow up and monitoring activities are costly and there are generally not provisions made for either fiscal resources or staff to provide these.*

Section 2 – Implications

It was encouraging to find that the offense specific evaluations are almost always being done with the inclusion of the necessary elements of evaluations being reported as typically occurring. It is unclear to what extent on-going assessments are routinely being done across the jurisdictions. Identified gaps suggest that evaluations are not always being done prior to treatment termination and often there may be no formal follow up or post-treatment release for a variety of reasons including a lack of jurisdiction or resources to fund the services post treatment. It bears consideration that in some cases this might be an acceptable and normal circumstance for individuals that have met all their obligations and treatment outcomes satisfactorily per decision of the MDT. For those individuals that are still under court jurisdiction post-treatment, it is appropriate to utilize follow up assessments to measure the effectiveness of treatment and the readiness for living safely in the community. Policy makers and agency management personnel encouraged to identify the level of need and resources required to meet the need for post-treatment and follow-up evaluations and allocate the required fiscal resources to make this possible.

A complicating factor identified in the assessment process is the use of language referring to evaluations and assessment without specificity. Many of the participants in the assessment project indicated a level of confusion regarding the use term “assessment” versus the term “evaluation.” Specifically, there were questions raised whether or not the references were to formal “offense specific evaluations” versus more informal evaluation and/or assessment activities done routinely by MDT members during the ongoing treatment and supervision. In other words, what is required to meet the intent of this segment of the standards? Many forms of “assessment and evaluation” activities do not rise to the level of that delineated by a formal “offense specific psychosexual evaluation” but are useful and relevant in guiding the course of the treatment and supervision process. The dilemma becomes one of knowing what are the adequate and appropriate quality, quantity and formats of documentation? It is recommended that this area of the standards be examined with the goal of clarification of the expectations, language and documentation formats regarding evaluation and assessment.

Section 2 – Implications (continued)

One concern noted regarding evaluations is the tendency to put more emphasis on deficits and less focus on strengths and aspects of health that a juvenile may possess. The

unintended consequence of this may lead towards an unbalanced perspective on a juvenile, which does not take into consideration the "developmental and contextual considerations" of that specific juvenile. It is the intent of the Juvenile Standards to engender the use of individualized approaches and the evaluation process is the cornerstone for the development of individualized comprehensive treatment and supervision plans. Failure to integrate strengths and elements of health into the treatment process have the potential for hindering healthy growth in juveniles who need to develop alternatives to deviant behaviors. To this end, evaluators are encouraged to be mindful of the need to fully identify strengths and resources of youth in addition to deficits and areas of needs and more routinely integrate this into evaluations if they are not currently doing so. On-going research, information sharing and training are needed to assist practitioners with developing and maintaining expertise driven by identified "best practices." The evolving arena of juvenile risk assessment holds potential promise for expanding the knowledge of subtypes of individuals and further support efforts to individualize evaluations and treatment approaches.

Section 3: Standards of Practice for Treatment Providers

Strengths

Regarding treatment in the judicial districts that participated in the project, their implementation of the Juvenile Standards appeared to be strong with respect to the following:

- Juveniles receive sex offense specific treatment and care (and not solely receive traditional psychotherapy) as described in the Juvenile Standards.

- The treatment plans were designed to address strengths, risks, deficits, and all areas of need identified by the evaluation.

- These treatment plans were reviewed at least every 3 months and at transition points.

- A combination of individual, group and family therapy were used unless contraindicated. Measurable outcomes, as prescribed in the Juvenile Standards, were used in treatment planning and relapse prevention planning and aftercare were included as elements of the treatment plan.

- Client files included evaluations, assessments, presentence investigations and treatment plans; documentation of treatment goals, interventions, clarification assignments, progress toward outcomes, critical incidences during treatment, impediments towards success; non-compliance by juvenile, family, or support system; discharge criteria, relapse prevention plan; recommendations for aftercare; and availability of family and/or community resources to support aftercare.

- Furthermore, providers developed and utilized a written treatment contract/advisement that meet the criteria listed in the Juvenile Standards with each juvenile who has committed a sexual offense prior to commencing treatment.

- Juveniles who successfully completed treatment accomplished the goals set forth in the Juvenile Standards. If a juvenile has been otherwise compliant yet has not achieved his or her treatment goals by an approaching supervision expiration date, supervising officers/agents seek a means of continued court ordered supervision.

- If used, plethysmograph (PPG) and Abel Assessment results are used as an adjunct tool, not replacing other forms of monitoring.

Section 3: Standards of Practice for Treatment Providers

Gaps and Barriers

Although not a Juvenile Standard, an additional question included in this section of the assessment tool identified a possible concern. This question, along with the challenges it poses, is outlined below:

- Are juveniles assessed as higher risk separated from lower risk juvenile offenders in group treatment and in residential settings?

➢*While this is understood as a best practice, many participants reported that is not always feasible from a resource perspective - they may not have sufficient staff to do this.*
➢*Some participants reported that high-risk only groups did not work as well as mixing populations.*
➢*Staffing limitations, size of facility and program may not allow for splitting groups.*
➢*There may not be enough youth in a program or group to split up the groups. If a youth was not appropriate for group they will do individual treatment until they are ready for group.*
➢ *It was reported that there is an inadequate continuum of care in rural communities, there is a need more training for judges and district attorneys, and more funding is needed to create foster and Therapeutic - Foster placements, and more cooperation is needed from the local Department of Human Services.*

One required standard also appeared to be a challenge:

- 3.61: The MDTs consult with a PPG examiner* when the following indicators listed in 3.610 are met:

  ➢*Philosophical issues about PPG use with juveniles were reported with the comment that" it is not always considered good practice" and there are concerns that it may be damaging to some youth.*
  ➢*Parental approval is necessary and is sometimes difficult to obtain.*
  ➢ *PPG evaluations may not be appropriate because of the young age or maturity level of the clients.*

  ** NOTE: The Juvenile Standards empower MDT's to use their discretion to make this determination.*

Section 3 – Implications

The general indicators of this section are that SOMB approved providers are providing services to juveniles that fall under the purview of the Juvenile Standards, however, the issue of limited accessibility of providers in rural areas were repeatedly mentioned by participants. Smaller rural communities typically report small numbers of juveniles who have committed sexual offenses. Consequently, it may be difficult for a potential provider to meet the supervision hours required to meet SOMB approval and/or economically justify their practice with juveniles who have sexually offended. Available providers, in some cases, have been willing to travel some distance to meet the needs of outlying communities, but again are limited by the economics of travel for such a small numbers of clients.

The Juvenile Standards support the use of individual, group and family services for juvenile who have committed sexual offenses. Furthermore, the standards support separating juveniles according to developmental and intellectual status, seriousness of offending behaviors, and other variables. It was reported that for various reasons (such as staffing ratios, small numbers of clients and economics) that this is not always logistically possible. In some settings more focus may be given to group approaches with juveniles who have committed sexual offenses even though in some cases their needs may be better served with individual therapy. Possible "iatrogenic" effects such as secondary traumatization, actual victimization or "deviancy training" may occur with mixed populations of juvenile offenders.

Some concerns have been anecdotally identified that some providers use a "cookie cutter" approach to evaluations and services provided. The intent and design of the Juvenile Standards is to provide individualized evaluation, treatment and supervision plans, which acknowledge developmental and contextual considerations. Given that every case may possess unique aspects that pertain to risk and protective factors, it is essential that the methodologies utilized to formulate treatment and supervision plans identify and incorporate the strengths of both the juvenile and their ecosystem in a holistic fashion and support the development of treatment and supervision plans that match the individual circumstances found in each case.

Section 4: Qualifications of Providers, Evaluators and Programs for Juveniles Who Have Committed Sexual Offenses

Strengths

Question 1 of this section in the Assessment Tool asked, "Are referrals made only to listed providers?" This typically appears to be happening in the judicial districts that participated in the project.

Gaps and Barriers

One other standard referred to in this section posed some challenges. This standard, along with the barriers to implementation, is as follows:

- 4.510: 2/3 of the milieu child-care staff is trained to fulfill the role of therapeutic care providers.

➢*Some participants described difficulty meeting this requirement due to issues of limited resources and staff turnover. (Resources do not always allow for multiple staff to be present to provide coverage when others are being trained).*
➢*It was reported that referring agencies do not always know the level of training of the staff at some placements and may assume that the staff is trained without verification.*

- 4.510: Residential staff is trained in informed supervision during orientation or within 14 days of hire.

  ➢*Cost, staffing/timing issues, and staff turnover were mentioned as barriers to getting staff trained within 14 days, however it was reported that staff typically are trained within the 1-2 months and that they are not allowed to do informed supervision if not trained.*
  ➢*Trainers and resources to allow for training are not always readily available.*

Section 4 – Implications

Overall, this section of the Juvenile Standards was reported as being met consistently. While this is positive, there remain challenges with regard to availability of approved providers in many areas of the state.

Some rural communities have very few juvenile clients and no approved providers in their community. Available providers are considerable distance away, which increases costs, travel time and logistical complications. In some cases there are not lower level placements or resources in the community that might address the needs of juveniles that do not require high-level residential treatment services.

There are significant challenges with regard to the practical realities of getting staff trained within the parameters set forth by the Juvenile Standards in residential facilities for a variety of reasons. Staffing ratios, turnover and costs are the primary factors identified. Facilities indicated that they would typically get the staff trained as soon as is feasible and they will not authorize them to supervise until this has been done.

The quality and expertise of a program is invariably determined by the competence levels of the staff and professionals in that program at a given point in time. In many cases, residential programs may rely heavily on individuals who have recently completed their education and obtain entry-level employment to gain experience in the field. Often these

types of agencies become career "stepping-stones" for individuals that work for a brief period of time then move towards other agencies. Fiscal constraints, which limit the levels of compensation for employees in such programs, may well contribute to staff turnover issues that further impact program stability and quality of care.

Section 5: Establishment of a Multidisciplinary Team for the Management and Supervision of Juveniles Who Have Committed Sexual Offenses

Strengths

Within the participating districts, it appeared that several of the standards in Section 5 of the Juvenile Standards were being sufficiently implemented, including the following:

- Supervising officers (or DHS/DSS case managers in the absence of an officer) convened multi-disciplinary teams (MDTs) after adjudication or a deferred adjudication had been entered;
- A referral to probation, parole, or out-of-home placement was generally made;
- The members of the MDT acted as a team;
- The MDT met at least quarterly.
- If the juvenile is enrolled in a school, a representative from the school participates as a member of the MDT.
- Both the supervising officers/agents and their managers completed sex offender management training as well as the DYC client managers/parole officers.

Gaps and Barriers

Some challenges to Section 5, along with the barriers to implementation include:

- 5.11: There is victim representation on the MDT.

  ➢*Often there is no means to pay for victim representative's time for attendance at MDT meetings and other activities.*
  ➢*Therapists that are providing treatment to victims may not have specific training about sex offenders and offense specific treatment issues, specifically contact, clarification and reunification.*
  ➢*No central resource exists for representatives for victims.*

- 5.51: Caseworkers have completed training specific to sex offender management.

  ➢*Barrier includes finding caseworkers that want to specialize in working with juveniles who commit sexual offenses.*

  ➢*The Department of Human Services does not support training specific to juveniles who commit sexual offenses as a routine practice in their agency.*

  ➢*Workers have time limitations and conflicts with other training requirements and job duties.*

- 5.711: Polygraph examiners are trained in informed supervision.

  ➢*This is sporadic – polygraph examiners are not required by standards to be trained in informed supervision.*

- 5.711: Victim representation is trained in informed supervision.

  ➢*Some victim representatives are not eagerly involved in training.*
  ➢*The limited availability and costs of training are barriers.*
  ➢*Victim representatives appear to have very limited knowledge of sexual offenders and the issues that need to be addressed.*
  ➢*The Standards do not require victim representatives to be trained in informed supervision.*

- #15: School representatives on the MDT have completed training specific to sex offender management.

  ➢*Schools do not agree to participate in MDT's all the time.*
  ➢*Schools are not always aware of or invited to training.*
  ➢*Scheduling issues for school staff impact their availability for trainings.*

- #17: Schools/school districts conduct trainings for school representatives on the MDT regarding juveniles who commit sexual offenses.

  ➢*Barrier includes philosophy and attitudes of some school personnel who are negative about juveniles who have committed sexual offenses. We need more willingness from them to be involved in the process.*
  ➢*Some schools have lack of knowledge as to what is going on or what is needed to effectively manage juveniles who have committed sexual offenses and to participate effectively on MDT's.*
  ➢*Need outreach and training to schools.*

- App F: The juvenile's caregiver in any out-of-home placement has received the training outlined in Appendix F.

  ➢*We could do better with cultural sensitivity and diversity, and the application of this information in decision-making.*

Section 5 – Implications

The Multidisciplinary Team (MDT) is a core element in the evaluation, supervision and treatment of juveniles who have committed sexual offenses. The jurisdictions that participated in the assessment project indicated that MDT's were almost always operating and held regular meetings, included required agencies and engaged in team decision-making. Unfortunately, there are numerous gaps and concerns to be noted with regards to MDT's in various jurisdictions.

The level and types of training that various MDT representatives had regarding juvenile sexual offending appear to vary greatly. It was noted that oftentimes victim representatives, school personnel, human service workers and out of home caregivers may have had little or no training with regarding to offender dynamics, offense specific issues and other topics relevant to the supervision and treatment of juveniles who have sexually offended.

School districts are required to provide training regarding juveniles who commit sexual offenses to school personnel that function as MDT representatives and informed supervisors; however, this does not appear to occur on a regular basis. In some cases this shortcoming has direct negative impact on the manner in which juveniles who commit sexual offenses are involved in the educational process. Informed supervision is a critical piece of the process for safe and successful integration into the educational process when appropriate. Those functioning as informed supervisors must possess sufficient knowledge to manage the delicate balance of ensuring safety for their school populations and also promoting normalizing experiences for juveniles who have sexually offended. School personnel that are not adequately trained may inadvertently mismanage risk in a way that decreases safety or overly restricts the juvenile's school involvement in a manner that is not conducive to learning, health promotion and normalizing social interactions.

Often human/social service workers have had little or no training with regards to juveniles who commit sexual offenses, as this is not currently part of the mandated training that social caseworkers receive. Many human/social service agencies utilize "generalist" caseworkers that may, at any one time, being working with numerous cases that cross a wide spectrum of issues and needs. Caseworkers need to be equipped with

the knowledge and skills to make safe and appropriate recommendations and decisions regarding juveniles who have sexually offended and their families. Caseworkers are often the frontline for the investigation of sexual offenses and also for making recommendations regarding safety, removal from the home, out of home placements, contact and visitations, and the reunification of families. Having specialized knowledge and skills regarding juveniles who have sexually offend will have significant impact on their ability to understand the inherent risks and safety issues with regards to victim and potential victim contact, the victim clarification process and family reunification issues.

The involvement of victim representatives on MDT's was defined best as sporadic and more likely to occur when the offenses were involving family members. In general, there is considerable concern that often times victim representatives may have very limited knowledge of sexual offending, contact and clarification issues and offense specific

Section 5 – Implications (continued)

treatment issues. Consequently, there are concerns that in some instances their involvement with victims may be harmful or detrimental to the victim.

There is also concern that at times school personnel or victim representatives have not been invited or made aware of the MDT process. Given that victims can choose their own therapists independently they may be receiving services from individuals that are unaware of the existence of an MDT, let alone an understanding of how their involvement in the process can be helpful for the victim and the MDT. The process for informing school personnel of a particular juvenile's status varies from district to district. If they are not contacted directly by someone from the MDT they may not receive any information regarding that particular juvenile. There are concerns that in some circumstances the information may not be passed to the appropriate school staff to participating MDT members although it may have been provided to someone in the school district. It has also been noted that in some cases, schools have indicated that they do not wish to participate in MDT's and do not engage in the process unless they become motivated by circumstances they cannot avoid. Additionally, in some instances school personnel or victim representatives indicate that they cannot justify the time to be involved especially if it requires travel from their workplace to attend meetings and staffings. Victim therapists and advocates that are not reimbursed for their time in MDT's may find it not feasible to attend for economic reasons.

The final concern noted is the cultural awareness and diversity issues that may be present with juveniles who have committed sexual offenses and their families and as well as victims and their families. Various participants indicated that they believed that MDT's could do a better job of being knowledgeable and sensitive to issues of cultural and diversity issues which are numerous and often complex. MDT's will often consist of a wide range of individuals with considerable diversity in their background, education and knowledge of cultural and diversity issues. While some agencies and organizations have considerable emphasis on training workers in issues of cultural awareness and diversity others may have little or no such emphasis and there is not a formalized process or means for imparting this knowledge to the various individuals who may be MDT members.

Section 6: Additional Conditions of Community Supervision

The standards regarding section 6 were reported as being implemented most of the time in the judicial districts that participated in this project. It appears that both probation and client managers are generally applying additional conditions of community supervisions for juveniles who have committed sexual offenses and the courts are routinely incorporating additional conditions into their dispositions. Such conditions are specialized to address the issues and concerns that arise specific to individuals who have sexually offended and the specific challenges of supervision and treatment that occur with this population.

Section 6 – Implications

None noted.

Section 7: Polygraph Examination of Juveniles Who Have Committed Sexual Offenses

Strengths

- For the participating judicial districts, MDTs typically referred juveniles for polygraph examinations only when the appropriate criteria were met.

- The rationale, type, and frequency of polygraph testing were documented in case files and the reasons for exceptions to the requirement to use polygraph testing were also documented.

- Polygraph examiners submitted a written report within 2 weeks of the examination that was factual and descriptive of the information and results of each examination.

- The polygraph was used as an adjunct tool when making treatment or supervision decisions.

- Sexual history polygraph examinations were initiated within 3-9 months following the onset of treatment (for those who meet the criteria); if this was not the case, the reasons for this were documented.

- The MDT prepares the juveniles for polygraph examinations as outlined in the Juvenile Standards.

Gaps and Barriers

One standard in Section 7 appeared to be a challenge and is outlined below, along with the barriers to implementation:

- 7.17: Maintenance/monitoring polygraph examinations are initiated 2-4 months prior to transition from one supervision level to another. *

  - *Financial issues inhibit doing frequent polygraph exams.*
  - *Polygraphs are done according to need rather than time frames.*
  - *Lack of knowledge of standards at the time resulted in misapplication of this standard, but the practice has been changed to fit the standards.*

  * *NOTE: The Juvenile Standards empower MDT's to use their discretion to make this determination.*

Section 7 – Implications

The use of polygraphs with juveniles is a topic not without controversy. The responses to the assessment tool were generally indicative of Section 7 the Juvenile Standards typically being met. Some jurisdictions reported using some discretion around doing polygraph examinations on the finite timeframes delineated by the Juvenile Standards and in keeping with the Juvenile Standards giving MDT's discretion regarding this provided the MDT make's this exception and also documents this accurately.

The respondents to the survey indicated that they would not always meet the 2-4 months requirements, but would make individualized decisions based on resources, needs and concerns and what was most practical for a specific case. It was their thinking that their overall knowledge of the case gave them a realistic sense of when the routine timeframes of the polygraph were contraindicated.

In some rare instances there was concerns raised that there was too much reliance on the polygraph results for decision making by the MDT. The Juvenile Standards clearly delineate that it is not appropriate to make decisions based solely on polygraph findings, but should include a variety of information obtained from multiple sources and means by the MDT information sharing process. There are concerns noted about the polygraph process having a negative impact on some juveniles that outweigh the value of information that may be gained. Juveniles with trauma histories and post-traumatic stress issues may not only be negatively impacted by the process but the results of their polygraph examination may be less than credible due to responses triggered by the examination itself. While there are some professionals that disagree with the use of polygraph examinations with juveniles, there is significant support for the value of information garnered from the polygraph exam which can impact the decision making process regarding both treatment and community supervision.

There were a few reports of misapplication of polygraphs due to misunderstanding of the Juvenile Standards that was corrected with accurate information. It remains incumbent on MDT members to be fully apprised of the contraindications of polygraph use for some juveniles as defined in Section 7 and the appendix C of the Juvenile Standards and to consult with the polygraph examiner regarding any issues of concern or doubt regarding particular juvenile's appropriateness for polygraph examination or the validity of findings.

Section 8: Victims and Potential Victims: Clarification, Contact and Reunification

Strengths

- Within the participating judicial districts, the MDT, which included the victim's therapist or advocate*, typically approved victim clarification procedures.

- The MDT also approved victim contact procedures.

- Family reunification occurred only after clarification had occurred.

Gaps and Barriers

An additional question included in this section, although not required in the Juvenile Standards, appeared to highlight an important challenge in the participating districts. This question, along with the barriers to implementation, is outlined below.

- Are victims provided assistance with the development of safety plans?

  ➢*Victims may not be involved with plans that revolve around the offending juvenile if the victim therapist or representative is not involved with an MDT.*
  ➢*Victims are left out of the process for a variety of reasons.*
  ➢*This is a victim therapist issue and should be done with the victim by the victim's therapist.*
  ➢*Victim therapists do not know what to do and need training and education on offender issues, safety plans, etc.*
  ➢*There is not a victim therapist in the community to be involved in the MDT.*

* Note: Victim representation reportedly usually only occurs with intra-familial cases.

Section 8 – Implications

The issue of victim representation is challenging in many regards for a variety of reasons. While the Juvenile Standards are written with a strong emphasis on victim representation, there is a wide-ranging array of approaches to victim representation being displayed in MDT's across the state. The nature and types of involvement of victim representatives

on MDT's appear to be less than consistent in many areas and there are concerns regarding their knowledge and skills, lack of awareness of the MDT process, awareness of the nature of the victim representative's role and how to interact effectively with MDT's, as well as inadequate participation on MDT's in some jurisdictions.

While there are many excellent victim therapists providing helpful and valuable services to victims and their families in Colorado, concerns remain about the knowledge base and skills of some therapists in relation to sexual offenses, contact, clarification and reunification, and offender dynamics, and collaboration with MDT's. Victim therapists are chosen by the victim or their family and are not bound to meet any standards of knowledge or approval process by the Sex Offender Management Board. Consequently, a victim and their family may have a very skilled, knowledgeable therapist who interacts with an MDT or a therapist unfamiliar with many sexual offense issues which are relevant for victim safety and protection. The overriding concern stated is that some well-intended therapists may actually be engaging in practices that may be less than effective or actually harmful to victims.

Financial remuneration is usually not available for the time therapists spend as part of an MDT. As a result, many therapists either do not participate or end up participating on MDT's pro bono. When their involvement also requires travel time in addition to lost paid clinical hours, they may have significant negative financial impact by representing the victim in an MDT. This reality invariably results in less participation on MDT's by therapists than would be desired in many instances. Often victim compensation funds are limited in both time frames for which they are available as well as the scope of what they will cover. It has been stated that they are often not available to fund victim representation on MDT's, which further exacerbates this issue.

Finally, victim representation is a concept that is widely supported yet in some sense not clearly defined in terms of what is looks like and who does it. The criminal justice system is often confusing to victims, offenders and their families. Different agencies may have victim advocates or representatives involved for their portion of the process, but there may be little or no continuity or consistency for a victim as a case progresses through adjudication and beyond. The roles and responsibilities of various victim advocates and representatives may differ significantly dependent on the funding source, whether an agency is public or private, agency mandates, and other factors. The overall effect on the victim may be one of confusion and inconsistency. As the field evolves it will be necessary to continue to refine the concept of victim representation, identify best practices and educate communities as to the value and importance of providing victims representation and a voice in the criminal justice process.

MACRO LEVEL "SYSTEMS" ISSUES

Although some of the gaps with respect to the implementation of the Juvenile Standards in participating districts can be addressed through specific action planning at the local level, several common issues were identified that reflect larger system issues. These broader systemic issues are worthy of mention in that they have significant impact on the implementation of the Juvenile Standards statewide and may require specific attention at the state or policy level. For example, some of these systemic issues may have legislative, policy and funding implications for stakeholder agencies on the state and

countywide level. Ideally, the identification of these issues will promote further investigation into the barriers and potential solutions for these systemic barriers.

Resource constraints

To illustrate, participants in the assessment process often mentioned "resources" issues as a barrier to full implementation of the Juvenile Standards, often referring to insufficient funding for optimum level of service provision within their judicial districts. This resource issue can be defined on different levels.

- On the interpersonal level, families with marginal incomes typically cannot meet the financial requirements of treatment and court costs. Numerous participants described clients that cannot afford treatment, evaluation, travel and other expenses associated with engaging in offense specific treatment that is required for their child.

- On the larger systemic level, there are funding challenges for both Probation and the County Departments of Human/Social Services. These challenges manifest as limitations on the ability to fund for evaluations, treatment, and testing (i.e. polygraph) services when clients and their families are not capable of paying for such services, and also in out of home placement costs for which County Departments of Human/Social Services are primarily responsible.

- Changes in Medicaid reimbursement rules for juveniles in out of home placement took effect on July 1, 2006, which restrict using Medicaid funds for offense specific treatment for juveniles who have committed sexual offenses. This has resulted in a shift in both placement classifications and allowable reimbursements to County Departments of Human/Social Services. These changes and their subsequent ramifications be made evident in the coming months as programs restructure how they provide services and Counties determine alternative funding for offense specific services.

- The resources available to support victims are limited in both amount and duration in many instances. Funds available through victim's compensation are time limited and may be unavailable for therapy needs that arise beyond the time limitations set forth. There is not specific funding source available to support efforts and activities required for victim representation on MDT's by victim therapists and other parties not funded by existing agencies.

Resource constraints (continued)

The reimbursement levels to treatment providers may, in some instances, be insufficient to allow for them to compensate staff in a competitive fashion and therefore affects their ability to maintain stability and continuity in their programs, which affects quality of service delivery.

Limited specialized treatment capacities

- In some of the smaller communities, there are very few or no Sex Offender Management Board-approved treatment providers available, in part because of the small number of juveniles in need of these specialized services in those areas. This factor makes it inherently challenging to provide community-based offense

specific treatment in a manner that is logistically feasible. Some of the participants in the assessment project expressed their concern that they were working with therapists and treatment providers who were highly respected and skilled in working with juveniles, but did not meet the necessary requirements for approval by the Sex Offender Management Board. Oftentimes it was reported that such providers simply could not meet the clinical contact and /or training hour requirements to meet the Sex Offender Management Board approval process. It was also stated that some highly competent therapists stated that they would not apply as a result of the lengthy and onerous process.

- Residential treatment programs often are seen as the appropriate setting for juveniles that have committed sexual offenses due to the belief that they provide more intensive levels of treatment and the level of structure provides more protection for the community. Ironically, residential treatment providers have described difficulty in recruiting, hiring, training and retaining qualified staff that meet the Sex Offender Management Board requirements. This difficulty is further exacerbated by fiscal uncertainties and insufficiencies with regard to funds available for out of home placements for juveniles who have committed sexual offenses.

- The differences between individual juveniles can be significant for various reasons including: age, developmental status, intellectual and cognitive capabilities, learning styles, type of offending behaviors, etc. Group treatment may be contraindicated in some circumstances and individual treatment intervention being more appropriate in those situations. Staffing patterns in most programs do not always allow for the differentiation of specialized groups to meet the individualized needs of juveniles and in some instances may not afford the ability to provide individual treatment as frequently as needs dictate due to staffing levels.

Continuum of services barriers

Another significant challenge identified is the inadequacy of a "continuum" of services. Guiding Principle 15 of the Juvenile Standards calls for an accessible, community-based continuum of care options for offense specific treatment and management.

- In the assessment project, many participants described a dilemma where the services available are primarily limited for to two choices: juveniles placed in high level "out of home" residential treatment facilities or receiving outpatient treatment services while living at home. It was reported that there are very few programs or services in between these two options, and there is little availability of interim levels of care and transitional services for youth stepping down from higher levels of care and/or returning to their communities from placements out of their communities.

- During recent years, many communities have created well-intentioned ordinances known as "residency restrictions" which limit the number of persons who have committed sexual offenses in a particular residence or the distance they can reside

from schools, day care centers, etc. As a result, legal restrictions limiting the number of juveniles who have committed sexual offenses that can reside in a residence and/or where they live have proven to be a potential barrier for creating interim level programs in some communities. These restrictions also create fiscal challenges for agencies to hire and pay qualified staff to provide appropriate services in a cost effective manner if they are limited to one or two juveniles per placement.

- For those juveniles appropriate for less restrictive settings, the absence of community-based resources may necessitate placement in more restrictive settings by default. For these juveniles, their placement with other older, more sophisticated or dangerous juveniles may increase the likelihood of them being negatively impacted by their more pathological residential peers or being victimized themselves. Juveniles that experience "deviancy training" may possibly be learning attitudes and behaviors that can increase their risk level in the community.

- Placing youth beyond their level of need is counterproductive with regard to integrating youth into more normalizing environments, promoting greater health (Guiding Principle 12 of the Juvenile Standards), minimizing caregiver disruptions (Guiding Principle 14 of the Juvenile Standards) and integrating family members into the evaluation, assessment, treatment and supervision of the juvenile (Guiding Principle 13 of the Juvenile Standards).

- Many individuals who have traditionally provided out of home care for juveniles are not willing to work with juveniles who have sexually offended due to safety concerns for either their own or other children. This further limits the resources available to develop lower levels of care in communities. While this concern is certainly valid, in many cases the supervision needs of some of these juveniles can be readily met in lower levels of care given that their caregivers are competent informed supervisors and receive the support they need to create a safe environment for the juveniles in their care.

Continuum of services barriers (continued)

- The clinical needs of some juveniles are best met through boundaries education, and healthy sexuality and social skills training in lieu of long term, more intensive residential programs. The availability of such programs is limited and may not be available as a resource in some areas.

- Some communities may not utilize informal adjustments, diversion or deferred adjudications, or pre-trial release programs with any juveniles who have sexually offended, even for misdemeanor level cases determined to be very low risk. This inherently reduces the continuum of approaches that may be viable for a particular low risk juvenile and require using resources that would be better served for youth that create greater public safety risk or to fund other aspects of treatment and supervision more effectively. Excessive treatment with some youth may have unintended consequences that actually increase their risk levels long term.

Agency and Interagency Challenges

Challenges involving schools

An additional challenge identified by the participants in the assessment project is the need for consistent, on-going education and involvement of schools to participate as Multidisciplinary Team members, and to provide and maintain training for their staff and administrators related to the supervision and management of juveniles who have committed sexual offenses safely in school settings. Many judicial districts have described their involvement with schools as constructive, positive and appropriate, which is the result of a relatively long-term working relationship with their schools. In other districts there are very limited and fragmented partnerships which result in a lack of continuity in providing the optimum level of education opportunity for some juveniles who have sexually offended. Unfortunately, this appears to vary greatly from school district to school district and in some cases, from school to school within a given school district.

- In some communities it is believed that myths and misperceptions about juveniles who have committed sexual offense negatively impact how the schools and MDT's work together to manage these students.

- The school districts in Colorado are very much individualized in many respects and as such, have a varied approach to how they address juveniles who have committed sexual offenses. Some districts tend to work more on an "as needed" basis and as a result, may not have current information about the Juvenile Standards, juveniles who

commit sexual offenses, informed supervision, safety planning and how to participate on MDT's.

- Finally, turnover in school staff and administrators may create challenges for some schools with respect to providing on-going staff training related to this population, providing adequate informed supervision, and participating as effective MDT members with juveniles who have committed sexual offenses.

Challenges involving Human/Social Services

- Probation officers and Human/Social Service caseworkers frequently work together on MDT's and share vital roles and responsibilities on those teams. However, it has been reported that the mandates, philosophies and expectations of the two agencies can sometimes result in conflicts on MDT's. Probation officers make recommendations to the court based on a community safety focus, which often includes a recommendation for the court to order services or out of home placements that the caseworkers and their agencies are responsible to facilitate.

- The County Departments of Human/Social Services are required to fund these placements and also have federal mandates regarding the length of out of home placements and permanency planning timeframes, which may often be incongruent with the expectations of their colleagues on the MDT. The mandates that human/social agencies operate under impact the recommendations caseworkers make

Challenges involving Human/Social Services (continued)

regarding placements and services, which may differ from the recommendations of probation officers. This has been a source of tension in some jurisdictions from the perspective of County Departments of Human/Social Services that have prescribed mandates and finite fiscal resources yet do not have a sense of control over their placement process and the fiscal expenditures for those placements. In such circumstances, agencies believe that they may be forced to prioritize funding in ways that they believe are not most effective for their entire client population.

- A number of representatives from County Departments of Human/Social Services across the state have expressed reluctance to fully embrace the Juvenile Standards implementation. This response was primarily based on their beliefs that the Juvenile Standards were an "unfunded mandate" or were not realistic or workable. Some County Departments also questioned their legal obligation to follow the Juvenile Standards as well as the "evidence based" justification for the Juvenile Standards.

- County Departments of Human/Social services bear the costs for out of home placements and their staffs are key members of MDT's. Both of these factors have a direct fiscal impact on these agencies. Like most agencies, County Departments of Human/Social Services have finite budgets, which they must manage efficiently to fulfill their mandates and meet the myriad needs of their communities. The juveniles who have committed sexual offenses are a relatively small population of youth who may require a disproportionate amount of financial resources.

- Human/Social Service caseworkers that are tasked with case management and MDT participation for juveniles who have committed sexual offenses have varying degrees of training or specialization in this arena. The Colorado Department of Human Services provides "core training" to Human/Social Service caseworkers on a wide

variety of issues, but there is currently not any training provided related to juveniles who commit sexual offenses in the core training curriculum. Agencies that use "generalist" caseworkers may have workers handling complex cases with little or no knowledge of the issues regarding offending behaviors.

Challenges involving Probation

The probation officer is typically designated as the supervising agent with the responsibility of convening the MDT and bears responsibility of enforcing the terms and conditions set for by the court. Very commonly, the probation officers have had considerable training and experience regarding individuals who sexually offend. The manner in which their role as the supervising agent of the MDT is performed may create challenges to whether conflicts and differences on an MDT can be resolved by the team.

Challenges involving Probation (continued)

- While the majority of MDT's report strong, constructive relationships with the probation officers, there are occasional situations when the stance of the probation officer may be viewed as too "black and white" which may impact the ability to create a more individualized approach for a particular juvenile and therefore limit actions which other professionals may consider clinically appropriate for a specific juvenile.

- The intent of the Juvenile Standards is to create individualized supervision, treatment and management plans based on risk rather than time frames. The standard expectation set forth for juveniles who sexually offend is a 2-year supervision term. While this may be highly appropriate in many cases, for some juveniles this may be an overexposure to the system that has unintended negative consequences. There appears to be limited flexibility in probation guidelines to create a more individualized program for youth that are not deemed as great a risk to public safety and may be more effectively served through psychosocial education.

- Community and victim safety are paramount for juveniles who have sexually offended. The probation officer may face a challenging dilemma of addressing conflicting interests of various parties in the community in a balanced manner that both promotes victim and community safety while allowing the offending juveniles opportunities to develop and practice healthy behaviors in a normalized manner. Juveniles that are not afforded these growth opportunities may well have a higher potential for sexual offending in the future as adults.

- Typology and sub-type research support the concept of differential treatment approaches based on the individual and their behaviors patterns, developmental status and other factors. The assessment tools currently being utilized by probation for determining treatment and supervision levels have been in use for quite some time and have limitations in their efficacy. New developments in the field suggest that additional or different tools may be worthy of exploration and consideration to ensure

that the most current and valid instruments are being utilized to address the needs of juveniles who have sexually offended.

- Limited probation resources have been an issue that impacts both the time allowed for presentence investigations and the supervision and management of juveniles who have sexually offended. The time and workload intensity of cases involving juveniles who have sexually offended can be greater than cases which do not require MDT involvement, safety planning, and the additional supervision needs these cases present. Also, juveniles who have sexually offended may be required to have longer sentences and supervision than non-sex offense cases. Consequently, they are on probation caseloads for longer periods of time, which either create larger less manageable caseloads or necessitate more probation officers to maintain caseload standards. With larger caseloads, officers are forced to prioritize the quantity of their supervision response, which may dilute the intensity of supervision and impact public safety.

Challenges involving Division of Youth Corrections and Juvenile Parole:

The Division of Youth Corrections (DYC) is responsible for providing services to a significant number of juveniles who have committed sexual offenses. DYC appears to have some challenges in regards to training and expertise with juveniles who have committed sexual offenses. Additionally, there is a potential for parole youth to be disconnected from other systems and agencies in some circumstances such as return to a community that that they have disengaged from for the period of their commitment.

- The knowledge and expertise of client managers varies across a spectrum influenced by their level of training and experience with juveniles who have sexually offended.

- The frequency of ongoing training regarding issues of treatment and management of juveniles who sexually offend is variable across the four DYC regions and competes with other training issues and needs in the organization.

- Client managers are defined as "generalists" and may not possess specialized training or knowledge regarding juveniles who sexually offend although they may be charged with responsibility for providing specialized management for juveniles that have committed sexual offenses.

- Client managers must clearly understand their role as the supervising agent of the MDT and how to coordinate effectively with various other systems and agencies to maximize the success of transition and integration into the community. (For example, a youth returning to a community and school system without prior notice or planning with the school system to address safety planning, victim issues, etc.)

- Client managers must coordinate with victim representatives/advocates and support the appropriate involvement of these persons in the MDT process.

Challenges Regarding Judges, Magistrates and Prosecutors:

The issues and challenges regarding juveniles who sexually offend have direct implications for judges, magistrates and prosecutors that have responsibility for handling cases involving juvenile sexual behaviors and sexual offenses. The decisions judges, magistrates and prosecutors make create direct and indirect consequences for victims and

their families, juveniles who have sexually offended and their families, community members, and the agencies and programs providing supervision, treatment and education of the sexually offending juvenile. It is common knowledge that in many jurisdictions the judges and magistrates may be responsible for the entire spectrum of cases in their courts and juvenile sexual offense cases are a very small number of cases in front of the court. The vast majority of participants in the assessment project had favorable comments regarding the decisions made by judges, magistrates and prosecutors regarding sexually offending juveniles. The areas of concerns noted focused mostly on knowledge and expertise issues, consistency of staffing, and pre-trial and alternative prosecution issues.

Challenges Regarding Judges, Magistrates and Prosecutors (continued)

- Judges, magistrates and prosecutors are challenged with learning about a vast continuum of issues that may present in their caseloads. Individuals who sexually offend require interventions that are specialized and specific to their nature of offenses. The "offense specific" concept is widely accepted as a way of responding to individuals who sexually offend with approaches that are specialized to the population and issues, needs and challenges that this population manifests. Juveniles who sexually offend are a heterogenous population with a range of typologies and subtypes, risk levels and protective factors that require differential diagnosis and intervention. It is believed that when judges, magistrates and prosecutors lack specialized knowledge regarding juveniles who sexually offend their decisions may have unintended negative consequences on multiple levels. It can be argued that some judges, magistrates and prosecutors could benefit from "offense specific" education with emphasis an on: the Juvenile Standards; etiology, typologies and sub-types; risk and protective factors; clarification and reunification; current research; and best practices for supervision, management and treatment.

- Participants have expressed a belief that juveniles who sexually offend can be better managed and supervised when there is a consistent approach from the courts. Challenges faced by courts such as staff turnover, docket changes, and other factors outside the control of judges, magistrates and prosecutors may impact the consistency and nature of how cases are managed in a particular jurisdiction. Participants in the project have indicated that, when possible, having consistency from both the bench and District Attorney's office helps them operate MDT's more effectively with juveniles that sexually offend.

- As typology and sub-type research indicate, there is a wide continuum of juveniles that vary in age, developmental status, intellectual and cognitive functioning levels, offending behaviors, level of risk to the community. Some jurisdictions have developed creative methods to capitalize on the full continuum of options available to judges, magistrates and prosecutors such as informal adjustments, diversion programs, deferred adjudications, and pre-trial supervision programs. These various options still allow for supervision and management, but afford more ability to individualize the interventions to be congruent with the specific juvenile rather than a "one size fits all" approach.

Victim representation issues

While the Juvenile Standards clearly endorse the involvement of victim representatives and advocates, the implementation of this concept has been a challenge in most jurisdictions. The inconsistent level and nature of involvement with victim representation on MDT's is a major concern across the state. It has been frequently reported that there is often little or no victim representation for sexual abuse victims, especially when a family member did not commit the sexual offense.

- First and foremost, the concept of victim representation is not clearly defined and articulated in a manner in which professionals and concerned parties can understand what victim representation is and how they can incorporate it into treatment, supervision and management in a manner congruent with the intent of the Juvenile Standards. Consequently, agencies and individuals are often unclear about their roles and responsibilities in relation to victim representation

- Victim representatives and advocates may come from a very wide range of agencies both public and private. Consequently, their services may also vary greatly depending on their available funding and resources, agency mandates and philosophies, and staff knowledge and skill levels. These factors impact the availability and consistency of responses to victim issues in each jurisdiction.

- Some communities are fortunate to have the availability of skilled therapists that understand the intricacies of sexual offending, treatment of sexual abuse victims and the how to appropriately facilitate contact, clarification and reunification. Although the guiding principles and underlying philosophy of the Juvenile Standards strongly endorse a victim-centered approach, the Juvenile Standards do not contain qualifications or requirements for victim therapists or representatives to have specific training, knowledge or experience in these areas.

- In some cases the lack of involvement can be attributed to the fact that often victim representatives have not been made aware of or invited to MDT's by other members of MDT's. This could be remedied by a more aggressive approach by MDT's to learn who victim representatives are and to actively encourage their involvement in the MDT process.

- More often than not, it has been described that there are many different agencies and individuals providing these services and often they may have limited knowledge and training in the critical areas of sexual offending, offense specific treatment, and contact, clarification and reunification. It was frequently mentioned that there are therapists providing treatment to victims using practices that are considered not best practice and in some cases are potentially harmful.

Community information and awareness

There is a consistent need for accurate and realistic education regarding sexual offending in our communities. The topics of sex offenders, predators, sex offender registration, residency restrictions (and many more) are found almost daily in the media across America. Unfortunately, the stories often presented in the media are highly emotionally charged and help perpetuate a distorted or limited understanding of the issues surrounding sexual offending. The term "predator panic" has been coined and reflects the tendency of many citizens and communities to react from a fear based stance rather than a knowledge-based stance. The differences between juveniles and adults are not well understood by the public this lack of knowledge may drive community reactions that harshly categorize or label juveniles and also support practices that may, in the long run, be counterproductive for victim and community safety.

Efforts are needed to provide accurate information to citizens, agencies, institutions, and policy and decision makers regarding the heterogenous nature juveniles who sexually offend and the role that the communities and agencies can play in creating a more efficient and effective continuum of care for these juveniles in a manner which also appropriately addresses victim and community safety. Communities will be better able to address this complex issue through gaining knowledge of: the differences between adults and juveniles; the varying degrees of risk that juveniles may present; best practices for supervision, treatment and management; developing wider continuums of service; the importance of individualization and normalization for juveniles if they are going to be safely and constructively integrated into society; teaching and modeling healthy sexuality; and preventative strategies.

Research tends to indicate that the vast majority of juveniles who have sexually offended will not become adult sex offenders. The ability to discriminate the difference between those juveniles who present high-risk and those that do not is critical to responding effectively in a manner that matches resources with risk and need. Further research is needed in the areas of risk assessment; typologies and sub-groups; brain functioning and developmental issues; and effective treatment approaches for the different sub-types and typologies of juveniles who sexually offend.

Summary of overall implications:

The assessment project has noted a number of positive accomplishments indicating that many jurisdictions have developed effective MDT's and a strong core of services to juveniles who sexually offend. Additionally, some areas that have not participated in the assessment process have become more involved in creating collaborative teams in their area. Other jurisdictions have been highly innovative in using alternative sources of funding to develop services to increase their continuum of care in their communities. In spite of these successes, the implications stated in this report reflect a wide range of issues that hold challenges for Colorado on multiple levels.

One primary implication is the issue of knowledge and awareness of the issues surrounding juveniles who sexually offend. Communities could benefit from greater knowledge and understanding of the wide range of behavior and risks presented by juveniles who sexually offend. In addition, communities can learn the role they play in creating more safety for victims and potential victims by supporting juveniles who sexually offend to increase their health and provide safe opportunity for them to practice normalizing behaviors in their communities when appropriate. More research is needed to advance our knowledge of "what works" and also how to best tailor treatment and supervision to the various typologies and subtypes of juveniles who sexually offend. Accurate, reality-based and timely education and training is needed across a wide spectrum of audiences to stay informed on the latest of both research and effective practices for this population. Effective communication and coordination is needed between communities, legislators, agencies and the professionals serving this population to allow promote more proactive solutions to the challenges identified in macro systems portion of this report. Increased collaboration and resource sharing will present new opportunities for addressing some of the conflicts in agency mandates and the role confusion experienced by professional in various agencies which are driven by differing resources, philosophies and expectations. Creativity, risk taking and additional resources are needed to create a wider continuum of care that will allow include more community based and lower levels of care in addition to alternatives to out of home placement, when appropriate. With future advances in knowledge and new resources, the Juvenile Standards may require review for possible revision to remain congruent with emerging practices. Finally, more work is needed to clearly define and articulate how to improve victim representation and gain greater participation from various agencies and professionals in this regard.

Steps taken since the assessment project began:

As previously indicated, at the time of the initial data gathering, the level of implementation of the Juvenile Standards was very strong in many aspects. The findings indicated in this report were generated primarily from information that was received in late 2005 and early 2006. Since that time, the Site Coordinator for the Juvenile Standards Implementation Assessment Project has had continued involvement with many of the participants in the project and also agencies and judicial districts that have become engaged in technical assistance and training activities since the grant project was extended in late 2006. One of the steps in the process was for participants was to identify their own areas of challenges, barriers and needs and develop action plans for addressing concerns that were identified. While the manner and methods in which this was done varied in different jurisdictions, most participants were able to identify steps for changing and improving services and resources that they often implemented shortly thereafter. Some significant steps have been taken in various jurisdictions across Colorado since the inception of the assessment project. Additionally, the Sex Offender Management Board has been actively addressing many of the issues addressed in this report through the committees, collaborative groups and training efforts.

Training and educational activities

Although the Juvenile Standards have been present since 2003, there continues be a need to educate and inform the many individuals and agencies in Colorado that have involvement with juveniles who have committed sexual offenses. The Juvenile Standards Coordinator and Site Coordinator have been very active in providing training and educational activities in attempts to educate those not familiar with the Juvenile Standards and also to keep others informed of new information in the field. They have provided numerous trainings to a wide variety of audiences and also have presented at conferences geared towards statewide audiences. Trainings have included those provided as open trainings as well as trainings tailored to a specific jurisdiction at the request of the jurisdiction. Trainings have ranged from basic Introduction to the Juvenile Standards to Informed Supervision as well as more specialized trainings to address issues identified by the specific jurisdiction.

DCJ and the Sex Offender Management Unit sponsored several large conferences featuring nationally known experts in the field of sexual offending. In the summer 2006, Richard Packard presented on risk assessment and in 2007 Robert Longo presented on treatment approaches for juveniles who sexually offend. In addition, DCJ and the Sex Offender Management Unit have offered local trainings on a variety of topics including: healthy sexuality, physiological assessment, victim issues, etc. The BJA grant project has also provided a follow-up conference for participants in the assessment project in June of 2007 as well as four regional 2-day conferences focusing on specific areas of concern noted from the assessment project. The Juvenile Standards Coordinator and/or Site Coordinator have presented that the annual statewide National Association of Social Workers (NASW) conference, the annual Colorado Child and Adolescent Mental Health conference, and the annual Child Welfare conference in 2007. The focus of these conference presentations has addressed issues related to juveniles who have committed sexual offenses, systems issues and collaboration.

SOMB Committees

Victim Advocacy Committee

The Victim Advocacy Committee has been meeting regularly and the Site Coordinator from the assessment project has been active on that committee since early 2006. The

committee has strived to learn more about what victim advocacy and representation looks like in various jurisdictions. The committee created a survey instrument and the data from the responses gathered was used by the committee to use as a basis for the development of several trainings that were presented in both the metro Denver area and on the western slope. This training material was also integrated into the four BJA follow up trainings that were provided across the state in the summer of 2007. The committee remains active and is working on articulating the definition of victim representation, the roles various agencies and individuals have in victim representation as well as creating a handbook as a resource for victim representation/advocacy issues and to increase the level of victim representation on MDT's across the state.

Standing Committee Related to County Considerations

Issues relevant to many County Human/Social Service agencies were brought to the attention of the Site Coordinator early in the assessment process. Of significance, there was a common mindset by many Human/Social Service agencies that their issues and needs were not being addressed in a manner that they believed was fully inclusive. The Sex Offender Management Board responded to this matter by requesting opportunities to meet with representatives from Human/Social Service agencies and to engage in dialogue regarding issues and concerns identified by the group. Due to the constructive progress made, the committee decided to formalize and continue to meet as The Standing Committee Related to County Considerations. Attendees include representatives from County Human/Social Services agencies, Colorado Department of Human Services, Division of Probation Services, probation supervisors, private treatment agencies and other interested parties. The committee is co-chaired by a Director of a County Human Service agency and a SOMB board member. The committee has worked diligently to educate and inform participants regarding systemic issues faced by the Human/Social Service agencies. The discussions have focused on systemic issues such as federal mandates, funding allocations and restrictions, training needs, use of polygraphs with juveniles, and other topics as determined by the committee. One concern the group has tackled is the belief that there needs to be more specific focus by the SOMB on juvenile issues. Discussions regarding how to achieve this have resulted in several outcomes including the proposal of either a separate Juvenile Board or the creation of a "Juvenile Advisory Board" as well as how to increase county membership on the Sex Offender Management Board.

Best Practices Committee

As the field of sexual offender-management develops, Colorado remains challenged to stay current with the latest in research and emerging practices related to juveniles who sexually offend. The Sex Offender Management Board recognized the need to be "dynamic, relevant and responsive" in this regard and created the Best Practices Committee to ensure that new information about research and emerging practices are being evaluated and provided to the Sex Offender Management Board. The Best Practices Committee has developed a protocol for evaluating proposed practice models and incorporates a multi-disciplinary perspective to help assure that the committee's recommendations to the Sex Offender Management Board are based on objective

information. An ecologically based treatment model called Multi-Systemic Therapy-Problem Sexual Behavior (MST-PSB) was the first application for review by the Best Practice committee by the new protocol.

Training Committee

The Training Committee is in some sense, complementary to the Best Practice committee. The need for keeping agencies and professionals across the state up to date in their levels of training is ongoing. Staff turnover impacts the knowledge base of agencies and also perpetuates the need for training that is timely, relevant and available to the meet the needs identified. The Training Committee has met regularly to work with various other agencies to identify ongoing training needs and resources and to plan future training based on identified needs. The group also coordinates with other organizations and professional associations to avoid training duplication and scheduling conflicts as well as to maximize the number and quality of trainings offered. Additionally, the Training Committee is in the preliminary stages of exploring innovative ways to provide alternative methods of training via more current technologies such as web based and distance learning models.

County Representatives added to Sex Offender Management Board

In response to the needs and concerns of the Standing Committee Related to County Considerations, the Sex Offender Management Board endorsed the concept of increasing the membership of the board to include more county level representation. Since the required members of Sex Offender Management Board are set by legislation, action was necessary to authorize additional membership on the Board. The state legislature recently authorized the addition of three new members on the board that include a County Human Services Director and two County Commissioners (one from a rural area and one from an urban area). The new members have been chosen and are beginning their tenure at the time of this writing.

Variance Process

The Sex Offender Management Board has developed a Variance Process to assist jurisdictions to address compliance issues created by resource limitations. The Variance Process provides a mechanism to allow MDT's to create alternatives regarding ***Systemic Non Case Specific Compliance*** issues after requesting a variance and receiving approval by Sex Offender Management Board.

Juvenile Advisory Board

The Sex Offender Management Board is dual focus Board in which the issues of both juveniles and adults are under the purview of the Board. Numerous stakeholders have raised concerns that the dual focus of the Board has an unintended consequence of diluting the intensity of efforts related to juveniles. Two possible solutions were promoted: the creation of either a Juvenile Advisory Board, or a separate and distinct Juvenile Board. The creation of a distinct Board for juveniles who have committed sexual offenses would be a lengthy process and would face many logistical hurdles, including the need for new or modified legislation. An alternative, the concept of a Juvenile Advisory Board, was a suggested. It is generally believed that a Juvenile Advisory Board would be more expedient, would not require legislation and could make use of existing expertise on the Sex Offender Management Board and also that of new members who possess any specific knowledge and expertise that is desired. To that end, the Sex Offender Management Board endorsed the Juvenile Advisory Board. By-laws

are under review and recruitment is underway for new members. The Juvenile Advisory Board will address juvenile issues and present information and recommendations to the full Sex Offender Management Board, which will still bear responsibility for voting on and approving those recommendations.

Listserv and Resource Directory

In order to improve the nature of information sharing with stakeholders, the Division of Criminal Justice is developing an Internet based listserv to be managed by the Juvenile Standards Coordinator**.** The listserv will be provided as a free resource to interested professionals who and will serve as a forum for communication and sharing about topics and issues related to juveniles who sexually offend. Additionally, a free online resource directory is being created to share a wide range of information and will include electronic copies of articles and research; references for articles and books; web links; and sample copies of forms and documents used by various agencies.

Provisional Provider Status

The absence of a SOMB approved treatment providers in some communities in Colorado has been identified as a barrier to having an adequate continuum of care. To address the need for more approved treatment providers, the Sex Offender Management Board created the Provisional Provider Status. This process grants individuals temporary approval to work towards Associate Level Provider status under the supervision of a Full Operating Level treatment provider. The requirements for training and experience for Provisional Provider applicants are less than that of Associate Level and allow the applicant a one-year period to achieve applicant status for Associate Level Provider. For communities and agencies that document the need for SOMB approved treatment providers, the Provision Provider Status is a flexible option for meeting the identified needs.

Risk Assessment Tool

As the concepts of typologies and subtypes become more integral to decision-making, the need for differential, individualized approaches to supervision are better indicated. Numerous stakeholders have indicated the need for a more current risk assessment tool to help guide the supervision of juveniles who sexually offend. The Division of Probation Services has received grant funding to work in conjunction with the Division of Criminal Justice research unit to develop a new juvenile risk assessment and case management-planning tool.

Division of Probation Services

At the time of the initial data collection, issues related to the Division of Probation Services were identified. Since that time the agency has implemented some new programming, and there have also been legislative actions that have impacted services to provided to juveniles who sexually offend. The Division of Probation has made modifications to the 80-hour advanced training program that addresses both juveniles who have sexually offended and adult sex offender issues. The training now includes

information about typologies and subtypes of juveniles who sexually offend. The agency partnered with the Division of Criminal Justice to access Sex Offender Surcharge funds to assist with training costs and also has invited participants outside of probation that include polygraph examiners, treatment providers, DYC staff, human/ social service caseworkers and other related agencies. A statutory change, effective July 1, 2007, requires that a PSI will be done for any juvenile adjudicated for a sexual offense. The Division of Probation Services is automating the PSI process to standardize the process to allow for greater consistency of information. Finally, the Division has received additional funding allowing jurisdictions to increase staff capacity based on needs identified by each jurisdiction. Some jurisdictions have utilized these additional resources to provide more intensive supervision services to juveniles who have sexually offended with.

Division of Youth Corrections:

At the time of the initial data collection, there were numerous issues of concern identified with the Division of Youth Corrections (DYC). Since the initial data collection period DYC has taken aggressive action to make changes on various levels. The division hired a victim services coordinator to assist the agency to coordinate and improve the agency's responses to victims. The division also has received additional funds to allow for creating new positions that include licensed mental health and offense specific treatment staff and funds have been allocated to allow for contracting with approved SOMB evaluators to provide offense specific evaluations for juveniles who sexually offend. Flexible funds have been utilized to allow for a wider range of services and creating "wrap around" plans to youth transitioning to the community. Internal agency efforts have increased the amount of training related to juveniles who sexually offend and informed supervision. More focus is being placed on using typologies and, when possible, matching juveniles in the population to services that fit the needs indicated by their typologies.

FUTURE DATA NEEDS

Overall, the findings from the current assessment are encouraging and suggest several trends related to the implementation of the Juvenile Standards. Because the project included participants from only 11 of the 22 judicial districts in the state, the findings cannot be generalized to non-participating judicial districts. The diversity of the participating districts, however, did allow for an examination of different issues faced by jurisdictions that may be representative of other districts throughout the state, and thus may be instructive in some ways for non-participating districts..

While the assessment tool was specifically designed to address the implementation of the Juvenile Standards, there were limitations to the assessment tool's ability to capture certain data directly. For example, the assessment tool did not gather statistical data from the participating districts related to caseload numbers; the number of youth in placement; types and intensity of treatment; types and intensity of supervision; or the nature of offense behaviors of the juveniles under supervision. This data was not within the purview of this assessment but would be helpful in defining specifically the population of juveniles who commit sexual offenses in Colorado and the nature of their offending behaviors. This data could be instrumental in further refinement of the responses to juveniles who have committed sexual offenses in Colorado and the development of a

wider, more effective continuum of care. More specifically, this data would help determine that services are being individually tailored to match the needs, risk levels, and specific offenses of each juvenile and to promote the optimum level of community safety, supervision, treatment, and health for each juvenile.

Appendix A

Frequency Responses To Assessment Tool Questions

Section 1: Presentence Investigations of Juveniles Who Have Committed a Sexual Offense

Tables 1a – 1c below, represent the *frequency* of scores for all the participating judicial districts. For example, 65 percent of the participating sites answered "Always" to question number 1 of Section 1 of the Assessment Tool.

Table 1a: Frequency of scores
Juvenile Standards Assessment Tool: **Section 1**

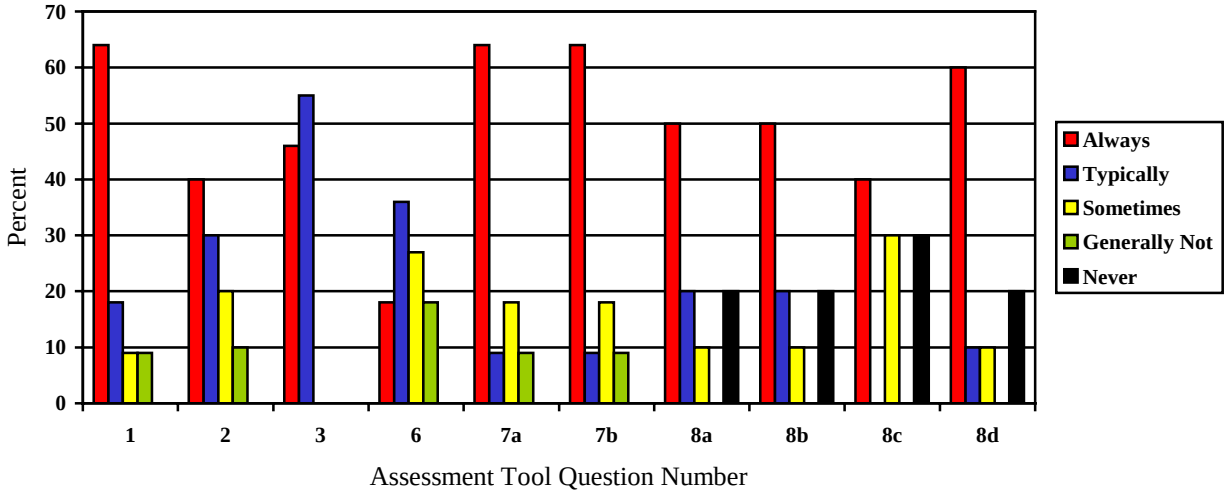
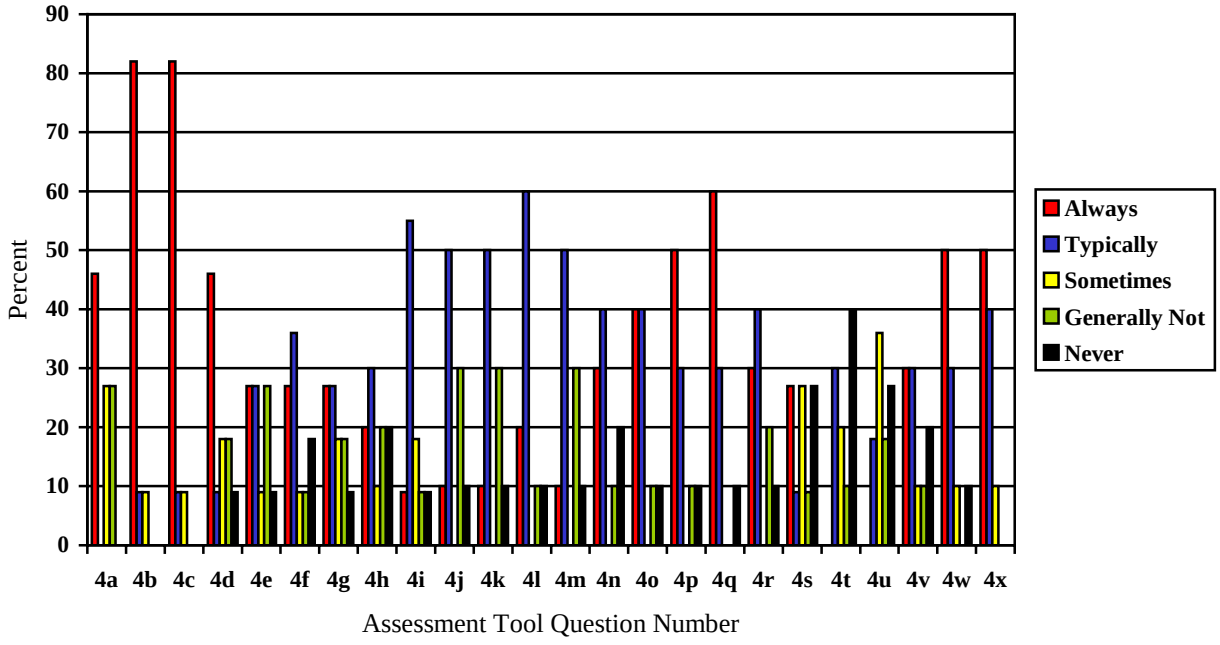
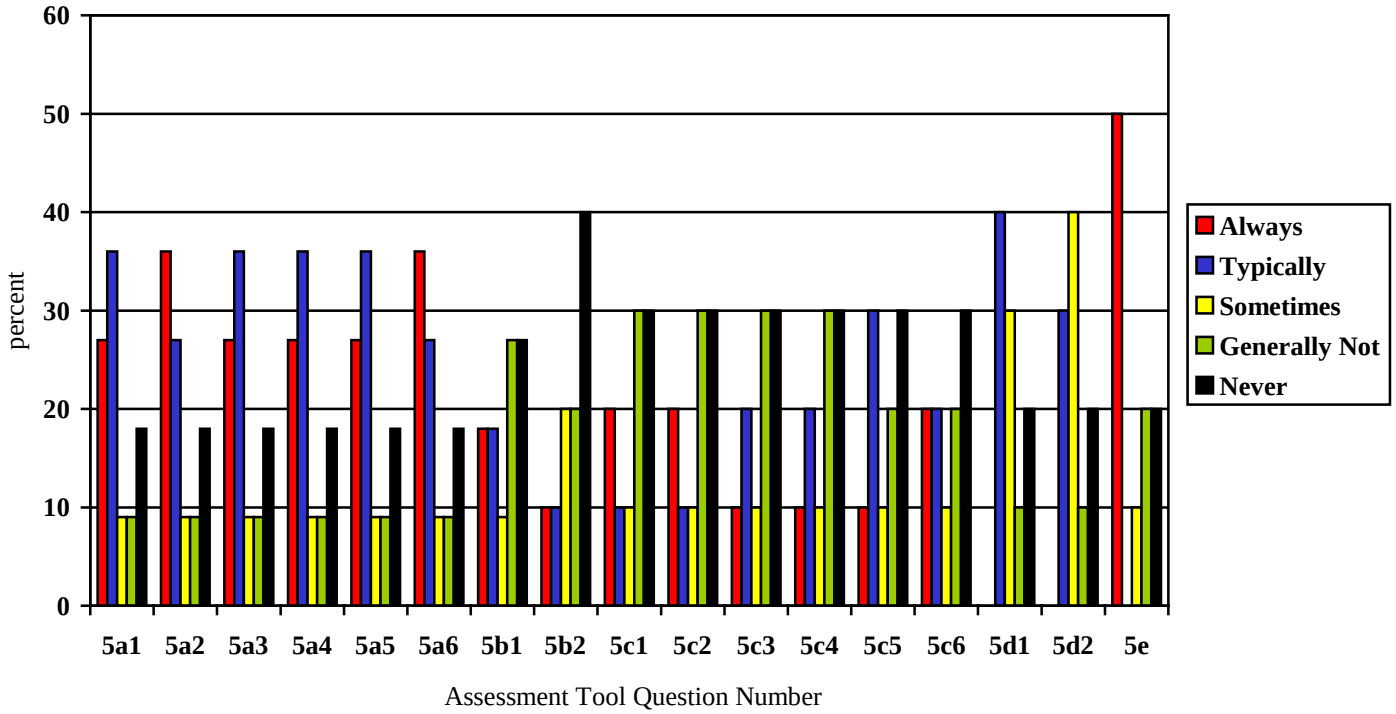


Table 1b: Frequency of scores
Juvenile Standards Assessment Tool: **Section 1, #4**



Juvenile Standards Assessment Tool: **Section 1, #5**



Section 2: Evaluation and Ongoing Assessment of Juveniles Who Have Committed Sexual Offenses

Tables 2a – 2b below, present the *frequency* of scores for all the participating judicial districts. .

Table 2a: Frequency of scores
Juvenile Standards Assessment Tool: **Section 2**

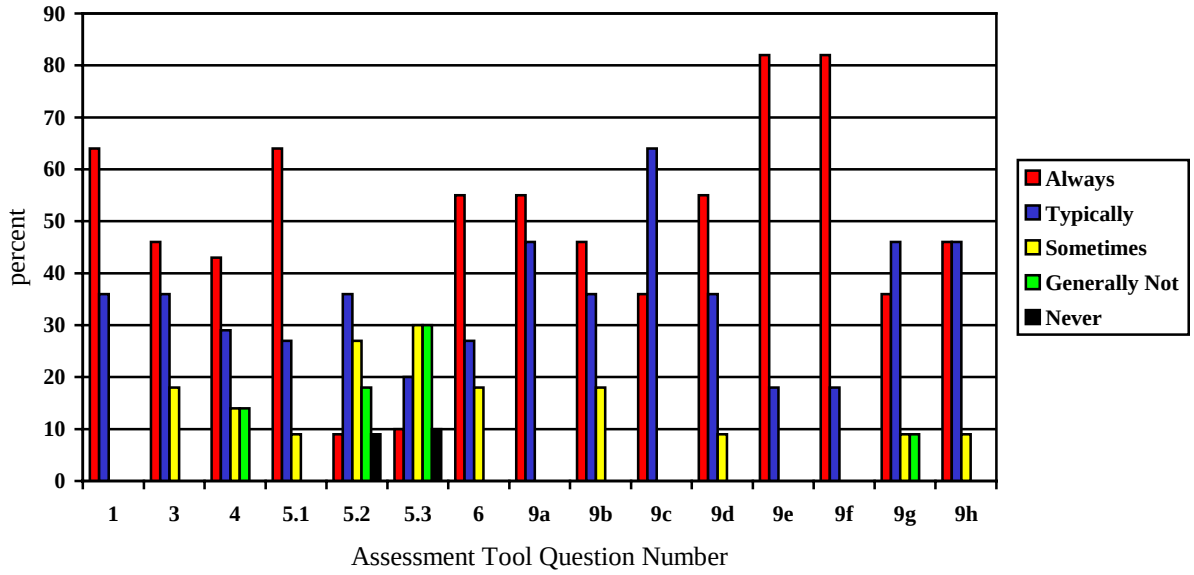
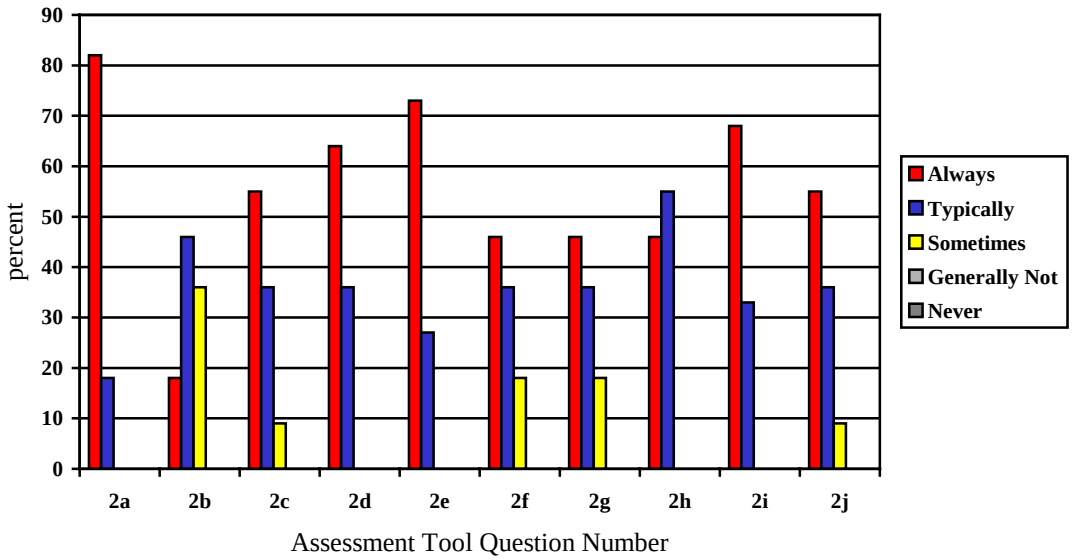


Table 2b: Frequency of scores
Juvenile Standards Assessment Tool: **Section 2, #2a - j**



Section 3: Standards of Practice for Treatment Providers

Tables 3a – 3e below, present the *frequency* of scores for all the participating judicial districts.

Table 3a: Frequency of scores
Juvenile Standards Assessment Tool: **Section 3, # 1-3**

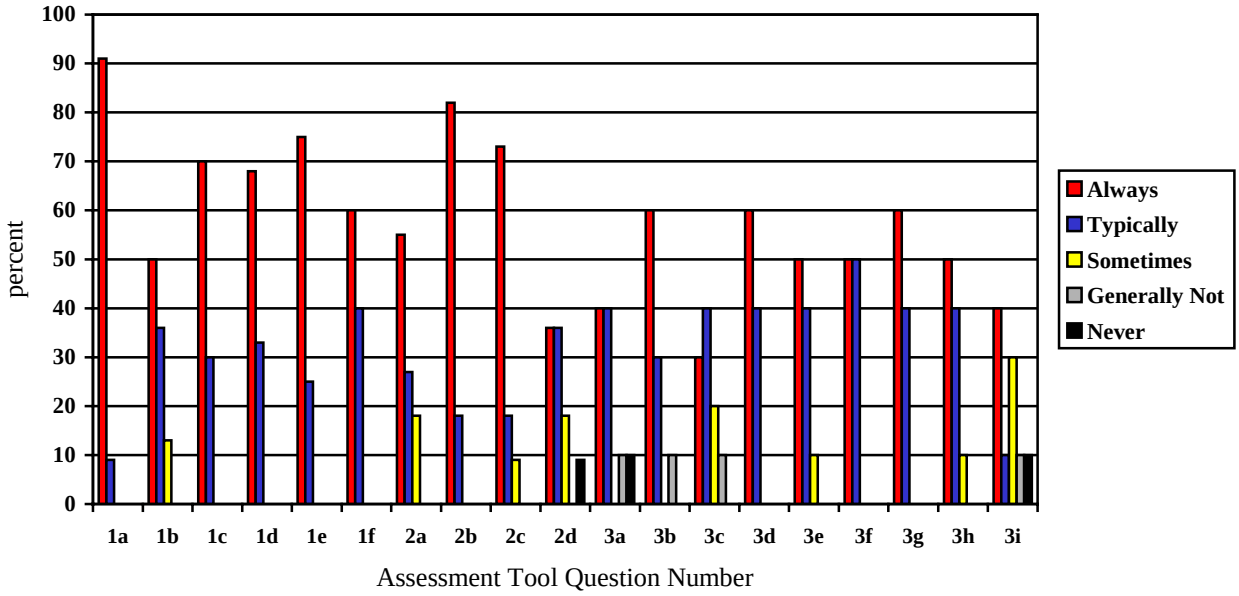
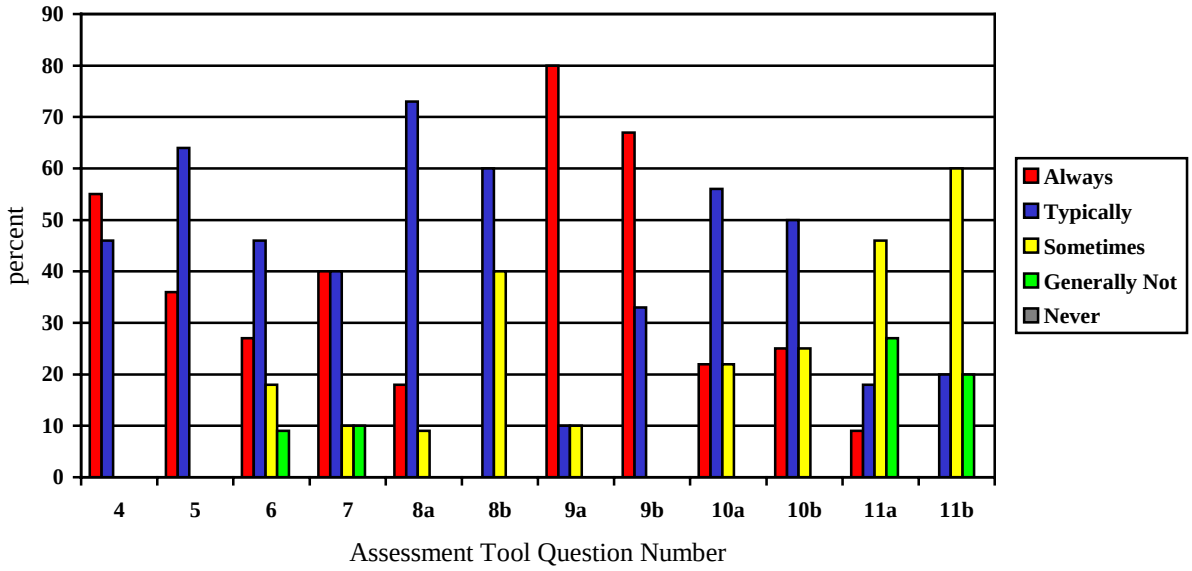


Table 3b: Frequency of scores
Juvenile Standards Assessment Tool: **Section 3, #4-11**



Juvenile Standards Assessment Tool: **Section 3, #12**

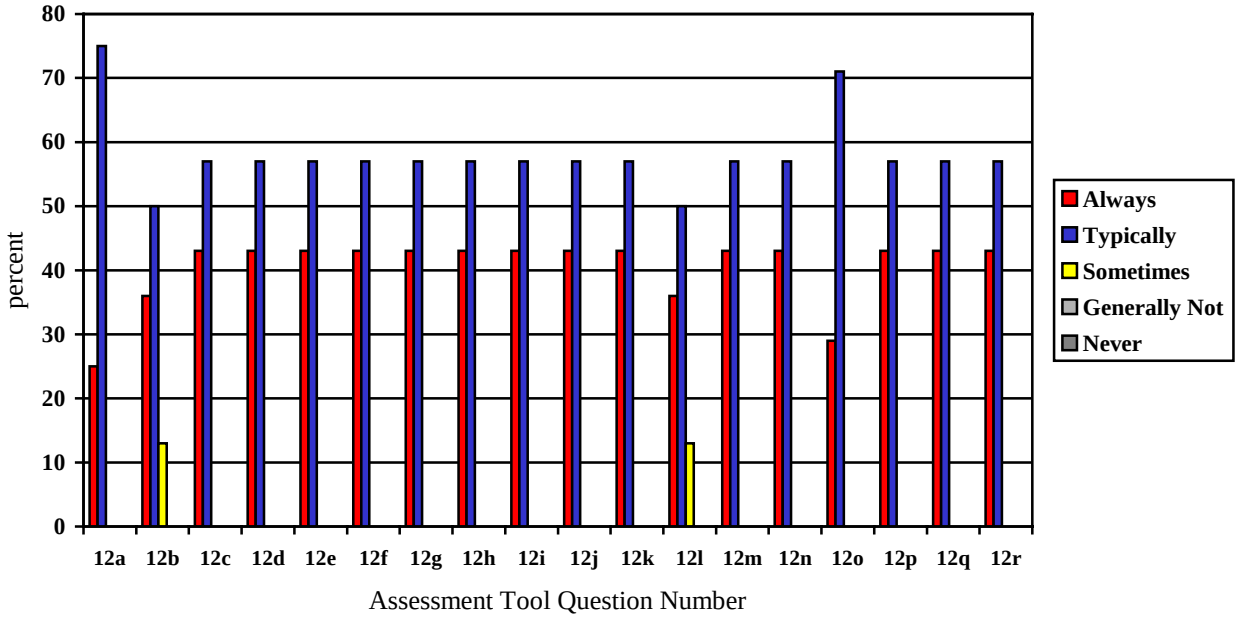


Table 3d: Frequency of scores
Juvenile Standards Assessment Tool: **Section 3, #13 - 16**

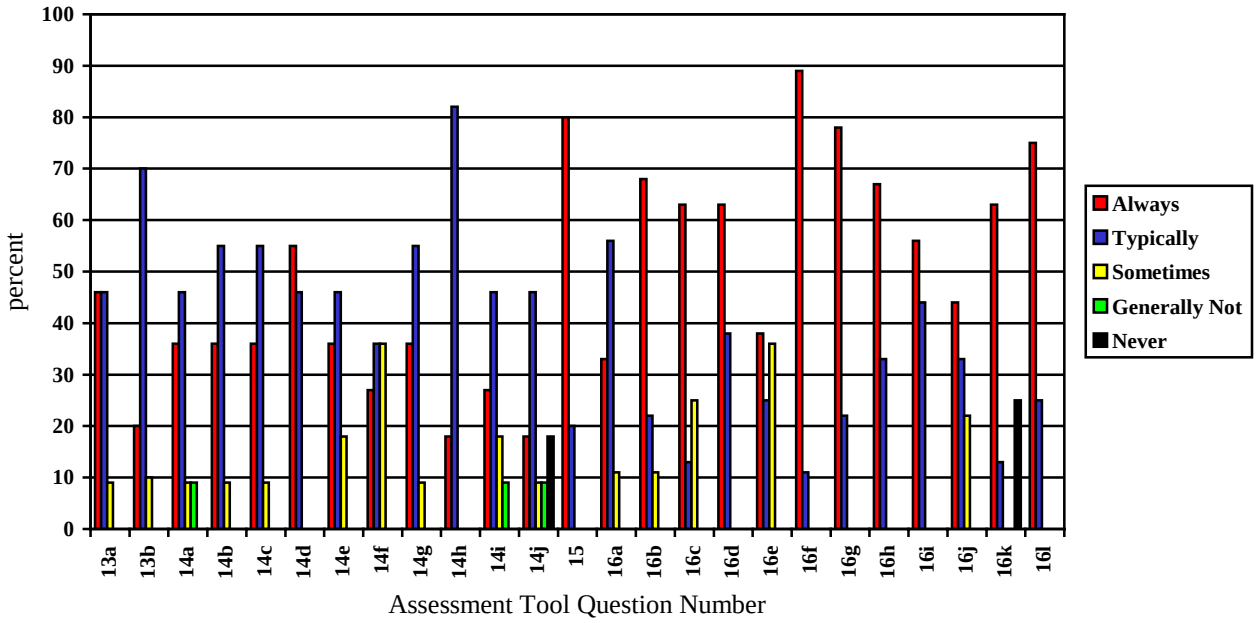
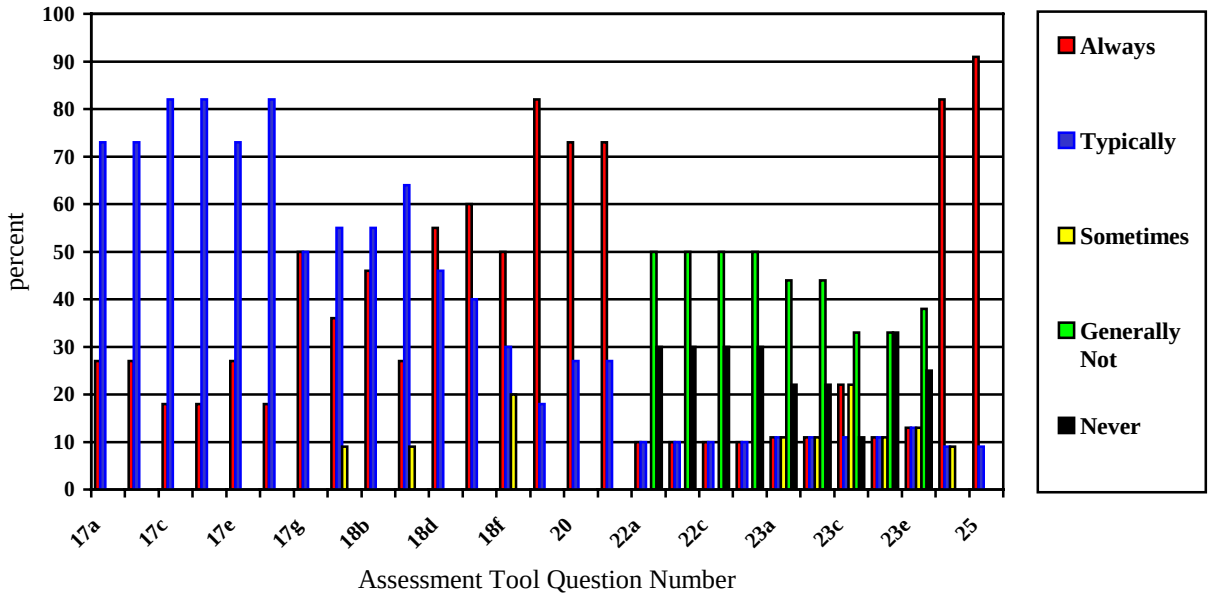


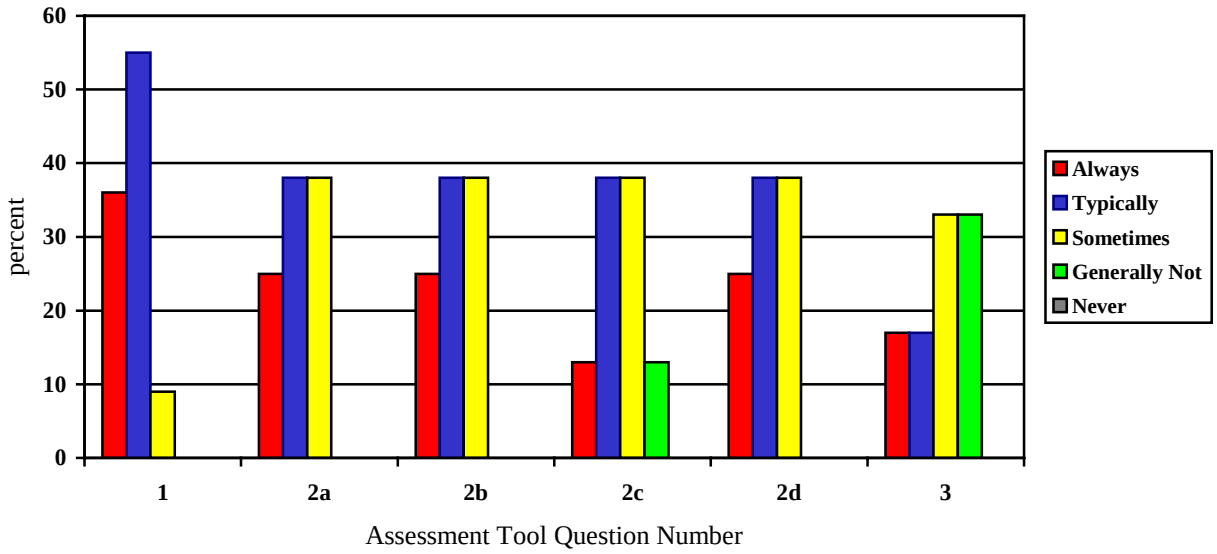
Table 3e: Frequency of scores
Juvenile Standards Assessment Tool: **Section 3, #17 - 25**



Section 4: Qualifications of Providers, Evaluators and Programs for Juveniles Who Have Committed Sexual Offenses

Table 4a below, presents the *frequency* of scores for all the participating judicial districts.

Table 4a: Frequency of scores
Juvenile Standards Assessment Tool: **Section 4**



Section 5: Establishment of a Multidisciplinary Team for the Management and Supervision of Juveniles Who Have Committed Sexual Offenses

Tables 5a – 5b below, present the *frequency* of scores for all the participating judicial districts.

Table 5a: Frequency of scores
Juvenile Standards Assessment Tool: **Section 5, #1-15**

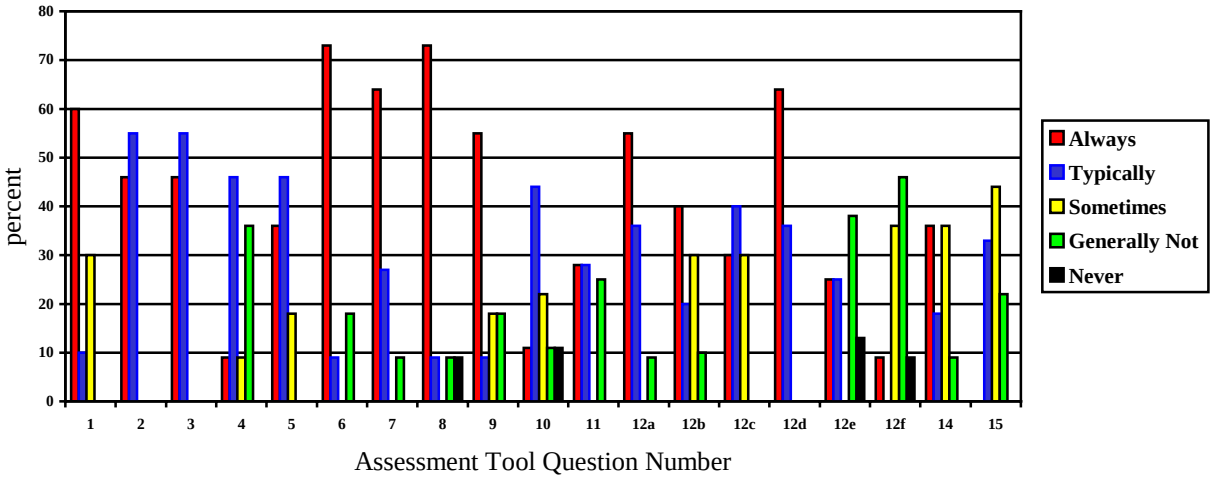
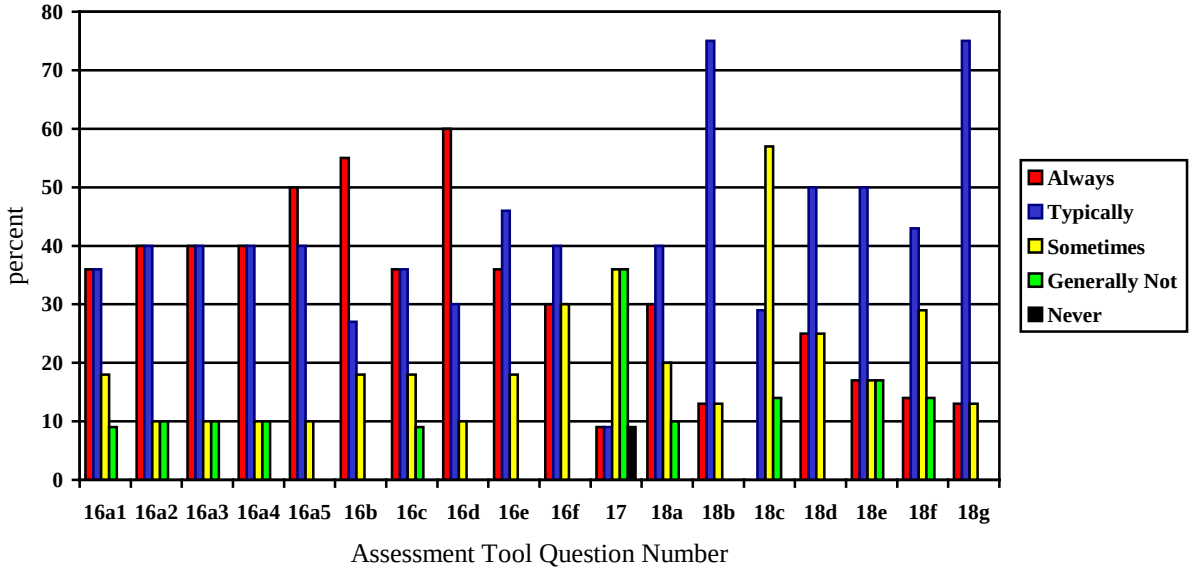


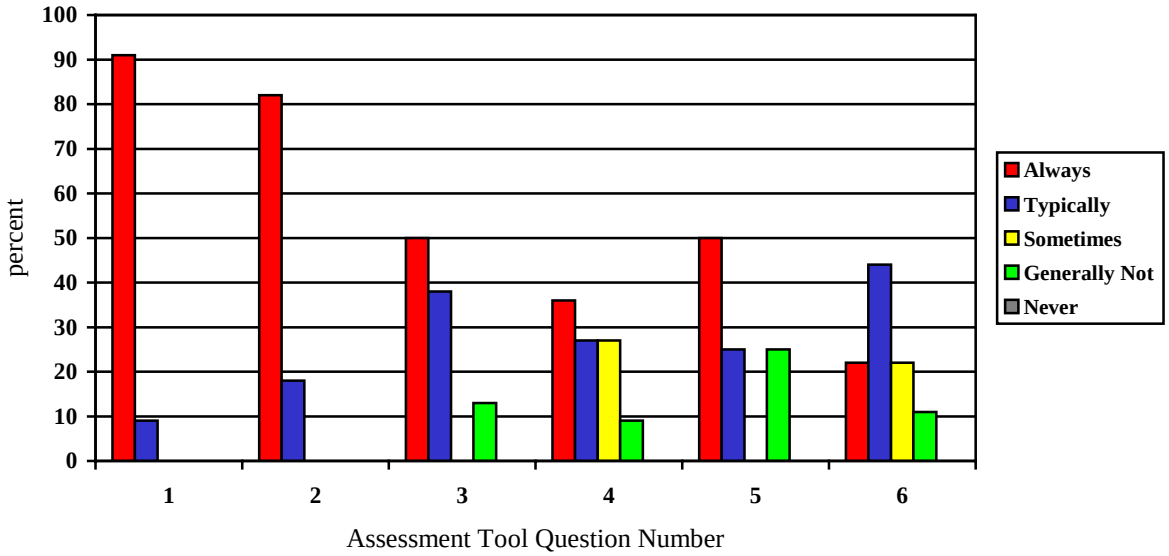
Table 5b: Frequency of scores
Juvenile Standards Assessment Tool: **Section 5, #16-18**



Section 6: Additional Conditions of Community Supervision

Table 6a below, presents the *frequency* of scores for all the participating judicial districts.

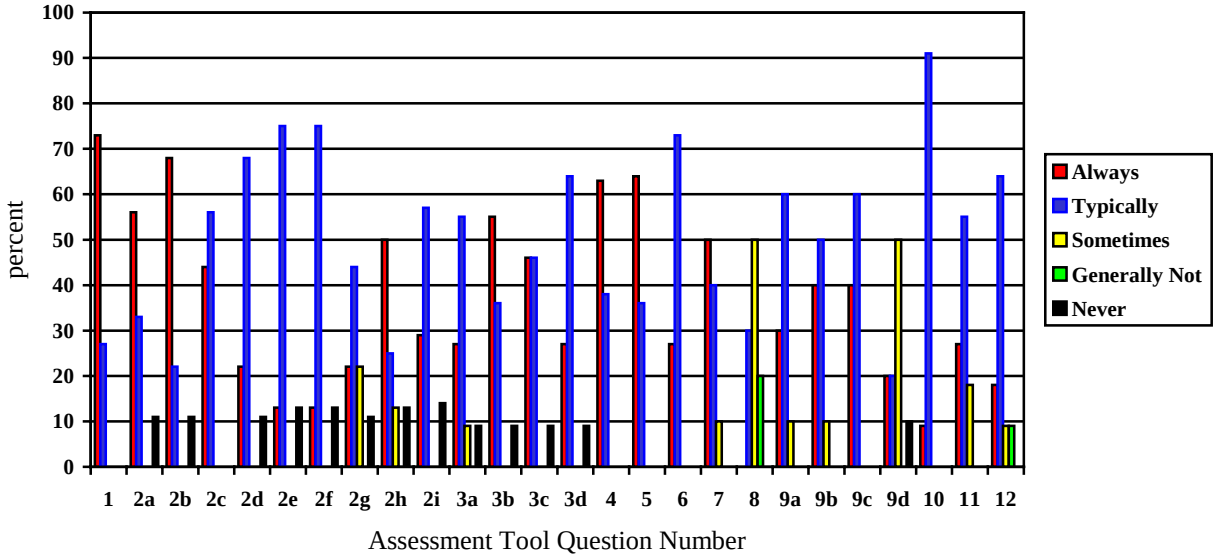
Juvenile Standards Assessment Tool: **Section 6**



Section 7: Polygraph Examination of Juveniles Who Have Committed Sexual Offenses

Table 7a below, presents the *frequency* of scores for all the participating judicial districts.

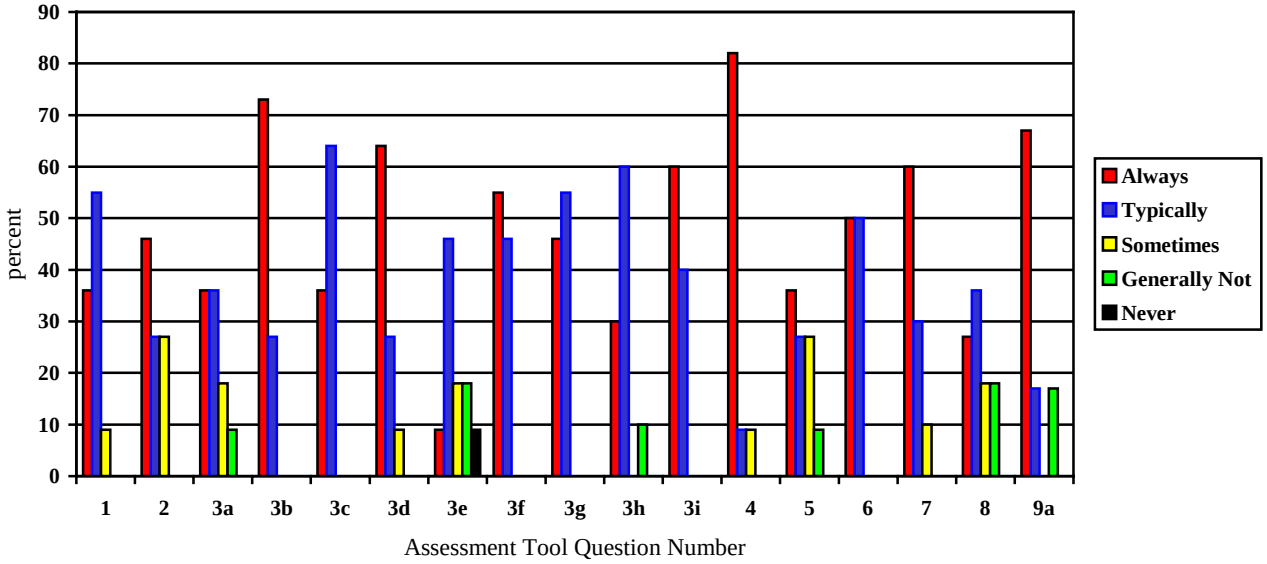
Juvenile Standards Assessment Tool: **Section 7**



Section 8: Victims and Potential Victims: Clarification, Contact and Reunification

Table 8a below, presents the *frequency* of scores for all the participating judicial districts.

Table 8a: Frequency of scores
Juvenile Standards Assessment Tool: **Section 8**


90
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percent
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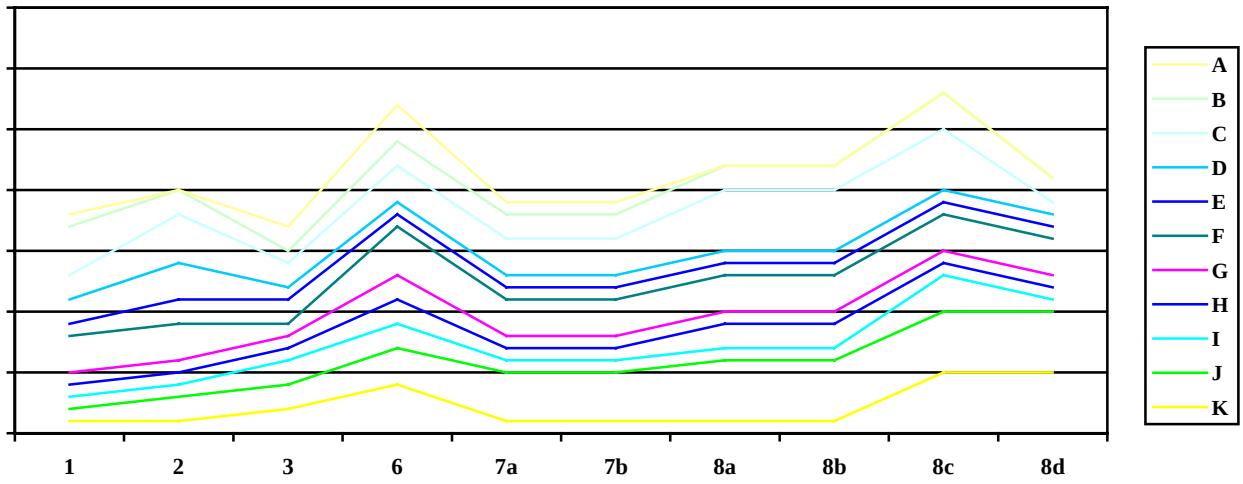
3h
3i
4
5
6
7
8
9a
Assessment Tool Question Number
Always
Typically
Sometimes
Generally Not
Never

Appendix B
Variation Across Sites

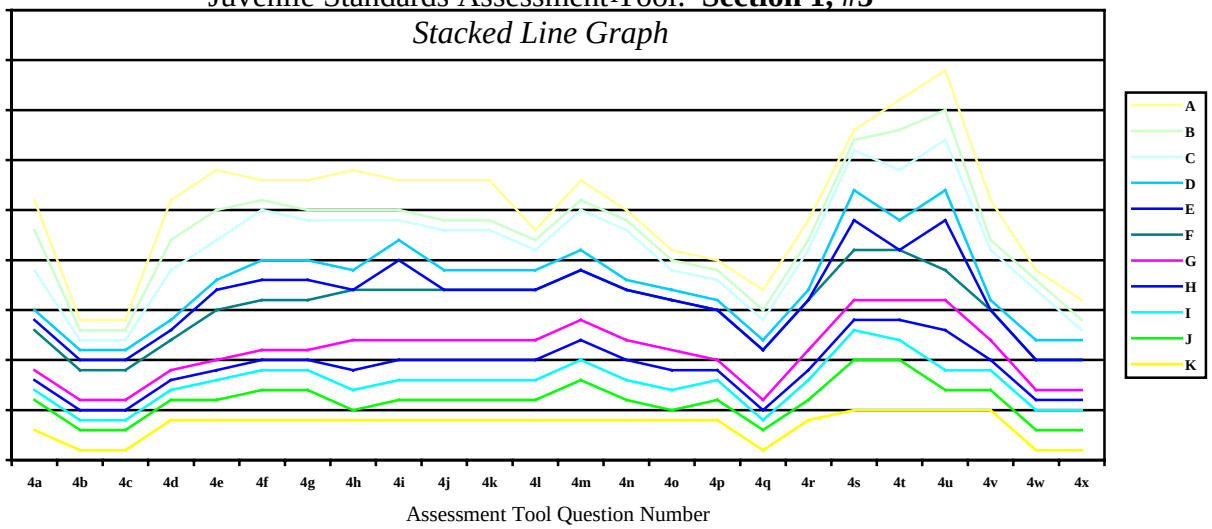
The following graphs illustrate a visual comparison of scores for each section of the assessment tool, for each participating site (each site is confidentially indicated with a letter A – K). The scores for each site are stacked to illustrate both the trend of the scores for each section of the assessment tool, as well as to demonstrate the differences between the sites.

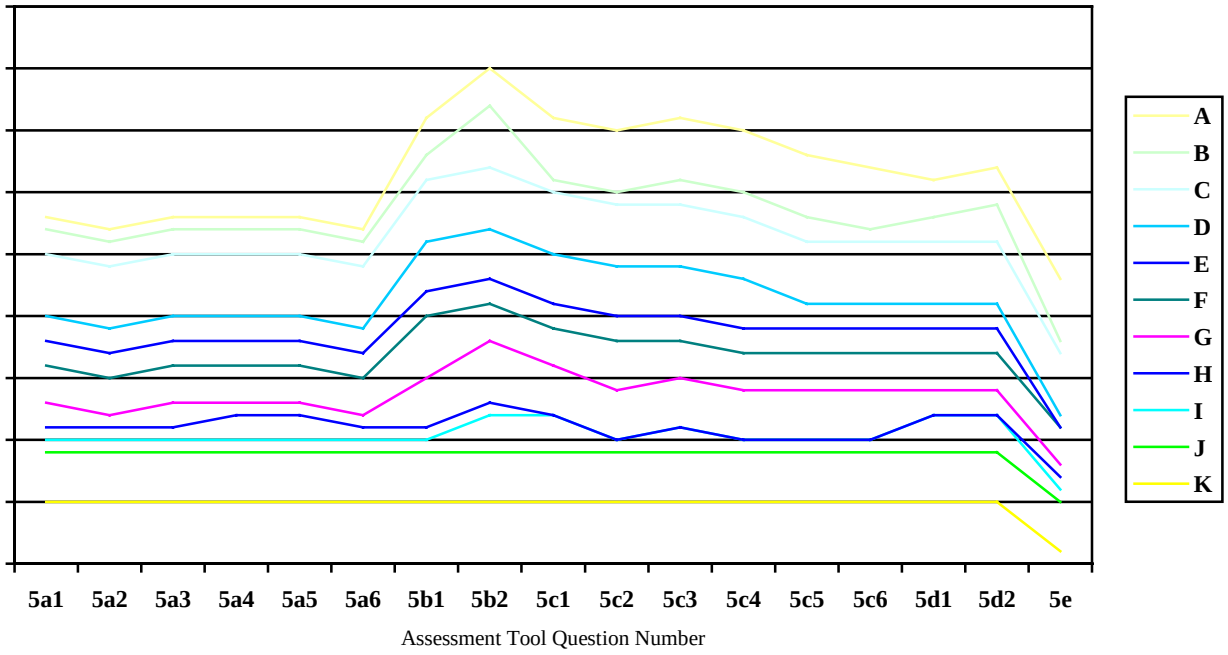
Juvenile Standards Assessment Tool: **Section 1**
Stacked Line Graph



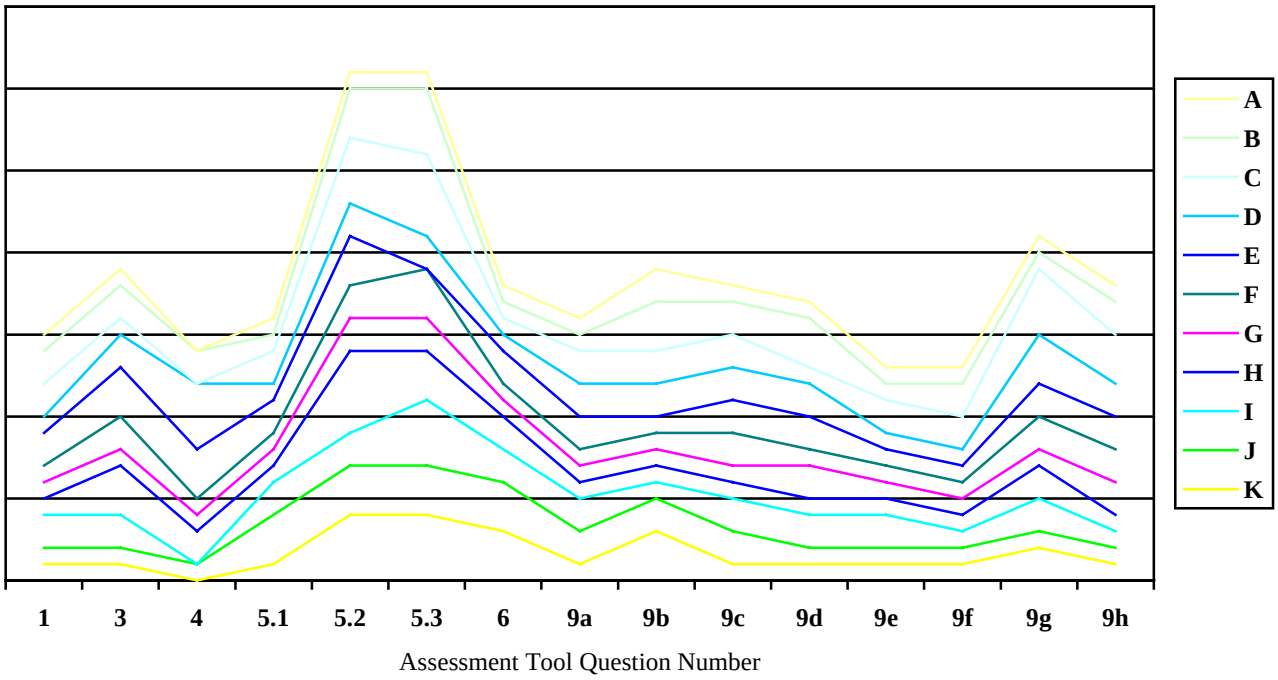
Juvenile Standards Assessment Tool: **Section 1, #4**
Stacked Line Graph

Juvenile Standards Assessment Tool: **Section 1, #5**
Stacked Line Graph

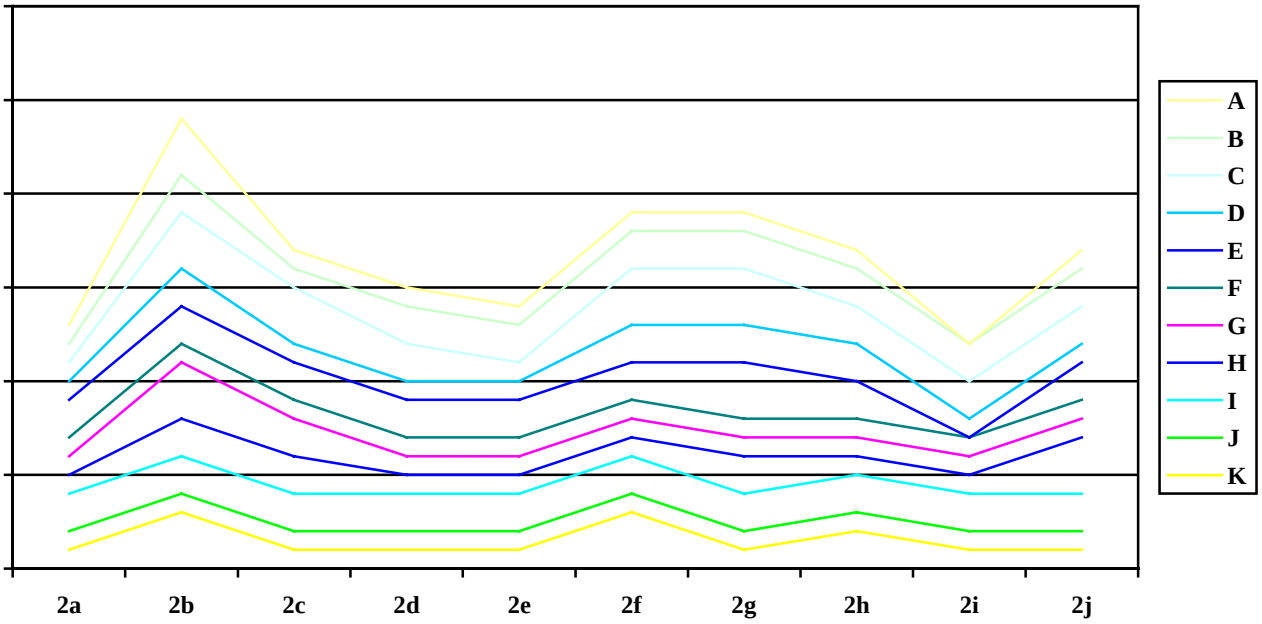




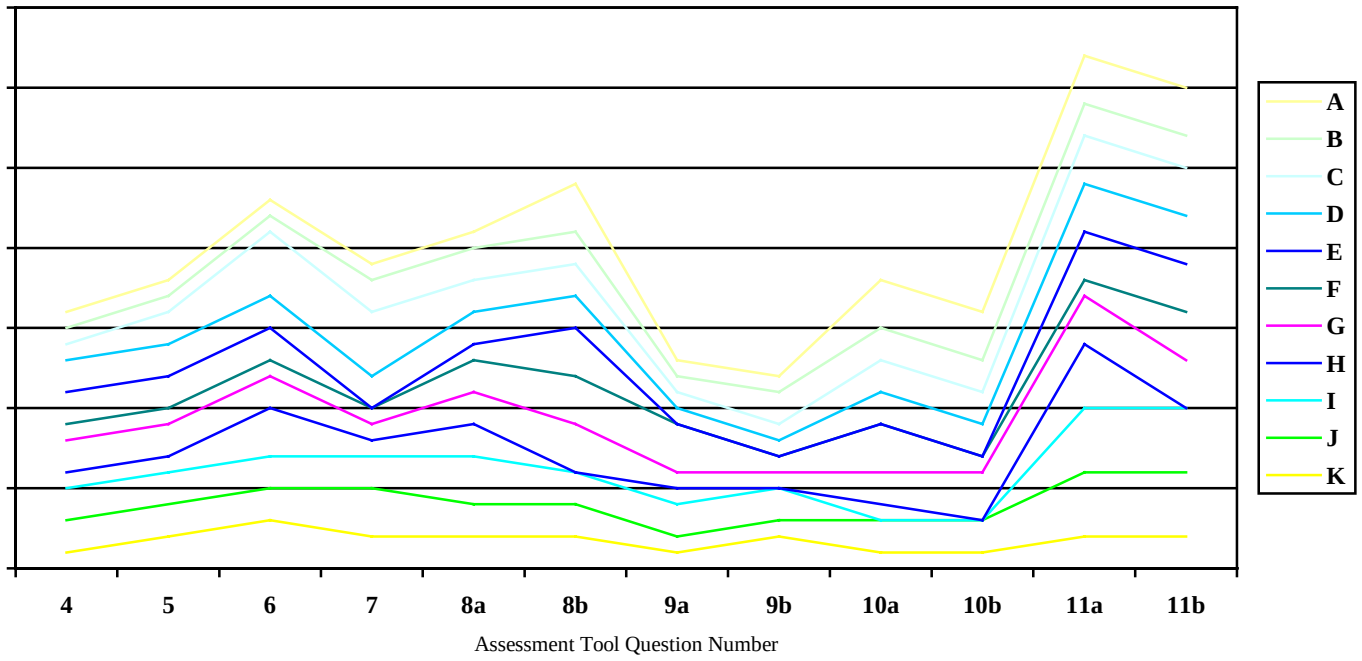
Juvenile Standards Assessment Tool: **Section 2**
Stacked Line Graph



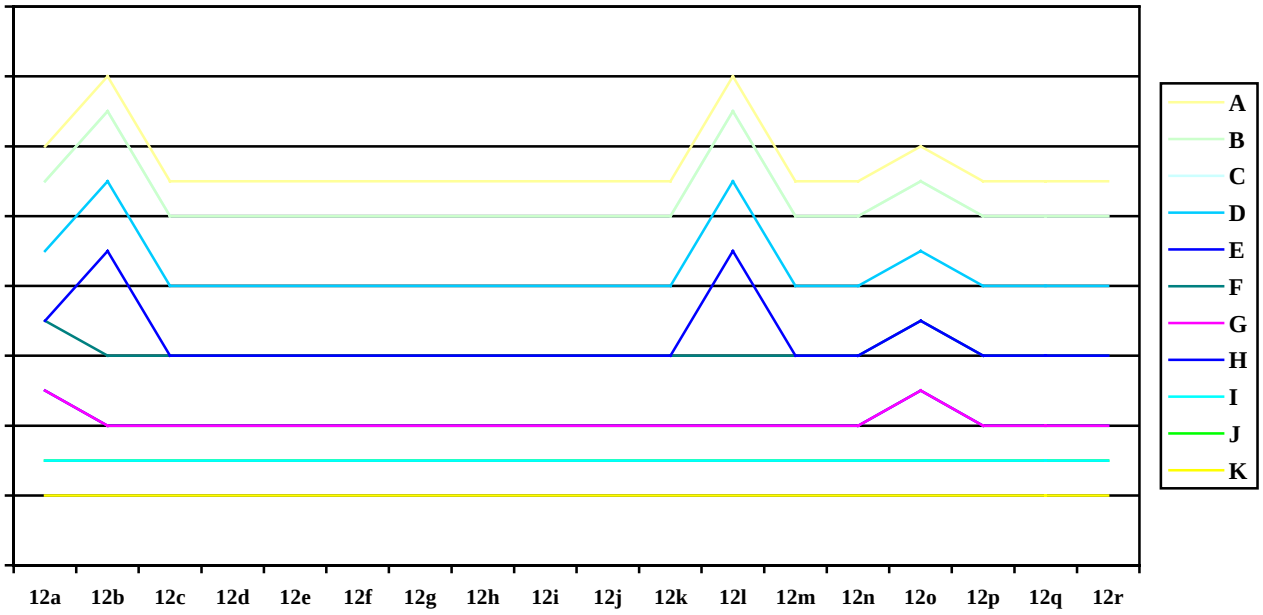
Juvenile Standards Assessment Tool: **Section 2, #2a - j**
Stacked Line Graph



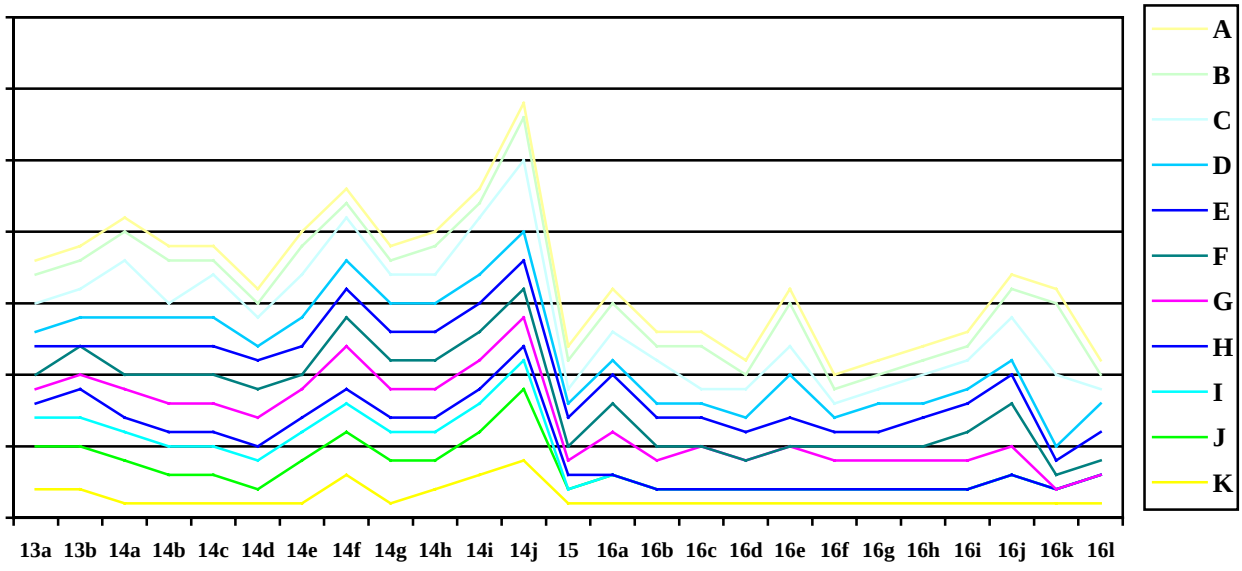
Juvenile Standards Assessment Tool: **Section 3, #4-11**
Stacked Line Graph



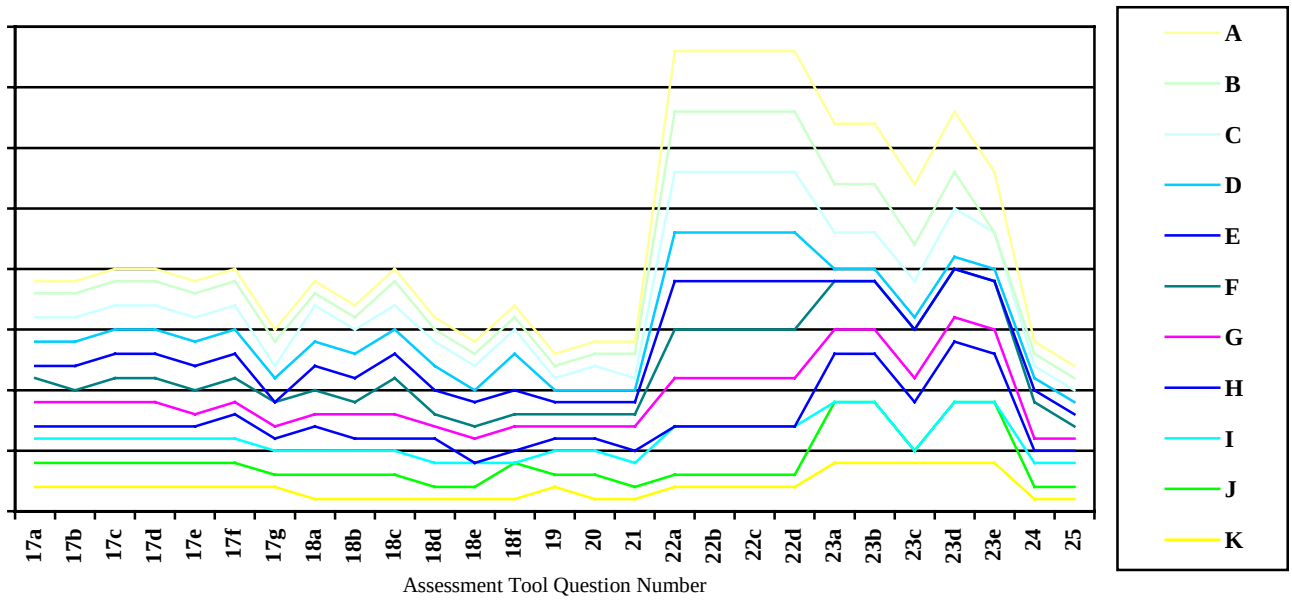
Juvenile Standards Assessment Tool: **Section 3, #12**
Stacked Line Graph



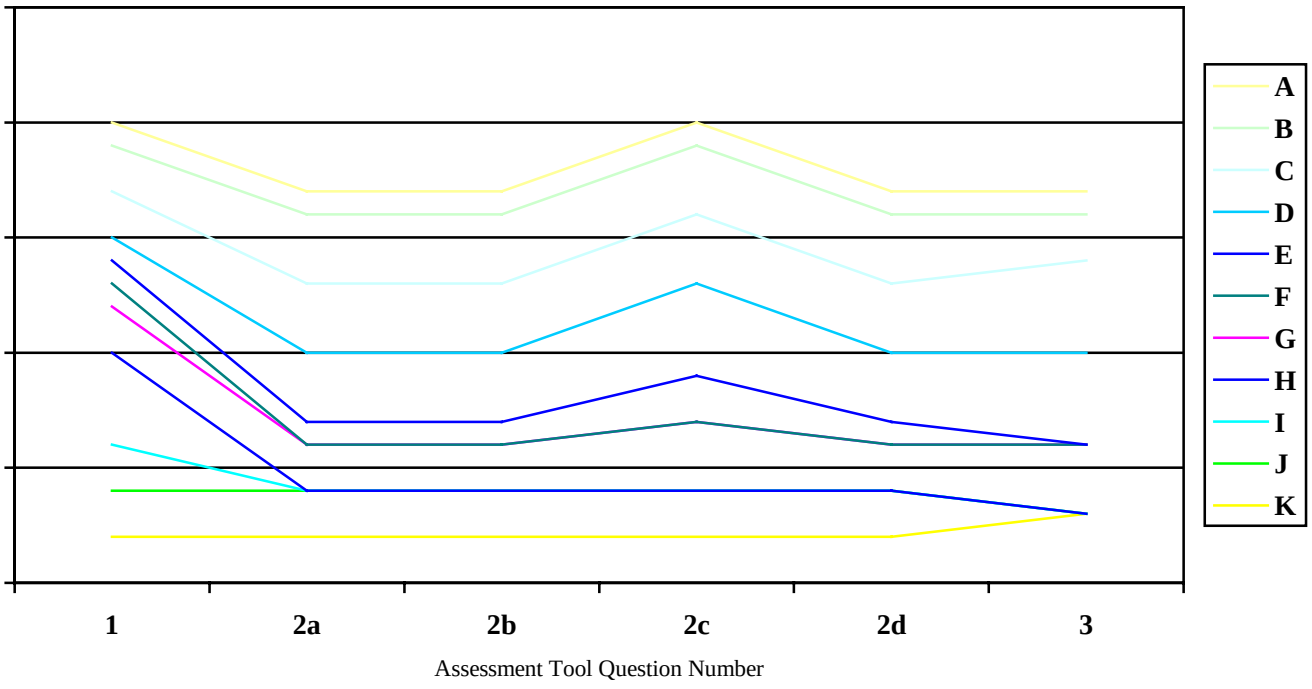
Juvenile Standards Assessment Tool: **Section 3, #13 - 16**
Stacked Line Graph



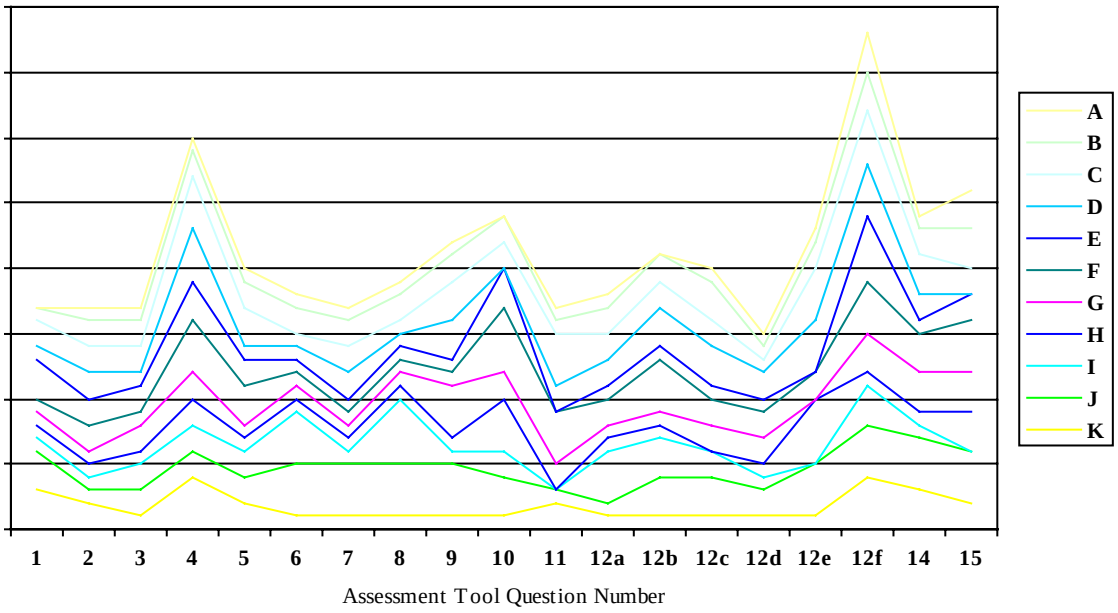
Juvenile Standards Assessment Tool: **Section 3, #17 - 25**
Stacked Line Graph



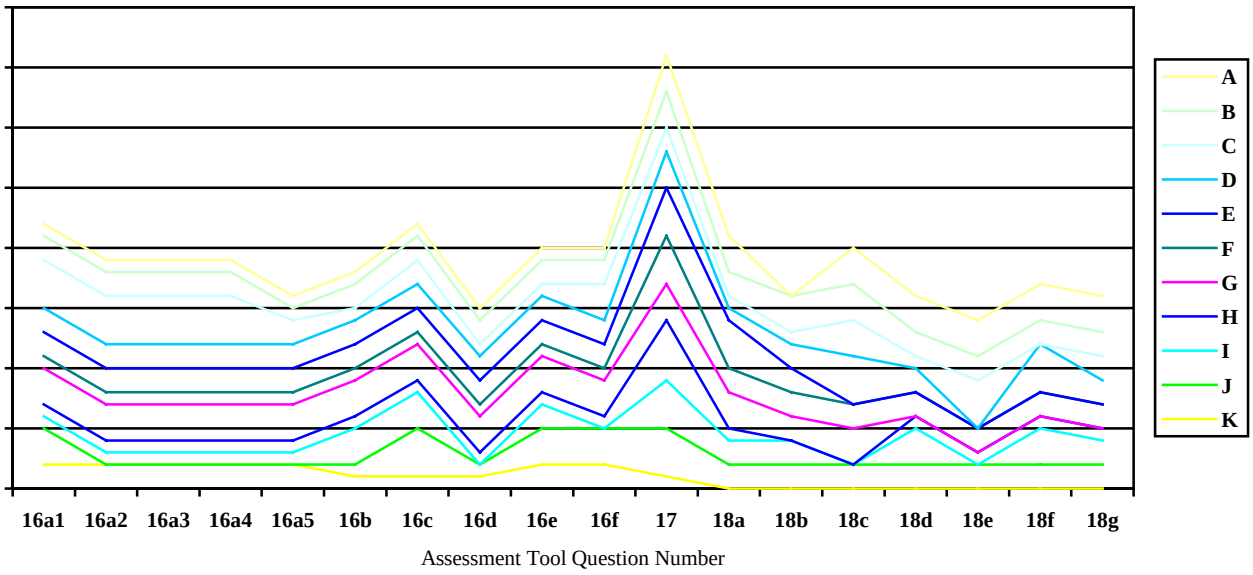
Juvenile Standards Assessment Tool: **Section 4**
Stacked Line Graph



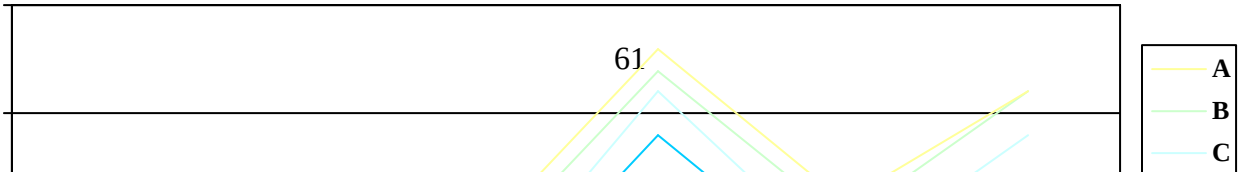
Juvenile Standards Assessment Tool: **Section 5, #1-15**
Stacked Line Graph



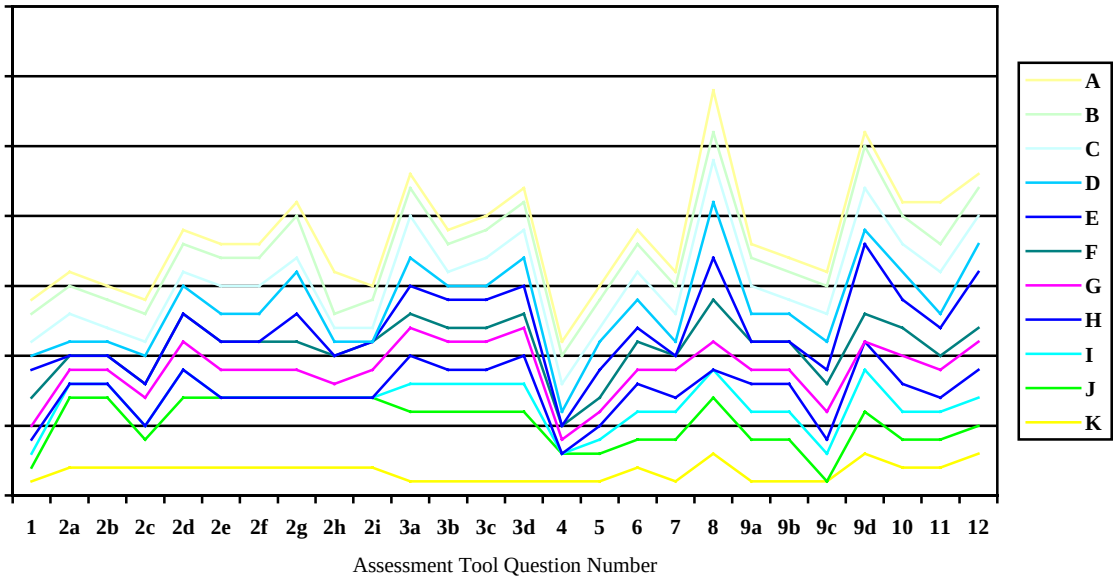
Juvenile Standards Assessment Tool: **Section 5, #16-18**
Stacked Line Graph



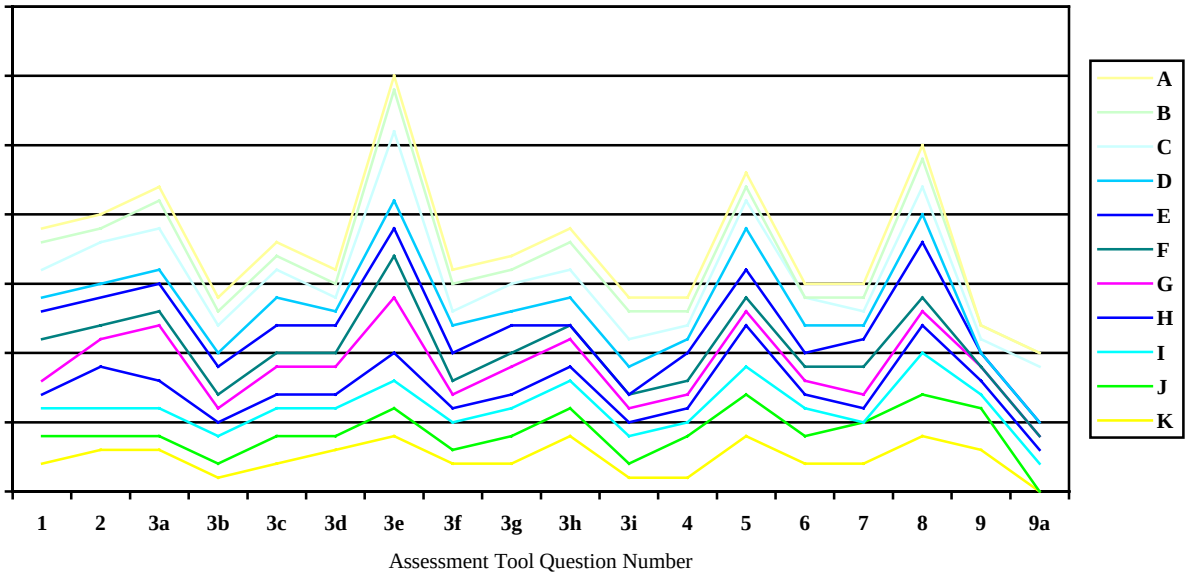
Juvenile Standards Assessment Tool: **Section 6**
Stacked Line Graph



Juvenile Standards Assessment Tool: **Section 7**
Stacked Line Graph



Juvenile Standards Assessment Tool: **Section 8**
Stacked Line Graph


A
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9a
Assessment Tool Question Number

Appendix C

Juvenile Standards Assessment Tool

The *Juvenile Standards Assessment Tool* can be downloaded from the Division of Criminal Justice, Office of Domestic Violence and Sex Offender Management website:

http://dcj.state.co.us/odvsom/Sex_Offender/index.html

SITE:_____

DATE(S):_____

JUVENILE STANDARDS ASSESSMENT TOOL

Site:_____
Date(s):_____

Agency(ies):_____
_____

Date Collection Method (include #):
i.e., 10 probation files, interviews with 5 treatment providers, etc. If different methods used for some questions, please note method used by question number.

_____
_____
_____

SECTION 1.000

PRESENTENCE INVESTIGATIONS OF JUVENILES WHO HAVE COMMITTED SEXUAL OFFENSES

SECTION 1.000: PRESENTENCE INVESTIGATIONS OF JUVENILES WHO HAVE COMMITTED SEXUAL OFFENSES

1=ALWAYS (100% of the time)
2=TYPICALLY (~75% of the time)
3= SOMETIMES (~50% of the time)
4=GENERALLY NOT (~25% of the time)
5=NEVER

1. Are presentence investigations (PSIs) conducted with each juvenile who has been adjudicated for a sexual offense? [1.100]_____

1a. If #1 does not equal ALWAYS or TYPICALLY, what are the barriers preventing this from *always or typically* happening?
1b. If #1 does not equal ALWAYS or TYPICALLY, what does the community/agency/etc. need to allow this to always or typically happen?
1c. If #1 does not equal ALWAYS or TYPICALLY, what is the community's/agency's/etc. current practice regarding this issue?

2. Are presentence investigations (PSIs) conducted with each juvenile adjudicated for a non-sexual offense, if the instant offense has an underlying factual basis of unlawful sexual behavior? [1.200]_____

2a. If #2 does not equal ALWAYS or TYPICALLY, what are the barriers preventing this from *always or typically* happening?
2b. If #2 does not equal ALWAYS or TYPICALLY, what does the community/agency/etc. need to allow this to *always or typically* happen?
2c. If #2 does not equal ALWAYS or TYPICALLY, what is the community's/agency's/etc. current practice regarding this issue?

3. Have probation officers investigating juveniles during the presentence stage successfully completed recommended sex offense specific training? [1.300]_____

3a. If #3 does not equal ALWAYS or TYPICALLY, what are the barriers preventing this from *always or typically* happening?
3b. If #3 does not equal ALWAYS or TYPICALLY, what does the community/agency/etc. need to allow this to always or typically happen?
3c. If #3 does not equal ALWAYS or TYPICALLY, what is the community's/agency's/etc. current practice regarding this issue?

4. Do PSIs include the following items? [1.400]

a. Victim Impact Statement_____
b. Juvenile's statement of the offense_____
c. Juvenile justice history, criminal history_____
d. Risk assessment_____

O'Brien _____
Other_____ _____
Other_____ _____
Other_____ _____

e. Sexual offending and abuse patterns, grooming and victim selection _____
f. Type of threat, use of coercion_____
g. Sexual and non-sexual assaultiveness pattern or history (frequency and duration)_____
h. Financial status_____
i. Leisure/recreation—activities and affiliations_____
j. Inter/intra-personal skills_____
k. Assets and coping abilities_____
l. Pertinent medical history_____
m. Disabilities (developmental, etc.)_____
n. Emotional/personal problems_____

o. Interventions including legal, academic and therapeutic_____
p. Officer's impressions of juvenile's attitude, orientation and amenability for supervision_____
q. Sex offense specific evaluation_____
r. Current degree of access to present, past or potential victim(s)_____
s. Placement recommendations and availability in Colorado_____
t. Potential impact of each sentencing option on the victim(s)_____
u. Restorative/reparative options_____
v. Initial case plan_____
w. Recommendations for sentencing including fees and surcharge_____
x. Recommendations for additional conditions_____

For each letter a – x that does not equal ALWAYS or TYPICALLY, please answer the following questions:

4a. What are the barriers preventing this from *always or typically* happening?
4b. What does the community/agency/etc. need to allow this to *always or typically* happen?
4c. What is the community's/agency's/etc. current practice regarding this issue?

5. When out-of-home placement is being considered, do PSIs include the following items? [1.410]
a. Assessment of the juvenile's physical health_____
Assessment of the juvenile's mental health_____
Assessment of the juvenile's developmental status_____
Assessment of the juvenile's family history_____
Assessment of the juvenile's social history_____
Assessment of the juvenile's educational status_____

b. List of recommended placements _____
List of the monthly cost of each recommended placement_____

c. Treatment plan, including:
- goals to be achieved by the placement_____
- services to be provided and by when_____
- intensity of services_____
- duration of services_____
- identification of services which can only be provided in a residential setting_____
- recommended duration of the placement_____

d. If a change in legal custody is being recommended:
- other alternatives explored and reasons for rejection_____
- 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._____

For each letter a – e that does not equal ALWAYS or TYPICALLY, please answer the following questions:

5a. What are the barriers preventing this from always or typically happening?
5b. What does the community/agency/etc. need to allow this to always or typically happen?
5c. What does the community/agency/etc. need to allow this to always or typically happen?

*6. Are the issues related to victims or potential victims addressed in relation to the recommendations made in the PSI?*_____
6a. If #6 does not equal ALWAYS or TYPICALLY, what are the barriers preventing this from always or typically happening?
6b. If #6 does not equal ALWAYS or TYPICALLY, what does the community/agency/etc. need to allow this to always or typically happen?
6c. If #6 does not equal ALWAYS or TYPICALLY, what is the community's/agency's/etc. current practice regarding this issue?

7. Do the PSIs make recommendations concerning a juvenile's: [1.500]

a. amenability to treatment?_____
b. suitability for community supervision?_____

For each letter a - b that does not equal ALWAYS or TYPICALLY, please answer the following questions:

7a. What are the barriers preventing this from *always or typically* happening?
7b. What does the community/agency/etc. need to allow this to *always or typically* happen?
7c. What is the community's/agency's/etc. current practice regarding this issue?

8. At the time of the PSI or intake interview, do the juveniles and the families/guardians: [1.700]

a. receive a copy of the disclosure/advisement form_____
b. sign the disclosure/advisement form _____
c. receive a copy of the complete waiver of confidentiality_____
d. sign the complete waiver of confidentiality_____

For each letter a – d that does not equal ALWAYS or TYPICALLY, please answer the following questions:

8a. What are the barriers preventing this from always or typically happening?
8b. What does the community/agency/etc. need to allow this to always or typically happen?
8c. What is the community's/agency's/etc. current practice regarding this issue?

9. Please describe any general barriers for conducting presentence investigations of juveniles who have committed sexual offenses that weren't already addressed in questions 1-8.

Site:_____

Date(s):_____

Agency(ies):_____

_____

Date Collection Method (include #):

i.e., 10 probation files, interviews with 5 treatment providers, etc. If different methods used for some questions, please note method used by question number.

_____

_____

_____

SECTION 2.000

EVALUATION AND ONGOING ASSESSMENT OF JUVENILES WHO HAVE COMMITTED SEXUAL OFFENSES

1=ALWAYS (100% of the time)
2=TYPICALLY (~75% of the time)
3= SOMETIMES (~50% of the time)
4=GENERALLY NOT (~25% of the time)
5=NEVER

1. Are offense specific evaluations of juveniles who have committed sexual offenses being conducted? [2.100]_____

1a. If #1 does not equal ALWAYS or TYPICALLY, what are the barriers preventing this from *always or typically* happening?

1b. If #1 does not equal ALWAYS or TYPICALLY, what does the community/agency/etc. need to allow this to *always or typically* happen?

1c. If #1 does not equal ALWAYS or TYPICALLY, what is the community's/agency's/etc. current practice regarding this issue?

2. Do offense specific evaluations of juveniles who have committed sexual offenses: [2.100]

a. Assess overall risk to the community?_____
b. Provide documentation regarding the protection for victims and potential victims? _____
c. Provide written clinical assessment of a juvenile's strengths, risks, and deficits? _____
d. Identify and document treatment and developmental needs? _____
e. Determine amenability for treatment? _____
f. Identify individual differences?_____
g. Identify potential barriers to treatment?_____
h. Identify static and dynamic risk factors? _____
i. Make recommendations for the management and supervision of the juvenile? _____
j. Provide information which can help identify the type and intensity of community based treatment, or the need for a more restrictive setting? _____

For <u>each</u> letter a – j that does not equal ALWAYS or TYPICALLY, please answer the following questions:

2a. What are the barriers preventing this from always or typically happening?
2b. What does the community/agency/etc. need to allow this to always or typically happen?
2c. What is the community's/agency's/etc. current practice regarding this issue?

3. Are recommendations regarding intervention based on a juvenile's level of risk and needs rather than on resources currently or locally available? [2.200]_____

3a. If #3 does not equal ALWAYS or TYPICALLY, what are the barriers preventing this from always or typically happening?

3b. If #3 does not equal ALWAYS or TYPICALLY, what does the community/agency/etc. need to allow this to always or typically happen?

3c. If #3 does not equal ALWAYS or TYPICALLY, what is the community's/agency's/etc. current practice regarding this issue?

4. If recommendations regarding intervention are <u>not</u> based on a juvenile's level of risk and needs, and, instead are based on resources currently or locally available; is this information documented? [2.200]_____

4a. If #4 does not equal ALWAYS or TYPICALLY, what are the barriers preventing this from always or typically happening?

4b. If #4 does not equal ALWAYS or TYPICALLY, what does the community/agency/etc. need to allow this to *always or typically* happen?

4c. If #4 does not equal ALWAYS or TYPICALLY, what is the community's/agency's/etc. current practice regarding this issue?

5. Are evaluations and assessments conducted during the following phases: [2.210]

5.1 Pre-sentence and post-adjudication? _____

5.1a. If #5.1 does not equal ALWAYS or TYPICALLY, what are the barriers preventing this from always or typically happening?
5.1b. If #5.1 does not equal ALWAYS or TYPICALLY, what does the community/agency/etc. need to allow this to always or typically happen?
5.1c. If #5.1 does not equal ALWAYS or TYPICALLY, what is the community's/agency's/etc. current practice regarding this issue?

5.2 Prior to release/termination from treatment?_____
5.2a. If #5.2 does not equal ALWAYS or TYPICALLY, what are the barriers preventing this from always or typically happening?
5.2b. If #5.2 does not equal ALWAYS or TYPICALLY, what does the community/agency/etc. need to allow this to always or typically happen?
5.2c. If #5.2 does not equal ALWAYS or TYPICALLY, what is the community's/agency's/etc. current practice regarding this issue?

5.3 Follow-up/monitoring post-treatment release?_____
5.3a. If #5.3 does not equal ALWAYS or TYPICALLY, what are the barriers preventing this from always or typically happening?
5.3b. If #5.3 does not equal ALWAYS or TYPICALLY, what does the community/agency/etc. need to allow this to always or typically happen?
5.3c. If #5.3 does not equal ALWAYS or TYPICALLY, what is the community's/agency's/etc. current practice regarding this issue?

6. Are ongoing needs assessments conducted and documented? [2.210]_____
6a. If #6 does not equal ALWAYS or TYPICALLY, what are the barriers preventing this from always or typically happening?
6b. If #6 does not equal ALWAYS or TYPICALLY, what does the community/agency/etc. need to allow this to always or typically happen?
6.cIf #6 does not equal ALWAYS or TYPICALLY, what is the community's/agency's/etc. current practice regarding this issue?

7. If offense specific evaluations are conducted during the pre-trial/pre-plea phase, please describe their use. [2.210]

8. Does each stage of an evaluation address each of these: strengths, risks and deficits in the following areas? [2.500]

	STRENGTHS	RISKS	
DEFICITS			
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	_____	_____	_____

For each letter a – m (in any area) that does not equal ALWAYS or TYPICALLY, please answer the following questions:

8a. What are the barriers preventing this from always or typically happening?
8b. What does the community/agency/etc. need to allow this to always or typically happen?
8c. What is the community's/agency's/etc. current practice regarding this issue?

9. Do evaluation methodologies include: [2.600]

a. Examination of juvenile justice information and/or department of human services reports?_____
b. Details of the:offense/factual basis?_____
- 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? _____

For each letter a – h that does not equal ALWAYS or TYPICALLY, please answer the following questions:
9a. What are the barriers preventing this from always or typically happening?
9b. What does the community/agency/etc. need to allow this to always or typically happen?
9c. What is the community's/agency's/etc. current practice regarding this issue?

10. Please describe any general barriers for the evaluation and ongoing assessment of juveniles who have committed sexual offenses in your community that weren't already addressed in questions 1-9.

Site:_____
Date(s):_____

Agency(ies):_____
_____

Date Collection Method (include #):
i.e., 10 probation files, interviews with 5 treatment providers, etc. If different methods used for some questions, please note method used by question number.

_____
_____
_____

SECTION 3.000

STANDARDS OF PRACTICE FOR TREATMENT PROVIDERS

1=ALWAYS (100% of the time)
2=TYPICALLY (~75% of the time)
3= SOMETIMES (~50% of the time)
4=GENERALLY NOT (~25% of the time)
5=NEVER

1. Are the following juveniles receiving sex offense specific treatment and care (and not solely receiving traditional psychotherapy) as described in the Juveniles Standards and Guidelines? [3.120]

a. on probation for a sexual offense_____
b. on parole for a sexual offense _____
c. in the custody of the county Department of Human Services for a sexual offense_____
d. committed to the State Department of Human Services for a sexual offense_____
e. sentenced to the Department of Corrections for a sexual offense_____
f. placed in out-of-home placement for a sexual offense_____

For each letter a – f that does not equal ALWAYS or TYPICALLY, please answer the following questions:
1a. What are the barriers preventing this from always or typically happening?
1b. What does the community/agency/etc. need to allow this to always or typically happen?
1c. What is the community's/agency's/etc. current practice regarding this issue?

2. Are sex offense treatment plans designed to address: [3.130]

a. strengths_____
b. risks_____
c. deficits_____
d. all areas of need identified by the evaluation?_____

For each letter a – d that does not equal ALWAYS or TYPICALLY, please answer the following questions:
2a. What are the barriers preventing this from always or typically happening?
2b. What does the community/agency/etc. need to allow this to always or typically happen?
2c. What is the community's/agency's/etc. current practice regarding this issue?

3. *Are the following considered in the development of the treatment plans for juveniles who have committed a sexual offense:*

*a. Parent/caregiver capacity?*_____
b. School activities? _____
*c. Employment*_____
d. Peer relationships? _____
e. Extracurricular activities? _____
*f. Home environment?*_____
g. Behavioral health needs? _____
h. Developmental level/maturity? _____
i. Transportation and travel needs? _____

For each letter a – i that does not equal ALWAYS or TYPICALLY, please answer the following questions:
3a. What are the barriers preventing this from always or typically happening?
3b. What does the community/agency/etc. need to allow this to always or typically happen?
3c. What is the community's/agency's/etc. current practice regarding this issue?

4. Are sex offense treatment plans reviewed at least every 3 months? [3.130]_____

4a. If #4 does not equal ALWAYS or TYPICALLY, what are the barriers preventing this from always or typically happening?
4b. If #4 does not equal ALWAYS or TYPICALLY, what does the community/agency/etc. need to allow this to always or typically happen?
4c. If #4 does not equal ALWAYS or TYPICALLY, what is the community's/agency's/etc. current practice regarding this issue?

5. Are sex offense treatment plans reviewed at transition points? [3.130]_____

5a. If #5 does not equal ALWAYS or TYPICALLY, what are the barriers preventing this from always or typically happening?
5b. If #5 does not equal ALWAYS or TYPICALLY, what does the community/agency/etc. need to allow this to always or typically happen?
5c. If #5 does not equal ALWAYS or TYPICALLY, what is the community's/agency's/etc. current practice regarding this issue?

6. Are a combination of individual, group and family therapy used unless contraindicated? [3.140]_____

6a. If #6 does not equal ALWAYS or TYPICALLY, what are the barriers preventing this from always or typically happening?
6b. If #6 does not equal ALWAYS or TYPICALLY, what does the community/agency/etc. need to allow this to always or typically happen?
6c. If #6 does not equal ALWAYS or TYPICALLY, what is the community's/agency's/etc. current practice regarding this issue?

7. If a specific type of intervention is contraindicated, are the reasons documented? [3.140]_____

7a. If #7 does not equal ALWAYS or TYPICALLY, what are the barriers preventing this from always or typically happening?
7b. If #7 does not equal ALWAYS or TYPICALLY, what does the community/agency/etc. need to allow this to always or typically happen?
7c. If #7 does not equal ALWAYS or TYPICALLY, what is the community's/agency's/etc. current practice regarding this issue?

8. Are older, more sophisticated juveniles separated from younger, more vulnerable juveniles?

*a. in group treatment*_____

*b. in residential settings*_____

For <u>each</u> letter a – b that does not equal ALWAYS or TYPICALLY, please answer the following questions:

8a. What are the barriers preventing this from always or typically happening?
8b. What does the community/agency/etc. need to allow this to always or typically happen?
8c. What is the community's/agency's/etc. current practice regarding this issue?

9. Are female offenders separated from male offenders?

*a. in group treatment*_____
*b. in residential settings*_____

For <u>each</u> letter a – b that does not equal ALWAYS or TYPICALLY, please answer the following questions:

9a. What are the barriers preventing this from always or typically happening?
9b.What does the community/agency/etc. need to allow this to always or typically happen?
9c. What is the community's/agency's/etc. current practice regarding this issue?

10. Are juveniles assessed as developmentally disabled separated from higher functioning offenders?

*a. in group treatment*_____

*b. in residential settings*_____

For <u>each</u> letter a – b that does not equal ALWAYS or TYPICALLY, please answer the following questions:

10a. What are the barriers preventing this from always or typically happening?
10b. What does the community/agency/etc. need to allow this to always or typically happen?
10c. What is the community's/agency's/etc. current practice regarding this issue?

11. Are juveniles assessed as higher risk separated from lower risk juvenile offenders?

*a. in group treatment*_____

*b. in residential settings*_____

For each letter a – b that does not equal ALWAYS or TYPICALLY, please answer the following questions:

11a. What are the barriers preventing this from always or typically happening?

11b. What does the community/agency/etc. need to allow this to always or typically happen?

11c. What is the community's/agency's/etc. current practice regarding this issue?

12. Are the following measurable outcomes, both for decreased risk and increased overall health, used in treatment planning? [3.151]

a. Juvenile consistently defines all types of abuse (self, others, property)_____

b. Juveniles acknowledges risks and uses foresight and safety planning to moderate risk_____

c. Juvenile consistently recognizes and interrupts patterns of thought and/or behavior associated with his/her abusive behavior (cycle) _____

d. Juvenile consistently demonstrates emotional recognition, expression and empathic responses to self and others (empathy) _____

e. Juvenile demonstrates functional coping patterns when stressed_____

f. Juvenile makes accurate attributions: takes responsibility for own behavior and does not try to control or take responsibility for others' behavior (accountability) _____

g. Juvenile has demonstrated the ability to manage frustration and unfavorable events, anger management and self-protection skills_____

h. Juvenile rejects abusive thoughts _____

i. Juvenile demonstrates pro-social relationship skills and is able to establish closeness, trust and assess trustworthiness of others_____

j. Juvenile has improved/positive self-image and is able to be separate, independent and competent_____

k. Juvenile is able to resolve conflicts and make decisions; is assertive, tolerant, forgiving, cooperative and is able to negotiate and compromise _____

l. Juvenile is able to relax, play, and is able to celebrate positive experiences_____

m. Juvenile seeks out and maintains pro-social peers _____

n. Juvenile has the ability to plan for and participate in structured pro-social activities_____

o. Juveniles has identified family and/or community support systems_____

p. Juvenile is willing to work to achieve delayed gratification; persists in pursuit of goals; respects reasonable authority and limits_____

q. Juvenile is able to think and communicate effectively; demonstrates rational cognitive processing, adequate verbal skills, and is able to concentrate_____

r. Juvenile has an adaptive sense of purpose and future_____

For each letter a – r that does not equal ALWAYS or TYPICALLY, please answer the following questions:

12a. What are the barriers preventing this from *always or typically* happening?

12b. What does the community/agency/etc. need to allow this to always or typically happen?

12c. What is the community's/agency's/etc. current practice regarding this issue?

13. Are the following included as elements of the treatment plan? [3.152]

a. relapse prevention planning_____

b. and aftercare_____

For each letter a – b that does not equal ALWAYS or TYPICALLY, please answer the following questions:

13a. What are the barriers preventing this from *always or typically* happening?

13b. What does the community/agency/etc. need to allow this to *always or typically* happen?

13c. What is the community's/agency's/etc. current practice regarding this issue?

14. Do client files include the following items? [3.180]

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 _____

For each letter a – j that does not equal ALWAYS or TYPICALLY, please answer the following questions:
14a. What are the barriers preventing this from always or typically happening?
14b. What does the community/agency/etc. need to allow this to always or typically happen?
14c. What is the community's/agency's/etc. current practice regarding this issue?

15. Do providers develop and utilize a written treatment contract/advisement with each juvenile who has committed a sexual offense prior to the commencement of treatment? [3.310]_____

15a. If #15 does not equal ALWAYS or TYPICALLY, what are the barriers preventing this from always or typically happening?
15b. If #15 does not equal ALWAYS or TYPICALLY, what does the community/agency/etc. need to allow this to always or typically happen?
15c. If #15 does not equal ALWAYS or TYPICALLY, what is the community's/agency's/etc. current practice regarding this issue?

16. Do treatment contracts/advisements: [3.310]

a. Define and provide timely statements of the applicable costs of evaluation, assessment and treatment, including all medical and psychological testing, physiological tests, and consultation_____
b. Describe the waivers of confidentiality, describe the various parties, including the MDT, 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_____
c. 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_____
d. Describe the procedure necessary for the juvenile or the parent/legal guardian(s) to revoke the waiver and describe the relevant time limits _____
e. Describe the type, frequency and requirements of treatment and outline how the duration of treatment will be determined_____
f. Describe the limits of confidentiality imposed on providers by the mandatory reporting law, section 19-3-304, C.R.S. _____

g. Explain 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 DOC, and/or in the agreement between the provider and the juvenile_____
h. Explain 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_____
i. Explain participation and progress in treatment_____
j. Explain payment for the costs of assessment and treatment of the juvenile and family_____
k. Explain notification of third parties as directed by the MDT _____
l. Explain notification of the treatment provider of any relevant changes or events in the life of the juvenile or the juvenile's family/support system_____

For each letter a – l that does not equal ALWAYS or TYPICALLY, please answer the following questions:
16a. What are the barriers preventing this from *always or typically* happening?
16b. What does the community/agency/etc. need to allow this to *always or typically* happen?
16c. What is the community's/agency's/etc. current practice regarding this issue?

17. Did juveniles who successfully completed treatment accomplish the following goals? [3.410]

a. Accomplishment of the goals identified in the treatment plan _____
b. Accomplishment of the goals listed in the Juvenile Standards, Section 3.150 (1-24) _____
c. Accomplishment of the treatment outcomes listed in question #6 (or Juvenile Standards Section 3.151B) _____
d. Demonstrated application in the juvenile's daily functioning of the principles and tools learned in sex offense specific treatment_____
e. Consistent compliance with treatment conditions_____
f. Consistent compliance with supervision terms and conditions_____
g. Completed written relapse prevention and aftercare plan that addresses remaining risks and deficits, and that has been reviewed and agreed upon by the MDT, the family and the community support system_____

For <u>each</u> letter a – g that does not equal ALWAYS or TYPICALLY, please answer the following questions:

17a. What are the barriers preventing this from always or typically happening?
17b. What does the community/agency/etc. need to allow this to always or typically happen?
17c. What is the community's/agency's/etc. current practice regarding this issue?

18. Did the MDT do the following when making the treatment completion decision? [3.412]

a. Consider all sources of collateral information_____
b. Assess and document evidence that the goals of the treatment plan have been met; 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 _____

For <u>each</u> letter a – f that does not equal ALWAYS or TYPICALLY, please answer the following questions:
18a. What are the barriers preventing this from *always or typically* happening?
18b. What does the community/agency/etc. need to allow this to *always or typically* happen?
18c. What is the community's/agency's/etc. current practice regarding this issue?

19. If a juvenile has been otherwise compliant yet has not achieved his or her treatment goals by an approaching supervision expiration date, do supervising officers/agents seek a means of continued court ordered supervision? [3.420]_____

19a. If #19 does not equal ALWAYS or TYPICALLY, what are the barriers preventing this from *always or typically* happening?
19b. If #19 does not equal ALWAYS or TYPICALLY, what does the community/agency/etc. need to allow this to *always or typically* happen?
19c. If #19 does not equal ALWAYS or TYPICALLY, what is the community's/agency's/etc. current practice regarding this issue?

20. *If a juvenile unsuccessfully terminates from treatment, are the specific violations or behaviors that subjected him or her to termination from treatment documented?*_____

20a. If #20 does not equal ALWAYS or TYPICALLY, what are the barriers preventing this from always or typically happening?
20b. If #20 does not equal ALWAYS or TYPICALLY, what does the community/agency/etc. need to allow this to always or typically happen?
20c. If #18 does not equal ALWAYS or TYPICALLY, what is the community's/agency's/etc. current practice regarding this issue?

21. Does initial treatment intervention specifically address denial and defensiveness when present? [3.540]_____

21a. If #21 does not equal ALWAYS or TYPICALLY, what are the barriers preventing this from always or typically happening?
21b. If #21 does not equal ALWAYS or TYPICALLY, what does the community/agency/etc. need to allow this to *always or typically* happen?
21c. If #21 does not equal ALWAYS or TYPICALLY, what is the community's/agency's/etc. current practice regarding this issue?

22. If denial or defensiveness was identified, does the MDT approve sex offense specific treatment only when the juvenile evidences: [3.550]

a. decreased resistance to treatment?_____
b. decreased defensiveness? _____
c. decreased denial?_____
d. increased victim empathy?_____

For <u>each</u> letter a – d that does not equal ALWAYS or TYPICALLY, please answer the following questions:
22a. What are the barriers preventing this from always or typically happening?
22b. What does the community/agency/etc. need to allow this to always or typically happen?
22c. What is the community's/agency's/etc. current practice regarding this issue?

23. Do MDTs consult with a plethysmograph (PPG) examiner when any of the following indicators are met? [3.610]
a. Pre-pubescent male and/or female victim(s) _____
b. Three or more known victims_____
c. Pairing of aggression and physiological arousal_____
d. Self-report of deviant arousal_____
e. Offense history indicative of a persistent pattern_____

For <u>each</u> letter a – e that does not equal ALWAYS or TYPICALLY, please answer the following questions:
23a. What are the barriers preventing this from *always or typically* happening?
23b. What does the community/agency/etc. need to allow this to *always or typically* happen?
23c. What is the community's/agency's/etc. current practice regarding this issue?

24. If used, are PPG results used as an adjunct tool, not replacing other forms of monitoring (not used in isolation when making treatment or supervision decisions)? [3.614]_____

24a. If #24 does not equal ALWAYS or TYPICALLY, what are the barriers preventing this from always or typically happening?
24b. If #24 does not equal ALWAYS or TYPICALLY, what does the community/agency/etc. need to allow this to always or typically happen?
24c. If #24 does not equal ALWAYS or TYPICALLY, what is the community's/agency's/etc. current practice regarding this issue?

25. If used, are Abel results used as an adjunct tool, not replacing other forms of monitoring (not used in isolation when making treatment or supervision decisions)? [3.623]_____

25a. If #25 does not equal ALWAYS or TYPICALLY, what are the barriers preventing this from always or typically happening?
25b. If #25 does not equal ALWAYS or TYPICALLY, what does the community/agency/etc. need to allow this to always or typically happen?
25c. If #25 does not equal ALWAYS or TYPICALLY, what is the community's/agency's/etc. current practice regarding this issue?

26. Please describe any general barriers regarding the standards of practice for treatment providers in your community that weren't already addressed in questions 1-25.

Site:_____
Date(s):_____

Agency(ies):_____
_____

Date Collection Method (include #):
i.e., 10 probation files, interviews with 5 treatment providers, etc. If different methods used for some questions, please note method used by question number.

_____
_____
_____

SECTION 4.000

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

1=ALWAYS (100% of the time)
2=TYPICALLY (~75% of the time)
3= SOMETIMES (~50% of the time)
4=GENERALLY NOT (~25% of the time)
5=NEVER

1. Are referrals made only to listed providers (treatment providers, evaluators, polygraph examiners, plethysmograph examiners and Abel Assessment examiners)? _____

1a. If #1 does not equal ALWAYS or TYPICALLY, what are the barriers preventing this from always or typically happening?
1b. If #1 does not equal ALWAYS or TYPICALLY, what does the community/agency/etc. need to allow this to always or typically happen?
1c. If #1 does not equal ALWAYS or TYPICALLY, what is the community's/agency's/etc. current practice regarding this issue?

2. Are staff in programs and placement settings such as residential treatment centers, residential child care facilities, DYC institutions, group homes, foster homes and day treatment settings that provide on-site sex offense specific treatment trained in the following informed supervision practices? [4.510]

a. All milieu child care staff are trained to provide informed supervision._____
On-site educators are trained to provide informed supervision._____
b. Two thirds of the milieu child-care staff are trained to fulfill the role of therapeutic care providers._____
c. At least one person is on duty, on site, at all times who meets the criteria of an informed supervisor._____

For <u>each</u> letter a – d that does not equal ALWAYS or TYPICALLY, please answer the following questions:

2a. What are the barriers preventing this from always or typically happening?
2b. What does the community/agency/etc. need to allow this to always or typically happen?
2c. What is the community's/agency's/etc. current practice regarding this issue?

3. Are residential staff trained in informed supervision during orientation or within 14 days of hire? [4.510]_____

3a. If #3 does not equal ALWAYS or TYPICALLY, what are the barriers preventing this from always or typically happening?
3b. If #3 does not equal ALWAYS or TYPICALLY, what does the community/agency/etc. need to allow this to always or typically happen?
3c. If #3 does not equal ALWAYS or TYPICALLY, what is the community's/agency's/etc. current practice regarding this issue?

4. Please describe any other barriers regarding the qualifications of providers, evaluators and programs for juveniles who have committed sexual offenses in your community or any barriers for making referrals to listed providers that weren't already addressed in questions 1-3.

Site:_____
Date(s):_____

Agency(ies):_____
_____

Date Collection Method (include #):
i.e., 10 probation files, interviews with 5 treatment providers, etc.
If different methods used for some questions, please note method used by question number.

_____
_____

SECTION 5.000

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

SECTION 5.000: ESTABLISHMENT OF A MULTIDISCIPLINARY TEAM FOR THE MANAGEMENT AND SUPERVISION OF JUVENILES WHO HAVE COMMITTED SEXUAL OFFENSES

1=ALWAYS (100% of the time)
2=TYPICALLY (~75% of the time)
3= SOMETIMES (~50% of the time)
4=GENERALLY NOT (~25% of the time)
5=NEVER

1. Do supervising officers (or DHS case managers in the absence of an officer) convene MDTs after an adjudication or a deferred adjudication has been entered, and a referral to probation, parole, or out-of-home placement has been made? [5.100]_____

1a. If #1 does not equal ALWAYS or TYPICALLY, what are the barriers preventing this from always or typically happening?
1b. If #1 does not equal ALWAYS or TYPICALLY, what does the community/agency/etc. need to allow this to always or typically happen?
1c. If #1 does not equal ALWAYS or TYPICALLY, what is the community's/agency's/etc. current practice regarding this issue?

2. Do members of the MDT act as team (i.e., utilizing shared information) for decision-making? [5.100]_____

2a. If #2 does not equal ALWAYS or TYPICALLY, what are the barriers preventing this from always or typically happening?
2b. If #2 does not equal ALWAYS or TYPICALLY, what does the community/agency/etc. need to allow this to always or typically happen?
2c. If #2 does not equal ALWAYS or TYPICALLY, what is the community's/agency's/etc. current practice regarding this issue?

3. Does the MDT consist of the supervising officer/agent, DHS caseworker (if assigned), the juvenile's caregiver in any out-of-home placement, the treatment provider, and the polygraph examiner (when utilized)? [5.110]_____

3a. If #3 does not equal ALWAYS or TYPICALLY, what are the barriers preventing this from always or typically happening?
3b. If #3 does not equal ALWAYS or TYPICALLY, what does the community/agency/etc. need to allow this to always or typically happen?
3c. If #3 does not equal ALWAYS or TYPICALLY, what is the community's/agency's/etc. current practice regarding this issue?

4. Is there victim representation on the MDT? [5.110]_____

4a. If #4 does not equal ALWAYS or TYPICALLY, what are the barriers preventing this from always or typically happening?
4b. If #4 does not equal ALWAYS or TYPICALLY, what does the community/agency/etc. need to allow this to always or typically happen?
4c. If #4 does not equal ALWAYS or TYPICALLY, what is the community's/agency's/etc. current practice regarding this issue?

5. Do MDTs meet at least quarterly? [5.120]_____

5a. If #5 does not equal ALWAYS or TYPICALLY, what are the barriers preventing this from always or typically happening?

5b. If #5 does not equal ALWAYS or TYPICALLY, what does the community/agency/etc. need to allow this to always or typically happen?
5c. If #5 does not equal ALWAYS or TYPICALLY, what is the community's/agency's/etc. current practice regarding this issue?

6. Have supervising officer/agents assessing or supervising juveniles who have committed a sexual offense successfully completed the "Introduction to Sex Offender Management Training"? [5.218]_____

6a. If #6 does not equal ALWAYS or TYPICALLY, what are the barriers preventing this from *always or typically* happening?
6b. If #6 does not equal ALWAYS or TYPICALLY, what does the community/agency/etc. need to allow this to *always or typically* happen?
6c. If #6 does not equal ALWAYS or TYPICALLY, what is the community's/agency's/etc. current practice regarding this issue?

7. Have <u>managers</u> of supervising officer/agents assessing or supervising juveniles who have committed a sexual offense successfully completed the "Introduction to Sex Offender Management Training"? [5.218]
_____

7a. If #7 does not equal ALWAYS or TYPICALLY, what are the barriers preventing this from *always or typically* happening?
7b. If #7 does not equal ALWAYS or TYPICALLY, what does the community/agency/etc. need to allow this to *always or typically* happen?
7c. If #7 does not equal ALWAYS or TYPICALLY, what is the community's/agency's/etc. current practice regarding this issue?

8. Have supervising officer/agents assessing or supervising juveniles who have committed a sexual offense successfully completed the "Advanced Sex Offender Management Training"? [5.218] _____

8a. If #8 does not equal ALWAYS or TYPICALLY, what are the barriers preventing this from *always or typically* happening?
8b. If #8 does not equal ALWAYS or TYPICALLY, what does the community/agency/etc. need to allow this to *always or typically* happen?
8c. If #8 does not equal ALWAYS or TYPICALLY, what is the community's/agency's/etc. current practice regarding this issue?

9. Have <u>managers</u> of supervising officer/agents assessing or supervising juveniles who have committed a sexual offense successfully completed the "Advanced Sex Offender Management Training"? [5.218]_____

9a. If #9 does not equal ALWAYS or TYPICALLY, what are the barriers preventing this from *always or typically* happening?
9b. If #9 does not equal ALWAYS or TYPICALLY, what does the community/agency/etc. need to allow this to *always or typically* happen?
9c. If #9 does not equal ALWAYS or TYPICALLY, what is the community's/agency's/etc. current practice regarding this issue?

10. Have caseworkers completed training specific to sex offender management? [5.510] If ALWAYS or TYPICALLY, please describe the training received._____

10a. If #10 does not equal ALWAYS or TYPICALLY, what are the barriers preventing this from *always or typically* happening?
10b. If #10 does not equal ALWAYS or TYPICALLY, what does the community/agency/etc. need to allow this to *always or typically* happen?
10c. If #10 does not equal ALWAYS or TYPICALLY, what is the community's/agency's/etc. current practice regarding this issue?

11. Have DYC client managers/parole officers successfully completed training specific to sex offender management? If ALWAYS or TYPICALLY, please describe the training received._____

11a. If #11 does not equal ALWAYS or TYPICALLY, what are the barriers preventing this from *always or typically* happening?
11b. If #11 does not equal ALWAYS or TYPICALLY, what does the community/agency/etc. need to allow this to *always or typically* happen?
11c. If #11 does not equal ALWAYS or TYPICALLY, what is the community's/agency's/etc. current practice regarding this issue?

12. Are the following MDT members trained in Informed Supervision? For each answer that is ALWAYS or TYPICALLY, please describe the training received. [5.711]

a. supervising officer/agent_____
b. DHS caseworker (if assigned) _____
c. the juvenile's caregiver in any out-of-home placement_____
d. treatment provider_____
e. polygraph examiner (when utilized) _____
f. victim representation_____

For each letter a – f that does not equal ALWAYS or TYPICALLY, please answer the following questions:
12a. What are the barriers preventing this from always or typically happening?
12b. What does the community/agency/etc. need to allow this to always or typically happen?
12c. What is the community's/agency's/etc. current practice regarding this issue?

13. What are the indicators that informed supervision is being provided in residential programs and placement settings?

14. If the juvenile is enrolled in a school, does a representative from the school or school district participate as a member of the MDT? [5.810]_____

14a. If #14 does not equal ALWAYS or TYPICALLY, what are the barriers preventing this from always or typically happening?
14b. If #14 does not equal ALWAYS or TYPICALLY, what does the community/agency/etc. need to allow this to always or typically happen?
14c. If #14 does not equal ALWAYS or TYPICALLY, what is the community's/agency's/etc. current practice regarding this issue?

15. Have school representatives on the multidisciplinary team completed training specific to sex offender management? If ALWAYS or TYPICALLY, please describe the training received._____

15a. If #15 does not equal ALWAYS or TYPICALLY, what are the barriers preventing this from always or typically happening?
15b. If #15 does not equal ALWAYS or TYPICALLY, what does the community/agency/etc. need to allow this to always or typically happen?
15c. If #15 does not equal ALWAYS or TYPICALLY, what is the community's/agency's/etc. current practice regarding this issue?

16. Do the school representatives on the multidisciplinary team do the following: [5.830]

a. communicate with the MDT regarding the juvenile's:
   - school attendance_____
   - grades_____
   - activities_____
   - compliance with supervision conditions_____
   - any concerns about observed high-risk behaviors_____

b. assist in the development of the supervision plan _____
c. provide informed supervision and support to the juvenile while in school_____
e. develop a supervision safety plan considering the needs of the victim(s) (if in the same school)_____

f. develop a supervision safety plan considering the needs of potential victims _____ participate in the development of transition plans for juveniles who are transitioning between different levels of care and/or different school settings_____

For each letter a – g that does not equal ALWAYS or TYPICALLY, please answer the following questions:

16a. What are the barriers preventing this from always or typically happening?
16b. What does the community/agency/etc. need to allow this to always or typically happen?
16c. What is the community's/agency's/etc. current practice regarding this issue?

17. Are schools/school districts conducting trainings for school representatives on the multidisciplinary team regarding juveniles who commit sexual offenses?_____

17a. If #17 does not equal ALWAYS or TYPICALLY, what are the barriers preventing this from always or typically happening?
17b. If #17 does not equal ALWAYS or TYPICALLY, what does the community/agency/etc. need to allow this to always or typically happen?
17c. If #17 does not equal ALWAYS or TYPICALLY, what is the community's/agency's/etc. current practice regarding this issue?

18. Have the following MDT members obtained the training and/or supervision necessary to ensure the adequacy of the services provided 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? For each answer that is ALWAYS or TYPICALLY, please describe the training and/or supervision received. [Appendix F]

a. supervising officer/agent_____
b. DHS caseworker (if assigned) _____
c. the juvenile's caregiver in any out-of-home placement_____
d. treatment provider_____
e. polygraph examiner (when utilized) _____
f. victim representation_____
g. school representative_____

For each letter a – g that does not equal ALWAYS or TYPICALLY, please answer the following questions:

18a. What are the barriers preventing this from *always or typically* happening?
18b. What does the community/agency/etc. need to allow this to *always or typically* happen?
18c. What is the community's/agency's/etc. current practice regarding this issue?

19. Please describe any general barriers regarding the establishment of a multidisciplinary team for the management and supervision of juveniles who have committed sexual offenses in your community that weren't already addressed in questions 1-18.

Site:_____
Date(s):_____

Agency(ies):_____
_____

Date Collection Method (include #):
i.e., 10 probation files, interviews with 5 treatment providers, etc.
If different methods used for some questions, please note method

used by question number.

_____

_____

SECTION 6.000

ADDITIONAL CONDITIONS OF COMMUNITY SUPERVISION

SECTION 6.000: ADDITIONAL CONDITIONS OF COMMUNITY SUPERVISION

1=ALWAYS (100% of the time)
2=TYPICALLY (~75% of the time)
3= SOMETIMES (~50% of the time)
4=GENERALLY NOT (~25% of the time)
5=NEVER

1. Are the Additional/Special Terms and Conditions being used on all juveniles who have been adjudicated for a sexual offense?_____

1a. If #1 does not equal ALWAYS or TYPICALLY, what are the barriers preventing this from *always or typically* happening?
1b. If #1 does not equal ALWAYS or TYPICALLY, what does the community/agency/etc. need to allow this to *always or typically* happen?
1c. If #1 does not equal ALWAYS or TYPICALLY, what is the community's/agency's/etc. current practice regarding this issue?

2. Are judges ordering sex offense specific Special Terms and Conditions for juveniles who have been adjudicated for a sexual offense?_____

2a. If #2 does not equal ALWAYS or TYPICALLY, what are the barriers preventing this from always or typically happening?
2b. If #2 does not equal ALWAYS or TYPICALLY, what does the community/agency/etc. need to allow this to always or typically happen?
2c. If #2 does not equal ALWAYS or TYPICALLY, what is the community's/agency's/etc. current practice regarding this issue?

3. Are juvenile parole boards ordering sex offense specific Special Terms and Conditions for juveniles who have been adjudicated for a sexual offense?_____

3a. If #3 does not equal ALWAYS or TYPICALLY, what are the barriers preventing this from always or typically happening?
3b. If #3 does not equal ALWAYS or TYPICALLY, what does the community/agency/etc. need to allow this to always or typically happen?
3c. If #3 does not equal ALWAYS or TYPICALLY, what is the community's/agency's/etc. current practice regarding this issue?

4. Are the special terms and conditions being ordered by judges individualized for juveniles who have been adjudicated for a sexual offense?_____

4a. If #4 does not equal ALWAYS or TYPICALLY, what are the barriers preventing this from always or typically happening?
4b. If #4 does not equal ALWAYS or TYPICALLY, what does the community/agency/etc. need to allow this to always or typically happen?
4c. If #4 does not equal ALWAYS or TYPICALLY, what is the community's/agency's/etc. current practice regarding this issue?

5. Are the special terms and conditions being ordered by juvenile parole boards individualized for juveniles who have been adjudicated for a sexual offense?_____

5a. If #5 does not equal ALWAYS or TYPICALLY, what are the barriers preventing this from *always or typically* happening?
5b. If #5 does not equal ALWAYS or TYPICALLY, what does the community/agency/etc. need to allow this to *always or typically* happen?
5c. If #5 does not equal ALWAYS or TYPICALLY, what is the community's/agency's/etc. current practice regarding this issue?

*6. Are additional rules and expectations, beyond the Additional/Special Terms and Conditions, required by probation, parole, supervising officers/agents or DHS caseworkers? If answer is ALWAYS or TYPICALLY, please describe the additional rules and expectations.*_____

7. Please describe any general barriers regarding additional conditions of community supervision in your community (that weren't already addressed in questions 1-6)?

Site:_____
Date(s):_____

Agency(ies):_____
_____

Date Collection Method (include #):
i.e., 10 probation files, interviews with 5 treatment providers, etc. If different methods used for some questions, please note method used by question number.

_____
_____

SECTION 7.000

POLYGRAPH EXAMINATION OF JUVENILES WHO HAVE COMMITTED SEXUAL OFFENSES

1=ALWAYS (100% of the time)
2=TYPICALLY (~75% of the time)
3= SOMETIMES (~50% of the time)
4=GENERALLY NOT (~25% of the time)
5=NEVER

1. Do MDTs refer juveniles for polygraph examinations who meet the criteria listed in the Juvenille Standards, # 7.100? [7.100]_____

1a. If #1 does not equal ALWAYS or TYPICALLY, what are the barriers preventing this from always or typically happening?
1b. If #1 does not equal ALWAYS or TYPICALLY, what does the community/agency/etc. need to allow this to *always or typically* happen?
1c. If #1 does not equal ALWAYS or TYPICALLY, what is the community's/agency's/etc. current practice regarding this issue?

2. Do MDTs NOT refer juveniles for polygraph testing when any of the following are present: [7.120]

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 _____
e. Presence of acute pain or illness_____
f. Presence of acute distress_____
g. Recent medication changes_____
h. Mean Age Equivalency or Standard Age Score is below 12 years_____
i. Clear indicators exist that results would be invalid_____

For <u>each</u> letter a – g that does not equal ALWAYS or TYPICALLY, please answer the following questions:

2a. What are the barriers preventing this from always or typically happening?
2b. What does the community/agency/etc. need to allow this to always or typically happen?
2c. What is the community's/agency's/etc. current practice regarding this issue?

3. Do MDTs document the following in case files?

a. the rationale for the polygraph testing_____
b. type of polygraph testing used _____
c. frequency of testing _____
d. the use of the results in treatment, behavioral monitoring and supervision _____

For <u>each</u> letter a – d that does not equal ALWAYS or TYPICALLY, please answer the following questions:

3a. If #3 does not equal ALWAYS or TYPICALLY, what are the barriers preventing this from *always or typically* happening?
3b. If #3 does not equal ALWAYS or TYPICALLY, what does the community/agency/etc. need to allow this to *always or typically* happen?
3c. If #3 does not equal ALWAYS or TYPICALLY, what is the community's/agency's/etc. current practice regarding this issue?

4. Are reasons for exceptions to the requirement to use polygraph testing documented in the juvenile's file? [7.121]_____

4a. If #4 does not equal ALWAYS or TYPICALLY, what are the barriers preventing this from always or typically happening?
4b. If #4 does not equal ALWAYS or TYPICALLY, what does the community/agency/etc. need to allow this to always or typically happen?
4c. If #4 does not equal ALWAYS or TYPICALLY, what is the community's/agency's/etc. current practice regarding this issue?

5. Are polygraphs used as an adjunct tool, meaning, not used in isolation when making treatment or supervision decisions? [7.160]_____

5a. If #5 does not equal ALWAYS or TYPICALLY, what are the barriers preventing this from always or typically happening?
5b. If #5 does not equal ALWAYS or TYPICALLY, what does the community/agency/etc. need to allow this to always or typically happen?
5c. If #5 does not equal ALWAYS or TYPICALLY, what is the community's/agency's/etc. current practice regarding this issue?

6. Are sexual history polygraph examinations initiated within 3-9 months following the onset of treatment (for those who meet the criteria)? [7.170]_____

6a. If #6 does not equal ALWAYS or TYPICALLY, what are the barriers preventing this from always or typically happening?
6b. If #6 does not equal ALWAYS or TYPICALLY, what does the community/agency/etc. need to allow this to always or typically happen?
6c. If #6 does not equal ALWAYS or TYPICALLY, what is the community's/agency's/etc. current practice regarding this issue?

7. If sexual history polygraph examinations are not initiated within 3-9 months following the onset of treatment, are the reasons for this documented? [7.170]_____

7a. If #7 does not equal ALWAYS or TYPICALLY, what are the barriers preventing this from always or typically happening?
7b. If #7 does not equal ALWAYS or TYPICALLY, what does the community/agency/etc. need to allow this to always or typically happen?
7c. If #7 does not equal ALWAYS or TYPICALLY, what is the community's/agency's/etc. current practice regarding this issue?

8. Are maintenance/monitoring polygraph examinations initiated 2-4 months prior to transition from one supervision level to another? [7.170]_____

8a. If #8 does not equal ALWAYS or TYPICALLY, what are the barriers preventing this from always or typically happening?
8b. If #8 does not equal ALWAYS or TYPICALLY, what does the community/agency/etc. need to allow this to always or typically happen?
8c. If #8 does not equal ALWAYS or TYPICALLY, what is the community's/agency's/etc. current practice regarding this issue?

9. Are specific issue polygraph examinations employed under the following conditions: [7.170]

a. substantial denial of offense_____
b. significant discrepancy between the account of the juvenile who committed a sexual offense and the victim's description of the offense_____
c. to explore specific allegations or concerns_____
d. prior to victim clarification per Standard 8.000 of the Juvenile Standards_____

For <u>each</u> letter a – d that does not equal ALWAYS or TYPICALLY, please answer the following questions:

9a. If #9 does not equal ALWAYS or TYPICALLY, what are the barriers preventing this from always or typically happening?
9b. If #9 does not equal ALWAYS or TYPICALLY, what does the community/agency/etc. need to allow this to always or typically happen?
9c. If #9 does not equal ALWAYS or TYPICALLY, what is the community's/agency's/etc. current practice regarding this issue?

10. Does the MDT prepare the juvenile for polygraph examinations as outline in Appendix C-1 in the Juvenile Standards?_____

10a. If #10 does not equal ALWAYS or TYPICALLY, what are the barriers preventing this from always or typically happening?
10b. If #10 does not equal ALWAYS or TYPICALLY, what does the community/agency/etc. need to allow this to always or typically happen?
10c. If #10 does not equal ALWAYS or TYPICALLY, what is the community's/agency's/etc. current practice regarding this issue?

11. Do polygraph examiners submit a written report within 2 weeks of the examination that is factual and descriptive of the information and results of each examination? [7.200]_____

11a. If #11 does not equal ALWAYS or TYPICALLY, what are the barriers preventing this from always or typically happening?
11b. If #11 does not equal ALWAYS or TYPICALLY, what does the community/agency/etc. need to allow this to always or typically happen?
11c. If #11 does not equal ALWAYS or TYPICALLY, what is the community's/agency's/etc. current practice regarding this issue?

12. Does the MDT respond to polygraph examination results as outlined in Appendix C-1 in the Juvenile Standards?_____

12a. If #12 does not equal ALWAYS or TYPICALLY, what are the barriers preventing this from always or typically happening?
12b. If #12 does not equal ALWAYS or TYPICALLY, what does the community/agency/etc. need to allow this to always or typically happen?
12c. If #12 does not equal ALWAYS or TYPICALLY, what is the community's/agency's/etc. current practice regarding this issue?

13. Please describe any general barriers regarding the polygraph examination of juveniles who have committed sexual offenses in your community (that weren't already addressed in questions 1-12).

Site:_____
Date(s):_____

Agency(ies):_____

_____

Date Collection Method (include #):

i.e., 10 probation files, interviews with 5 treatment providers, etc. If different methods used for some questions, please note method used by question number.

_____

_____

SECTION 8.000

VICTIMS AND POTENTIAL VICTIMS: CLARIFICATION, CONTACT AND REUNIFICATION

SECTION 8.000: VICTIMS AND POTENTIAL VICTIMS: CLARIFICATION, CONTACT AND REUNIFICATION

1=ALWAYS (100% of the time)
2=TYPICALLY (~75% of the time)
3= SOMETIMES (~50% of the time)
4=GENERALLY NOT (~25% of the time)
5=NEVER

1. Are victim clarification procedures approved by the MDT? [8.110]_____

   1a. If #1 does not equal ALWAYS or TYPICALLY, what are the barriers preventing this from always or typically happening?
   1b. If #1 does not equal ALWAYS or TYPICALLY, what does the community/agency/etc. need to allow this to always or typically happen?
   1c. If #1 does not equal ALWAYS or TYPICALLY, what is the community's/agency's/etc. current practice regarding this issue?

2. Are victim clarification procedures approved by an MDT that includes the victim's therapist or an advocate? [8.110]_____

   2a. If #2 does not equal ALWAYS or TYPICALLY, what are the barriers preventing this from always or typically happening?
   2b. If #2 does not equal ALWAYS or TYPICALLY, what does the community/agency/etc. need to allow this to always or typically happen?
   2c. If #2 does not equal ALWAYS or TYPICALLY, what is the community's/agency's/etc. current practice regarding this issue?

3. Are the following criteria used to approve victim clarification procedures? [8.110]

   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 MDT. The juveniles is able to acknowledge the victim's statement 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 the Juvenile 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_____

   For <u>each</u> letter a – i that does not equal ALWAYS or TYPICALLY, please answer the following questions:
   3a. What are the barriers preventing this from always or typically happening?
   3b. What does the community/agency/etc. need to allow this to always or typically happen?
   3c. What is the community's/agency's/etc. current practice regarding this issue?

4. Are victim contact procedures approved by the MDT? [8.200]_____

4a. If #4 does not equal ALWAYS or TYPICALLY, what are the barriers preventing this from always or typically happening?
4b. If #4 does not equal ALWAYS or TYPICALLY, what does the community/agency/etc. need to allow this to always or typically happen?
4c. If #4 does not equal ALWAYS or TYPICALLY, what is the community's/agency's/etc. current practice regarding this issue?

5. Are victim contact procedures approved by an MDT that includes the victim's therapist or an advocate? [8.200]_____

5a. If #5 does not equal ALWAYS or TYPICALLY, what are the barriers preventing this from always or typically happening?
5b. If #5 does not equal ALWAYS or TYPICALLY, what does the community/agency/etc. need to allow this to always or typically happen?
5c. If #5 does not equal ALWAYS or TYPICALLY, what is the community's/agency's/etc. current practice regarding this issue?

6. Does family reunification occur only after clarification has occurred? [8.320]_____

6a. If #6 does not equal ALWAYS or TYPICALLY, what are the barriers preventing this from always or typically happening?
6b. If #6 does not equal ALWAYS or TYPICALLY, what does the community/agency/etc. need to allow this to always or typically happen?
6c. If #6 does not equal ALWAYS or TYPICALLY, what is the community's/agency's/etc. current practice regarding this issue?

7. If family reunification has taken place, does the MDT continue to monitor family reunification and recommend services according to the treatment plan? [8.330]_____

7a. If #7 does not equal ALWAYS or TYPICALLY, what are the barriers preventing this from always or typically happening?
7b. If #7 does not equal ALWAYS or TYPICALLY, what does the community/agency/etc. need to allow this to always or typically happen?
7c. If #7 does not equal ALWAYS or TYPICALLY, what is the community's/agency's/etc. current practice regarding this issue?

*8. Are victims provided assistance with the development of safety plans?*_____

8a. If #8 does not equal ALWAYS or TYPICALLY, what are the barriers preventing this from always or typically happening?
8b. If #8 does not equal ALWAYS or TYPICALLY, what does the community/agency/etc. need to allow this to always or typically happen?
8c. If #8 does not equal ALWAYS or TYPICALLY, what is the community's/agency's/etc. current practice regarding this issue?

9. Do juveniles ever go back to a school where the victim is present?

0. NO→GO TO #10
1. YES:

If a victim is present in a school where a juvenile sex offender is anticipated to return, is the victim/parent of the victim notified prior to the juvenile's return and given an opportunity to provide input?

_____

9a. If #9 does not equal ALWAYS or TYPICALLY, what are the barriers preventing this from always or typically happening?

9b. If #9 does not equal ALWAYS or TYPICALLY, what does the community/agency/etc. need to allow this to always or typically happen?

9c. If #9 does not equal ALWAYS or TYPICALLY, what is the community's/agency's/etc. current practice regarding this issue?

10. Please describe any general barriers regarding clarification, contact and reunification of victims and potential victims in your communities (that weren't already addressed in questions 1-7).

Appendix D

ABBREVIATIONS AND ACRONYMS

Adult Standards=Standards and Guidelines For The Assessment, Evaluation, Treatment and Behavioral Monitoring of Adult Sex Offenders

Advisory Group = The Juvenile Standards Implementation Project Advisory Group

BJA= Bureau of Justice Assistance

Board = Sex Offender Management Board

CAP = Comprehensive Assessment Protocol

CDHS= Colorado Department of Human Services

CSOM = Center for Sex Offender Management

DCJ = Division of Criminal Justice

DHS – Department of Human Services

DSS = Department of Social Services

DYC = Division of Youth Corrections

Juvenile Standards = *Standards and Guidelines for the Evaluation, Assessment, Treatment and Supervision of Juveniles Who Have Committed Sexual Offenses*

MDT = Multi-disciplinary Team

PPG=Penile Plethysmograph

PSI = Pre-sentence Investigations

SOMB= Sex Offender Management Board