**PREA AUDIT REPORT ☐ INTERIM ☒ FINAL**

**COMMUNITY CONFINEMENT FACILITIES**


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|---|---|---|---|
| **Auditor Information** | | | |
| **Auditor name: Gerald McCormac** | | | |
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| **Telephone number: 267-679-2308** | | | |
| **Date of facility visit: September 21-23, 2015** | | | |
| **Facility Information** | | | |
| **Facility name: Addiction Research and Treatment Services: Peer 1** | | | |
| **Facility physical address: 3762 West Princeton Circle, Denver CO 80236** | | | |
| **Facility mailing address:** *(if different from above)* | | | |
| **Facility telephone number: 303-761-2885** | | | |
| **The facility is:** | ☐ Federal | ■ State | ☐ County |
| | ☐ Military | ☐ Municipal | ☐ Private for profit |
| | ☐ Private not for profit | | |
| **Facility type:** | ☐ Community treatment center ☐ Halfway house<br>■ Alcohol or drug rehabilitation center | ☐ Community-based confinement facility<br>☐ Mental health facility | ☐ Other |
| **Name of facility's Chief Executive Officer: Danielle Wolf** | | | |
| **Number of staff assigned to the facility in the last 12 months: 42** | | | |
| **Designed facility capacity: 125** | | | |
| **Current population of facility: 112** | | | |
| **Facility security levels/inmate custody levels: Minimum** | | | |
| **Age range of the population: 18-65+** | | | |
| **Name of PREA Compliance Manager: Barbara Sanchez** | | **Title:** | Peer 1 PREA Coordinator |
| **Email address: barbara.sanchez@ucdenver.edu** | | **Telephone number:** | 303-734-3307 |
| **Agency Information** | | | |
| **Name of agency: Addiction Research and Treatment Services (ARTS)** | | | |
| **Governing authority or parent agency:** *(if applicable) University of Colorado – Division of Psychiatry* | | | |
| **Physical address: 3762 West Princeton Circle, Denver CO 80236** | | | |
| **Mailing address:** *(if different from above)* | | | |
| **Telephone number: 303-734-7626** | | | |
| **Agency Chief Executive Officer** | | | |
| Kristen Dixion | | | |
| **Email address: Kristen.dixion@ucdenver.edu** | | **Telephone number:** | 303-734-5022 |
| **Agency-Wide PREA Coordinator** | | | |
| **Name: Barbara Sanchez** | | **Title:** | Peer 1 PREA Coordinator |
| **Email address: Barbara.sanchez@ucdenver.edu** | | **Telephone number:** | 303-734-3307 |

## AUDIT FINDINGS

### NARRATIVE

On September 21, 2015, the onsite portion of the PREA audit was conducted at the Peer 1 Therapeutic Community. Peer 1 is a 125 bed male therapeutic community currently operating under multiple contracts with local and state entities to include, but not exclusive to, the Colorado Division of Criminal Justice and the Colorado Department of Corrections, respectively, to provide community based substance abuse treatment. PEER 1 is operated by the University of Colorado's Addiction and Research Treatment Services (A.R.T.S.).

The PREA audit notice was posted by the PEER 1 staff on August 10, 2015; six weeks prior to the onsite audit. No communication or correspondence from PEER 1 residents, staff, visitors, or other third party individuals were received by this auditor related to the PEER 1 program and their PREA audit.

The onsite audit commenced shortly after 9:00 am on September 21, 2015. Following a brief entrance meeting, in which the expected audit schedule and format was discussed, a tour of the PEER 1 buildings was conducted. The tour of the PEER 1 buildings was conducted in accordance with the PREA audit compliance tool, "Instructions for PREA Audit Tour", with emphasis on resident living quarters, resident showers and bathroom areas, intake areas, kitchens, laundry rooms, recreational areas, and other resident accessible areas as it relates to staff's ability to monitor, supervise and otherwise detect, prevent, and deter incidents of sexual assault and sexual harassment within the PEER 1 program. The PEER 1 program has actively worked to minimize potential blind spots utilizing multiple detection measures including the strategic deployment and placement of video surveillance equipment and audible alarms (on seldom used egresses/entrances) in order to enhance Peer 1 staff's ability to prevent, detect, and deter incidents of sexual abuse and sexual harassment within the Peer 1 community/program. Upon conclusion of the program tour, random staff and resident interviews commenced.

Random and specialized staff interviews were conducted using the format and protocols for community confinement centers and as available on the National PREA Resource Center's website. In total, approximately 40%-50% of the PEER 1 staff were interviewed. The staff sample group included Peer 1 staff from all job classifications as well as encompassing staff from all shifts. Additionally, approximately 10%-20% of the PEER 1 program participants were interviewed during the onsite portion of the audit. All resident interviews followed the interview protocols for community confinement centers available on the PREA resource center website with emphasis on ensuring the sample size of residents interviewed included residents from: each of the various populations served at Peer 1, those specifically identified in the resident interviews protocols, and from varying room assignments from each of the three housing units (Dedication, Inspiration, and Motivation).

Prior to the onsite audit, and as part of the post audit review, supporting documentation provided by the PEER 1 program were reviewed. These items included were but not limited to: ARTS PREA Policies, University of Colorado Administrative Policy Statement #5014; Organizational Chart, PEER 1 floor plans for each of the four buildings/houses, Peer 1 Coordinated Response Plan; MOUs with local community entities and supportive services (as will be noted and named throughout this report), ARTS training curriculum (staff, specialized staff, contractor, volunteer, and resident); ARTS employee personnel files (background checks) and training records; ARTS Coordinated Response plan; Investigative reports and documents; Peer 1 pre-audit questionnaire; as well as many other forms of supportive documentation as will be referred to in the remainder of this audit report.

The interim Auditor Summary Report was issued to Peer 1 on October 23, 2015. The corrective action for the lone standard was quickly addressed with the posting of the A.R.T.S.: Peer 1 Annual Report on the program's website. As of issuance of this report, the Peer 1 Therapeutic Community has complied with all aspects of the national PREA standards governing community confinement facilities.

## FACILITY CHARACTERISTICS

Located at 3762 West Princeton Circle, Peer 1 campus is situated amidst other University and State operated programs/services. The Peer 1 campus consist of four historic Victorian homes beautifully maintained and across from a large soccer field providing for a scenic panoramic view. Of the four Peer 1 houses, three are used as residential housing and the fourth house is used primarily for administrative purposes. The three residential houses are referred to as Motivation, Inspiration, and Dedication. The Peer 1 program, to include all three residential houses, has a maximum rated capacity of 125 individuals; with approximately 40 program participants per house. While the Peer 1 program does accept referrals from criminal justice related entities, it is important to note Peer 1 services are not limited to only those involved with the criminal justice system. Those program participants who are under the supervision of a criminal justice entity typically range from minimum to low-medium risk individuals. All program participants have an extensive history with addictive disorders.

In all three houses, resident living quarters are primarily located on the upper floors. ARTS staff offices occupy portions of the first floor with some residential rooms scattered on the first floor as well. Given the Victorian style home design, there are bathrooms on both the first and second floors of each house. "Resident" bathrooms are equipped with shower(s), sinks, toilets and space to change prior to entering the residential hallways. Each bathroom provides residents with ample privacy and the program can accommodate individual resident showers should the need arise. Laundry machines are provided for Peer 1 residents in each house and are located in the basement of each house. Peer 1 employs measures to ensure tracking and monitoring of movement in and out of the basement area.

As noted above Peer 1 provides residents with adequate privacy when showering, changing, or using the lavatory. Female staff entering any area where a resident may be changing or in any state of undress are required to announce their presence as they enter the residential areas. Using the milieu tools, often times program participants are informed well in advance of a cross gender staff person's anticipated presence. In addition to announcing their presence as they enter residential areas, Peer 1 female staff are also required to "knock and announce" their presence prior to entering any bedroom or bathroom in which a male resident may be in any state of undress. These practice were confirmed through staff and resident interviews.

Each Peer 1 house is currently equipped with one DVR recording video footage from cameras strategically placed so as to assist staff in detecting, deterring and preventing sexual abuse and sexual harassment as well as detection of other potential hazards. Peer 1 staff have demonstrated due diligence in their efforts to prevent, detect, and deter incidents of sexual abuse and sexual harassment within their community as well in their efforts to provide the Peer 1 staff with tools to assist in that mission.

The fourth building, which reflects the physical plant design of the other three buildings, is primarily used as administrative space with staff offices occupying the second and third floors. The first floor area provides for a conference room, group spaces, and two reception areas. Both the interior and exterior of all four buildings and grounds were toured as part of the onsite audit protocols.

## SUMMARY OF AUDIT FINDINGS

Peer 1 did have one allegation of sexual harassment in the 12 months prior to the onsite audit. Peer 1 staff, in conjunction with and under the direction/supervision of the Peer 1 Program Director and PREA coordinator, are actively working to achieve compliance and/or refine their processes with the PREA standards. There are PREA posters posted throughout the facility which contain the telephone number for PREA reporting and additional information related to PREA, the facility's zero tolerance policies, and contact information for PREA reporting is included in a variety of printed materials (resident PREA information binders, and PREA "Facts You Should Know" pamphlet). Peer 1 residents, in addition to having access to community resources, also have access to emergency services through a variety of means such as: dedicated phones for calls to the posted toll free help line telephone numbers or other entity as it relates to PREA related reporting, mailing addresses for local community resources, and notification to any staff member whether verbal or written. During the onsite audit the auditor was able to confirm contact with the posted tip lines from the dedicated phone lines and reviewed the process by which residents are "permitted" to use the dedicated phone line. In review of these procedures and as was confirmed through staff and resident interviews, there do not appear to be any real barriers to the use of the PREA dedicated phone lines by program participants as restriction of phone privileges is primarily "honor system" based as compared to an institutional modality which would restrict or unduly impede (either through use of electronic measure or through utilization of segregation) a program participant's ability to access one of the three dedicated phone lines in a timely manner.

As conveyed during the random resident interviews, residents of Peer 1 were each provided with the facility's resident handbook, PREA pamphlet, ARTS PREA advisement and have all received screenings related to assessment of the individuals' potential for victimization and/or abusiveness during the intake process. Residents also relayed that staff "knock and announce" their presence whenever entering a resident's housing area and when entering the bathroom/shower area. Peer 1 residents were generally aware of the process for reporting PREA related concerns and were also generally aware of community resources available to them. All program participants, as relayed to this auditor through resident interviews, expressed no concerns with regards to their safety; rather, the unanimous consensus was just the opposite…all residents expressed they felt very safe.

The Peer 1 staff also play a part in actively working to implement a safe, secure environment for residents and staff alike. The staff, for the most part, were generally aware of their responsibilities to create a zero tolerance environment, reporting responsibilities, and first responder duties as was conveyed to this auditor during the staff interviews. Staff were also able to confirm receipt of PREA related trainings during their orientation, specialized training topics (where applicable) and frequent refreshers during their monthly all staff meetings.

Throughout the audit process, the Peer 1 audit team worked diligently to achieve compliance with all aspects of the national PREA standards. The thoroughness of the effort put forth by Peer 1 was quite evident in: the submission of the pre-audit questionnaire; questions posed to the auditor throughout the audit process so as to have a comprehensive, well rounded approach to achieving and maintaining compliance with the PREA standards; and in the dialogue and collaboration to implement auditor suggestions and recommendations.

A thorough review was performed of the supporting documentation provided by the Peer 1 program. The results of the thorough review, along with the information gathered from the tour as well as the interviews, were used to generate this report. Noted throughout this report will be references to the documentation used to support the determinations of compliance, non-compliance, or non-applicable. Overall, the audit findings for the Peer 1 program are as follows:

- Number of standards exceeded: 2
- Number of standards met: 36
- Number of standards not met: 0
- Number of standards not applicable: 1

## 115.211- Zero tolerance of sexual abuse and sexual harassment; PREA coordinator

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

**Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.**

The Addiction Research and Treatment Services program has written policies mandating zero tolerance towards all forms of sexual abuse and/or sexual harassment. As an extension of the University of Colorado, the ARTS programs, to include Peer 1 specifically, are governed by the University of Colorado's written policies which mandate zero tolerance toward all forms of sexual abuse and sexual harassment (ARTS PREA Policy 115.211) and the University of Colorado Administrative Policy Statement 5014 "*Sexual Misconduct*". Both individually and collectively, these policies outline the agency's (University of Colorado) and the ARTS' Peer 1 program's approaches to preventing, detecting, and responding to allegations of sexual harassment, sexual misconduct, and/or sexual abuse. Both policies meet the requirements of 115.211(a) and appropriately outline the expectations and required actions of staff when such conduct occurs or is suspected of having occurred.

Within the organizational structure of the ARTS programs exists upper-level PREA Coordinator positions specific the two ARTS residential programs; to include Peer 1 specifically. Peer 1 PREA Coordinator position is enabled sufficient time, authority, and empowerment within the position to effectively implement policies and procedures aimed at preventing, detecting, and responding to all incidents of sexual abuses and sexual harassment. As an extension of the University of Colorado, the duties, responsibilities and expectations of the Title IX Coordinator position, as identified in University of Colorado APS #5014, mimic the responsibilities, duties, and expectations set forth for community confinement centers through the PREA standards and is appropriately empowered through the University of Colorado's Chancellor.

## 115.212 Contracting with other entities for the confinement of residents

**This section does not apply to the ARTS –PEER 1 program. The ARTS program does not sub-contract with other entities to house offenders.**

## 115.213 Supervision and Monitoring

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

**Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.**

ARTS has created a staffing plan specific to Peer 1 program. Peer 1 staffing plan utilizes staffing levels (based on full complement of staffing positions filled) and video surveillance equipment in their efforts to protect residents from sexual abuse. In calculating the adequacy of staffing levels at the Peer 1 program, the staffing plan addresses all four required components of 115.213(a)(1-4) and was developed utilizing input from the Peer 1 PREA Coordinator, Peer 1 Director, and the ARTS Executive Director.

Peer 1 staffing plan provided was the program's initial staffing plan. Annual review of the staffing plan in accordance with 115.213(c) will be required moving forward. Year to date, Peer 1 has not deviated from the staffing plan identified as the only noted concerns involved the "call outs" of scheduled staff members however, minimum staffing was maintained as other Peer 1 employees were re-assigned in order to maintain compliance with the identified staffing patterns.

## 115.215 Limits to cross-gender viewing and searches

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

**Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.**

Peer 1, as outlined in ARTS Policy 115.215 ("*Limits to Cross Gender Viewing and Searches*", Procedures, (a)) prohibit staff from performing cross gender strip searches and/or cross gender visual body cavity searches. ARTS employees are also prohibited from performing a search of a resident in order to determine their genital status (ARTS PREA Policy 115.215 (e), Procedure: (e)). At the time of the audit, ARTS' Peer 1 program did account for situations in which strip searches were permitted. As was captured in Residential Policy 2.030 (Procedures: Section E, 4), Peer 1 staff were only permitted to perform strip searches if directed to do so by the program director. The policy further stipulated employees conducting the strip search would both be of the same sex as the offender to be strip searched and visual body cavity searches are never permitted (Residential Policy 2.030, Procedures: Section E, 4).

Transgender and intersex residents' personal comfort levels are taken into consideration when staff are conducting pat down searches. Residents are asked to identify their preference on which gender (male or female) will be conducting said searches. Whenever possible, unless in extreme exigent circumstance, pat searches are conducted in accordance with the resident's preference. A review of the expected pat search techniques and training curriculum were reviewed and the practice is consistent with PREA expectations as noted in the PRC FAQs. All searches performed are documented and recorded in accordance with contractual requirements (ARTS PREA Policy 115.215, Procedure: (c)). As verified via review of employee training records, all Peer 1 employees are provided trainings on the performance of pat down searches, strip searches, and searches of transgender and intersex residents in a professional, respectful, and the least intrusive manner possible while not compromising the safety and security of Peer 1 program.

Peer 1 has developed and implemented policies and practices which require staff members of the opposite gender to knock and announce their presence when entering an area where residents are likely to be changing, showering, or performing bodily functions (ARTS PREA Policy 115.215, Procedure: (d)). The current placement of the Peer 1 cameras does not allow for cross gender staff viewing of a female resident while showering, changing, or performing any other bodily functions.

## 115.216 Residents with disabilities and residents who are limited English proficient

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

**Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.**

The ARTS program, through a MOU with the Spring Institute for Intercultural Learning, has established a method and mechanism by which their programs, to include Peer 1 specifically, have access to interpreters who can impartially, accurately, and effectively communicate via sign language and with limited English proficient individuals in many languages to include rare and exotic languages spoken in Asia, Africa, Middle East, Eastern and Western Europe. Additional auxiliary aids can also be arranged

through the Program Director if needed. Peer 1 does not utilize resident interpreters, confirmed via resident and staff interviews, and this is a practice that is prohibited unless delays in communicating with an individual would present immediate danger to the individual's safety, compromise the performance of first responder duties, or the investigation of PREA allegations.

While Peer 1 program eligibility criteria requires each potential program participant to have some degree of English proficiency, Peer 1 has demonstrated due diligence in ensuring "written materials are provided in formats or through methods that ensure effective communication with residents with disabilities, including intellectual disabilities, limited reading skills, or who are blind or have low vision". All the PREA education materials, aside from PREA signage posted throughout the facility, are available in English and Spanish (resident training video, Peer 1 PREA "Facts You Should Know" informational pamphlet, and informational PREA posters). Peer 1 provides this information to all program participants upon their admission into Peer 1 therapeutic community and has sufficient number of posted signs containing outside resources and their respective contact information.

## 115.217 Hiring and Promotion Decisions

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

**Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.**

As described in the University of Colorado Administrative Policy Statement #5014 policies, the Agency 1 clearly establishes zero tolerance for all forms of sexual abuse and sexual harassment (APS 5014, Section II, (a)). The University's Administrative Policy Statement also clearly defines prohibited acts, gestures, comments, (APS 5014, Section III – *Definitions)* and measures to ensure protection from retaliation (APS 5014, Section II: (E) (11)).

From a programmatic perspective, the ARTS programs, to include Peer 1 specifically, also takes a firm stance on all forms of sexual abuse and/or sexual harassment and also defines prohibited acts, behaviors, gestures, comments, et al (ARTS PREA Policy 115.211, attachment 1). Background checks are conducted on all employees, contractors, and volunteers having contact with ARTS residents (as described via ARTS PREA policy 115.217). All background checks are conducted in coordination with the Colorado Division of Criminal Justice. The ARTS program does not hire or promote anyone who may have contact with residents who has engaged in any of the activities notated in 115.217(a) (1-3). Furthermore, incidents of sexual harassment are factored in to any offer of employment and/or promotion once hired. A review of all employee personnel files revealed the facilitation of employee background checks prior to commencement of the employee's employment and performance of an updated employee background check every five years. ARTS, through both policy and practice, and in accordance with governing federal, state, and local laws, engage in the exchange of information, as it relates to substantiated allegations of sexual abuse or any resignation during a pending investigation of an allegation of sexual abuse, between agencies for both potential employees and former employees respectively (ARTS

Personnel Manual, page 24, items #44 and 46 respectively). Finally, moving forward, with regards to the requirements of §115.217(f)(h), it is recommended ARTS incorporate a mechanism to capture staff's continuing duty to disclose all incidents described in §115.217(a). However, that aside, Peer 1 has met all the requirements as set forth in §115.217.

## 115.218 Upgrades to facilities and technologies

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

**Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.**

§115.218(a) is not necessarily applicable to Peer 1 as there has not been any substantial expansion to the facility nor acquisition of a new facility; however, ARTS has taken efforts to upgrade their technology.

As evidenced in Peer 1 staffing plan and via information acquired through the on-site staff interviews, Peer 1 considers the utilization of strategic placement and deployment of the cameras, mirrors, and other available tools to assist staff with the monitoring and supervision of the program participants.

## 115.221 Evidence protocol and forensic medical examinations

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

**Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.**

ARTS is responsible for conducting Administrative Investigations of sexual abuse. Sexual abuse investigations that do not appear to be criminal in nature are conducted by the Program Director, or the PREA Compliance Manager. These ARTS staff members have received specialized investigator's training as offered through the National Institute of Corrections. The training curriculum utilized is in accordance

with §115.234 and documentation of the training of identified staff members has been retained.

Criminal investigations would be conducted by the Denver Police Department – Sex Crimes unit. Peer 1 has formally requested of the Denver Police Department their compliance with the national PREA standards when investigating allegations of sexual abuse and/or sexual harassment involving ARTS program participants. Denver Police Department's Sex Crimes Unit policies were provided/reviewed and reflect the directives for the adherence to a uniform evidence protocol adapted from the "United States Department of Justices' Office on Violence Against Women publication, 'A National Protocol for Sexual Assault Medical Forensic Examinations' Adult/Adolescents', or a similar protocol".

ARTS has entered into a MOU with the Denver Hospital and Health Authority to provide ARTS resident victims with access to Sexual Assault Forensic Examiners and Sexual Assault Nurse Examiners 24 hours a day and seven days a week without financial cost to the resident victim. In said MOU, ARTS residents would be taken to the nearest Denver Health Medical Center in the event that they are involved in an incident of sexual assault. The Denver Health Medical Center, located at 777 Bannock Street in Denver, Colorado, will provide SAFE/SANE who will adhere to a uniform evidence protocol that maximizes the potential for obtaining usable evidence consistent with the requirements of §115.221(b).

ARTS also has entered into a MOU with the Blue Bench to provide resident victims with: support through the forensic exam and investigatory interview process; crisis intervention; emotional support; follow-up services and referrals to other community agencies.

## 115.222 Policies to ensure referrals of allegations for investigations

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

**Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.**

As stated throughout the ARTS PREA policies and specifically ARTS PREA policy 115.222, all allegations of sexual abuse and/or sexual harassment will be fully investigated either criminally or administratively if there is not a criminal element involved (ARTS PREA Policy 115.222). ARTS PREA policy (PREA policy 115.222, Procedures, (a-e)) outlines the responsibilities of both ARTS internal staff (first responders, investigators, and management staff) as well as the expected responsibilities of external parties. In that regard, Peer 1 is compliant with §115.222(a) and §115.222(c).

Peer 1 has published, for public consumption, the above referred to policies. These policies can be found on the ARTS website, www.artstreatment.org, and clicking on the PREA link on the left hand side of the page.

## 115.231 Employee Training

- ☒ Exceeds Standard (substantially exceeds requirement of standard)
- ☐ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

**Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.**

As revealed following a review of ARTS employee training records and the PREA related training curriculum, Peer 1 staff have all received training on the identified required elements of the standard (§115.231(a)(1-8)). The training curriculum, "Colorado Community Corrections PREA: Prison Rape Elimination Act 2003", captures many, but not all, of the required elements of 115.231(a)(1-10). Specifically, this training curriculum addresses eight of the ten required training items. Those eight topics being: the zero tolerance policy for sexual abuse and sexual harassment; how to fulfill their duties; the resident's rights to be free from sexual abuse and sexual harassment; the resident's and employee's rights to be free from retaliation for reporting sexual abuse and sexual harassment; fulfillment of staff responsibilities under the agency sexual abuse and sexual harassment prevention, detection, reporting, and responding to incidents; the dynamics of sexual abuse and sexual harassment in confined settings; common reactions of sexual abuse and sexual harassment victims; how to detect and respond to signs of threatened and actual sexual abuse; and how to avoid inappropriate relationships with resident. The two remaining required training topic items of 115.231(a)(1-10) are not specifically covered in the training curriculum; however, the two remaining training topics, how to communicate effectively and professionally with residents including those identifying as members of the LGBTI community and information on mandatory reporting laws for Colorado, are covered as part of other mandatory trainings (cultural diversity and certified abuse counselor licensure trainings).

As ARTS houses both male and female residents, though Peer 1 specifically is a male facility, ARTS staff have been trained using the curriculum which covers both populations. All employee trainings are recorded and documented with acknowledgment from the employee of the receipt and understanding of the training materials presented. Aspects of the PREA related training material are also routinely covered during monthly all staff meetings in order to refresh staff's familiarity with expectations and expected practices as well as to review potential breakdowns in staff practices as may be determined through internal auditing and monitoring. Staff member interviews confirmed the receipt of the aforementioned trainings and the routine training refreshers offered during the staff meetings. Peer 1 has also created a thorough PREA informational binder for each staff member so as to allow for easy reference to expected practices, procedures, and staff actions to be taken should an allegation arise.

Peer 1 has met all the required elements of 115.231(a)(b)(c)(d) and exceeds the frequency of staff "refresher" requirements of this standard through the use of the aforementioned staff PREA binders and the regular review of PREA policies, practices, and expectations in monthly Peer 1 staff meetings.

## 115.232 Volunteer and contractor training

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

**Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.**

The ARTS provides notification to all visitors of their zero tolerance policies related to sexual abuse, sexual harassment, and sexual misconduct upon signing into the program. Peer 1 has implemented a three tier category of volunteer/contractor depending on the level of potential contact with Peer 1 program participants (supervised/unsupervised) and the frequency of said potential contact (once a month, twice a month, etc.). ARTS volunteers and contractors having unsupervised access/contact with ARTS residents are provided additional training, based on the above identified qualifying criteria, on their duties and responsibilities as it relates to the ARTS zero tolerance policies in preventing, detecting, deterring, and responding to incidents of sexual abuse, sexual harassment, and/or sexual misconduct. Confirmation of said trainings are retained and were reviewed during the audit process.

## 115.233 Resident Education

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

**Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.**

Upon intake, as was confirmed in a review of Peer 1's supporting documentation and as was communicated through the Peer 1 resident interview process, all residents receive information educating

them on: the agency's zero-tolerance policy regarding sexual abuse and sexual harassment; how to report incidents or suspicions of sexual abuse and sexual harassment; their right to be free from retaliation for reporting such incidents; and, the agency policies and procedures for responding to such incidents. This information is provided to all residents upon their intake via a PREA "Facts You Should Know" pamphlet and through a short PREA video all residents watch as part of the intake process.

ARTS, as noted previously in the auditor's summary for PREA standard 115.216, has established a MOU with the Spring Institute for Intercultural Learning, in order to provide their facilities, to include Peer 1 specifically, with access to interpreters who can impartially, accurately, and effectively communicate via sign language and with limited English proficient individuals. Additional auxiliary aids can also be arranged through the Program Director. PREA related signs and posters have been posted in both English and Spanish. Educational videos, PREA "Facts You Should Know" pamphlet, are also available in English and Spanish. Each residential house is also equipped with a "PREA Information" binder containing all of the aforementioned educational information which is accessible to all program participants at any time.

## 115.234 Specialized training: Investigations

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

**Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.**

Select Peer 1 staff have been identified and appropriately trained on conducting administrative specialized investigations in community settings. The curriculum was reviewed and found to contain the following elements: techniques for interviewing sexual abuse victims; proper use of Miranda and Garrity warnings; sexual abuse evidence collection, and the criteria and evidence required to substantiate a case for criminal prosecution.

As with the employee training records noted in §115.231, documentation of the selected management staff members responsible for conducting administrative investigations is retained in the employee's training records along with formal acknowledgment of receipt of the training by the employee. It should be noted, ARTS staff do not conduct criminal investigations and refer sexual abuse and sexual harassment allegations appearing to be of possible criminal nature to the Denver Police Department.

## 115.235 Specialized training: Medical and mental health care

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

**Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.**

The ARTS program does employ mental health staff who work regularly in Peer 1 program. These staff members have received both the general employee training topics as identified in §115.231 as well as receiving specialized mental health training covering: How to detect and assess signs of sexual abuse and sexual harassment; (2) How to preserve physical evidence of sexual abuse; (3) How to respond effectively and professionally to victims of sexual abuse and sexual harassment; and (4) How and to whom to report allegations or suspicions of sexual abuse and sexual harassment. Documentation of these staff member's specialized training was provided and has been retained.

## 115.241 Screening for risk of victimization and abusiveness

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

**Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.**

As outlined in ARTS PREA Policy 115.241 "*Screening for Risk of Victimization and Abusiveness*" (Procedures (a-g)), newly admitted residents are screened upon their admission into Peer 1 program, and upon transfer to another facility, in order to determine their risk levels for possible victimization and/or possibility of abusiveness. Policy further stipulates the initial assessment must occur within 12 hours of their admission into the program; well in advance of the 72-hour time frame stipulated in §115.241. All assessments are performed utilizing an objective screening instrument and documented in the resident's electronic case file. A review of randomly selected completed risk assessments revealed that greater than 85% of the resident screenings reviewed were completed within the 72-hour time frame identified in

the PREA standard. Similarly, the performance of a re-assessment/review of the individual's risk levels of victimization and/or abusiveness within 30 days of their intake date was also greater than 85% compliance; hence, Peer 1 demonstrated substantial compliance with both their internal PREA risk assessment deadline and the 72-hour deadline identified in the national PREA standards. The ARTS PREA Policy 115.241 (g) requires re-assessments be performed upon referral, request, incident of sexual abuse, and/or following receipt of additional relevant information that bears on the client's risk of sexual victimization or abusiveness. ARTS staff are performing these risk screenings via an objective risk assessment tool which incorporates all ten criteria identified in §115.241(d).

As noted in ARTS PREA Policy 115.241(i), Peer 1 has placed appropriate levels of control on the information gathered through the aforementioned assessment/re-assessment process. ARTS staff are informed to maintain confidentiality with regards to information obtained as a result of the risk assessment as well as information learned as a result of the resident's participation in the Peer 1 program and achievement of programmatic milestones as part of the resident's treatment plan/process. The ARTS program equips staff with software allowing for each resident's case file to be maintained electronically. This software is equipped with mechanisms that enable and limit each permitted user's scope of access; dependent upon individual needs related to the performance of expected duties. ARTS Policy 115.241 (Procedures: (h) and (i)) prohibit staff members from disciplining residents who fail to disclose complete information or for refusing to answer questions pursuant to §115.241(a-i).

## 115.242 Use of screening information

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

**Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.**

ARTS PREA Policy 115.242 speaks directly to and mirrors the standard requirements set forth by §115.241(a-f). In the review of documentation, and as relayed by staff during the onsite random staff interviews, information acquired by Peer 1 staff during the assessment/re-assessment process performed pursuant to §115.241, is used to help Peer 1 management staff determine the most appropriate housing assignment for each program participant and to allow for residents at greater risk of victimization to be housed in such as manner as to enable maximum staff supervision.

As noted above in §115.241, the electronic case file software program utilized by Peer 1 staff is equipped with mechanisms to enable and/or limit each permitted user's scope of informational access dependent upon individual needs related to the performance of expected duties. All ARTS staff are informed of the "Code of Ethics" governing their respective positions and acknowledge their responsibility to maintain the confidential nature of information they may receive.

Peer 1 has the ability to accommodate individualized showers for their transgender and/or intersex residents and provide each resident with a PREA related "Facts You Should Know" pamphlet at intake in

which residents are informed that individualized shower accommodations can be made available if needed.

Finally, within the scope of their authority, as conveyed via the staff interview process, Peer 1 staff consider the safety and health of a transgender or intersex individual in the determination of housing placement. Peer 1 staff employs due diligence in the determination of which room (or bed) the individual is placed. Peer 1 has documented instances in which the information gathered in the assessment/re-assessment process was used to assist in the housing assignment of program participants. It is recommended that Peer 1 continue to utilize the information gathered during the assessment process as well as documenting the manner and occasions this information is used in housing and/or program assignments.

## 115.251 Resident reporting

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

**Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.**

Peer 1 staff informs and provides residents with multiple channels for reporting sexual abuse and sexual harassment, retaliation and other PREA related violations. All residents are provided contact information for the Colorado Department of Corrections Tip Line (1-877-DOC-TIPS), contact information for rape crisis counseling through the Blue Bench organization with whom ARTS has a MOU and is willing to accept toll free calls. In addition to these resources, Peer 1 residents are also encouraged to contact local law enforcement, their assigned parole officer (if applicable), county case worker (if applicable), and/or any staff member. This information is available in written format for all residents to retain throughout their participation in Peer 1 program, is posted throughout each of the four Peer I buildings, and each residential house is equipped with a PREA manual similar to the aforementioned staff PREA binders; however, are geared specifically to The Haven resident population. The information is presented in English, Spanish, and can be translated into other languages as needed.

The ARTS program accepts all reports of sexual abuse and/or sexual harassment to include anonymous and third party reporting, without weighted differentials for verbal or written reports. Finally, as is required by 115.253(d), ARTS has established several mechanisms for staff to utilize in reporting PREA related concerns privately including a PREA staff line which has been established for ARTS employees to utilize in communicating their concerns and/or suspicions. In addition to the internal reporting mechanisms, the employees of the ARTS programs also have access to the Human Resources individuals and Title IX Coordinators at the University level as well as access to reporting resources at the state level (as identified in the Colorado State Employee Assistance Programs).

## 115.252 Exhaustion of Administrative Remedies

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

**Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.**

ARTS PREA Policy 115.252 (Procedures) (a-e)) details the agency's procedures related to resident grievances. The ARTS PREA policy does not impose a time restriction for the filing of a grievance related to sexual abuse or sexual harassment. The ARTS PREA policy also provides for emergency grievance procedures if the resident alleges he/she is at substantial risk for imminent sexual abuse. In the event that program participants fear they are at risk of imminent sexual abuse, the program has implemented practices to suspend therapeutic community customs in order to allow the participant to break TC based orientation communication restrictions and contact any one of the identified external reporting resources, local law enforcement, etcetera. The ARTS PREA policy 115.252 conforms to the deadlines set forth in standard 115.252(d)(f) respectively. The Peer 1 PREA "Fact You Should Know" Pamphlet provided to Peer 1 residents upon intake as well as ARTS PREA Policy 115.252 also articulate that disciplinary action against a resident can only be taken if the allegation was made in bad faith.

## 115.253 Resident access to outside confidential supportive services

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

**Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.**

As previously noted, ARTS has entered into a MOU with the Blue Bench to provide emotional supportive services to residents of their programs to include Peer 1 specifically. This MOU also covers rape crisis advocacy; hospital accompaniment; support and accompaniment of the victim through the forensic examination process and the investigatory process; crisis intervention services, referrals for follow-up

services and/or additional community resources as needed. The contact information for the Blue Bench is included in Peer 1 PREA pamphlet provided to all residents at intake and appears on the ARTS website. A signed acknowledgment of the resident's receipt of the PREA information received at intake is retained as part of the resident's case file.

Speaking specifically to the standard's requirement that the facility "enable reasonable communication between residents and these organizations in as confidential a manner as possible", Peer 1 has identified telephones which can be used to make out going toll free phone calls. As noted above, while newly admitted program participants are placed on a no communication status during the first couple of weeks of program orientation, Peer 1 has established appropriate protocols to allow residents to break the "honor system" no communication stipulation in order to ensure residents are safe and feel free to express concerns for their safety (should the need arise). Additionally, Peer 1 staff inform residents the extent to which their communication with community resources will be monitored and which information will be sought in communication with these external entities via the completion of a release of information form.

## 115.254 Third-party reporting

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

**Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.**

Pursuant to the requirements set forth through 115.254(a), ARTS has publically distributed through its website, the methods through which incidents of sexual abuse and/or sexual harassment can be reported. This can be found on the University of Colorado's Addiction Research and Treatment Services website: http://artstreatment.org. The ARTS PREA specific information can be found via the "PREA" tab on the left hand side of the ARTS home webpage.

## 115.261 Staff and agency reporting duties

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

**Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.**

In review of ARTS PREA Policy 115.261, "*Staff and Agency Reporting Duties*", the directives set forth mirror all of the required elements of §115.261(a-e). ARTS PREA policy clearly articulates neither the location of an alleged incident (115.261(a)) nor the time period in which it is alleged to have occurred shall impact the ARTS staff's responsibility/obligation to report the allegation in accordance with the ARTS coordinated response and the national PREA standards. ARTS' PREA policy 115.261 (a) states:

"*all staff to report immediately and according to agency policy any knowledge, suspicion, or information regarding an incident of sexual abuse or sexual harassment that occurred in the facility, whether or not it is part of the agency; retaliation against resident or staff who reported such an incident; and any staff neglect or violation of responsibilities that may have contributed to an incident or retaliation*".

ARTS PREA Policy 115.261 captures and appropriately reflects the remaining components of the standard in that ARTS program has: placed sufficient levels of control on communication of information received by ARTS employees consistent with the requirements of 115.261(b) (ARTS PREA Policy 115.261, Procedure (b)); and outlines the duties and responsibilities of the ARTS staff, as mandated reporters within the State of Colorado (ARTS PREA Policy 115.261 and Colorado Revised Statute 19-3-304). Additionally, the mental health care staff are not prohibited from reporting information learned pursuant to §115.261(a) and inform residents receiving their services of the limitations of confidentiality at the onset of treatment. This is accomplished via completion of the ARTS Confidentiality and Consent to Treatment form by each newly admitted program participant upon intake.

## 115.262 Agency protection duties

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

**Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.**

Through a thorough review of ARTS PREA Policy 115.262 as well as information acquired during the staff interviews, Peer 1 staff, though not faced with a situation in which substantial risk to a ARTS resident occurred or is believed to have occurred, has mechanisms in place to immediately ensure each resident's safety. Staff members interviewed expressed knowledge of the agency coordinated response (specifically their duties as first responders, management responsibilities for the coordination of external parties with whom ARTS has a MOU, and consideration of resident safety in the facilitation of their respective job duties. In that regard, ARTS has the ability to transfer residents from one housing unit to another housing unit within the same residential house or between the three residential houses (Motivation,

Dedication, and Inspiration) to ensure the safety of each program participant is maintained. In addition to the internal adjustments to the individual's housing assignment, the ARTS program can coordinate with the respective referral sources for additional housing options should the need arise.

## 115.263 Reporting to other confinement facilities

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

**Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.**

ARTS PREA policy 115.263 outlines the Agency's expectation for Peer 1 management personnel to communicate information pertaining to allegations of sexual abuse which occurred at another confinement facility to said facility's/institution's director/warden/superintendent. Peer 1 Program Director will make notification to the facility head of the institution at which the alleged sexual abuse/sexual harassment is to have occurred. ARTS policy clearly identifies: the 72-hour time frame mandated by PREA standard 115.263(b) (ARTS PREA Policy, "*Reporting to Other Confinement Facilities*", Procedure (b)); said notification is to be formally documented (ARTS PREA Policy 115.263, Procedures (c)) as required in 115.263(c); and, the expectation that the director/warden/superintendent receiving the allegation ensures the allegation is investigated in accordance with the PREA standards as noted in 115.263(d) (ARTS PREA Policy 115.263, Procedures (d)).

## 115.264 Staff first responder duties

- ☒ Exceeds Standard (substantially exceeds requirement of standard)
- ☐ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

**Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.**

ARTS PREA Policy 115.264, "First Responders" and the ARTS coordinated response plan (discussed in greater detail below) cover all of the requirements in §115.264(a)(1-4)(b) with overall intent of preserving any evidence and protecting the crime scene. The ARTS PREA policy, staff training curriculum, and Peer 1 written coordinated response clearly capture all requirements of 115.264(a)(1-4). Given the uniqueness of Peer 1 program, that being a therapeutic community as opposed to a community corrections center/halfway house, the ARTS program has trained all personnel in first responder duties. While the PREA standards acknowledge distinction between job classifications (115.264(b) instructing non-security first responder staff only to request that the alleged victim not take any actions that could destroy evidence and then notify security staff), Peer 1 has incorporated the intent of this standard into their staffing pattern and staff trainings. Peer 1, through ARTS PREA Policy 115.264(b), instructs staff members not trained in first responder duties to direct the victim to refrain from showering, using the bathroom, or otherwise destroying potential evidence and then notify the nearest security staff (or staff member trained in first responder duties). As such, with nearly all staff trained in first responder duties and acknowledgement that untrained staff members engage the assistance of someone who is trained, Peer 1 exceeds the requirements of §115.264 in that more than just the "required" staff are trained on the requirements of this standard.

Year to date, Peer 1 has not had any incidents requiring a first responder response.

## 115.265 Coordinated response

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

**Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.**

ARTS has a written institutional plan of coordinated actions taken in response to an incident of sexual abuse as well as in written policy which speak to the same (ARTS PREA Policy 115.265). Per the stated expectations of the Auditor's Audit Summary tool, the written coordinated response plan is specific to the Peer 1 program. To that point, staff are directed to use specific locations within Peer 1 houses to separate the alleged victim and abuser. The coordinated plan, per 115.265(a), outlines the expected actions coordinated between first responders, facility management staff and external parties such as those with whom ARTS has a MOU to provide services for ARTS clients who are the victim of sexual abuse. These parties include, but are not limited to: law enforcement entities; victim advocacy services, and SAFE/SANE services at no cost to the resident victim.

## 115.266 Preservation of ability to protect residents from contact with abusers

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

**Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.**

ARTS employees, including those employed at their Peer 1 facility, are not unionized and no collective bargaining agreement exists. As such, there is nothing prohibiting the management staff of Peer 1 facility, and the ARTS program, as empowered through the ARTS PREA Policy 115.266 and the University of Colorado's Administrative Policy Statement #1504, from removing any alleged abusers (staff, contractor, visitor, or program participant) from contact with ARTS program participants. Peer 1 meets the requirements of standard 115.266.

## 115.267 Agency Protection against retaliation

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

**Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.**

In review of ARTS PREA Policy 115.267, Procedures (a-f), Peer 1 has established multiple mechanisms to protect all residents and staff who report sexual abuse, sexual harassment, and/or cooperate with sexual abuse and/or sexual harassment investigations from retaliation by other residents, staff, contractors, and volunteers. ARTS further identifies which staff members/departments are responsible for monitoring of both program participants and persons who express a fear and/or concern of retaliation. In the case of Peer 1 residents, the PREA compliance manager is responsible for completing the monitoring, through periodic status checks. The Program Director for Peer 1 is identified for monitoring "any other individual who cooperates with an investigation" and/or "expressed a fear of retaliation". Year to date, Peer 1 has had one allegation requiring monitoring of the client and witnesses involved. Documentation of the periodic client reviews was provided by Peer 1 and were performed in accordance within the required time frame/intervals and covered the specific criteria (housing/program assignment, grievances, disciplinary actions, etc.). Monitoring, per policy and per PREA standard §115.267(f) would continue for at least 90 days and terminate if the allegation was determined to be unfounded.

## 115.271 Criminal and administrative investigations

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

**Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.**

As outlined in ARTS PREA Policy 115.271, Procedures (a-l), ARTS has established policies for investigating all allegations of sexual harassment and/or sexual abuse; whether via criminal investigations and/or administrative investigations for cases that do not appear to be criminal in nature. In the 12-months prior to the onsite audit, Peer 1 had one allegation of sexual harassment of a program participant. The

investigation reports and related documentation pertaining to the allegation were reviewed thoroughly and in their entirety. The investigation appears to be handled in a timely, thorough manner and the outcome of the investigation appears to be reasonable based upon a preponderance of the evidence.

As previously noted in §115.221, the ARTS staff do not conduct criminal investigations; rather, these are forwarded to local law enforcement (Denver Police Department – Sex Crimes Unit). Peer 1 has formally requested the criminal investigative agency responsible for conducting criminal investigations into allegations of sexual harassment and/or sexual abuse comply with the requirements set forth in the national PREA standards. As an agency, select ARTS staff conduct administrative investigations into allegation of sexual abuse and/or sexual harassment. ARTS staff responsible for conducting such investigations have received specialized investigation trainings covering all required components as identified in §115.234.

## 115.272 Evidentiary standard for administrative investigations

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

**Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.**

ARTS PREA policy 115.272, "*Evidentiary Standards for Administrative Investigations*", Procedure (a) is consistent with the intent, expectations and spirit of PREA Standard 115.272. ARTS as an organization and Peer 1 as an extension of the agency, utilizes the preponderance of the evidence as the standard in determining whether allegations of sexual abuse and/or sexual harassment are substantiated. Peer 1 had no allegations of sexual abuse of a program participant and one allegation of sexual harassment of a program participant in the 12 months prior to the onsite audit. The investigation reports and related documentation pertaining to the allegation were reviewed in their entirety. The investigation appears to be handled in a timely, thorough manner and the outcome of the investigation appears to be reasonable based upon a preponderance of the evidence.

## 115.273 Reporting to residents

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

**Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.**

ARTS PREA Policy 115.273, "Reporting to Residents", Procedures, (a-f), outlines the expectation that resident victims of sexual abuse suffered in the ARTS programs will be informed of the outcome of an investigation into an allegation. Within said policy, the ARTS programs, in this case Peer 1, identify the individuals responsible for providing notification to the resident victim following receipt of final disposition of the investigation. ARTS Policy 115.276 also accurately captures and reflects the respective notification milestones for incidents involving both "staff on resident" sexual abuse and/or "resident on resident" sexual abuse (ARTS PREA Policy 115.276, Procedures (c) and d)). Per ARTS PREA Policy 115.276, should the resident victim be released from Peer 1 program, every effort will be made to attempt to contact the former client in order to provide them with an update on the investigation. Finally, while Peer 1 was unable to completely fulfil their notification requirements to the alleged victim due to this individual's decision to voluntarily (and without authorization) remove himself from the program, the ARTS program does have a resident notification template to be used in the event such notifications are required.

## 115.276 Disciplinary sanctions for staff

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

**Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.**

As is clearly articulated in both the ARTS Policies and Procedures and the University of Colorado's Administrative Policy Statements, termination shall be the presumptive disciplinary sanction for staff who have engaged in sexual abuse. Notification to appropriate regulatory and/or licensing agencies of

substantiated allegation(s) of staff on resident sexual abuse is required in cases of employee termination and/or in cases where the employee would have been terminated if not for their resignation. The formulation of this policy also takes into account intermediate disciplinary measures that could be imposed upon staff who have violated other aspects of the ARTS' "zero tolerance" policy/culture on sexual abuse and/or sexual harassment. For all allegations other than sexual abuse of a program participant, the ARTS programs disciplinary action can range from attendance/completion of mandatory trainings up to and including termination based on both the nature of the allegation as well as incorporating the specific considerations required of §115.276. As set forth by §115.276, ARTS management staff, when considering disciplinary action for staff members who have violated Agency policies and procedures, ARTS management consider corrective action(s) which are: commensurate with the nature and circumstances of the acts committed, the staff member's disciplinary history, and the sanctions imposed for comparable offenses by other staff with similar histories.

Peer 1 has not had a substantiated allegation of sexual abuse or sexual harassment involving a staff member in the 12 months prior to this audit requiring issuance of employee corrective actions nor termination of an employee for violations of the ARTS "zero tolerance" policies. The lone reported sexual harassment allegation, in the 12-month period prior to this audit, was fully investigated, well documented and did not meet the threshold criteria (as defined in the ARTS PREA policy).

While the outcome of the investigation did not meet the threshold to be considered substantiated, Peer 1 PREA committee used the allegation, and investigatory findings, to develop a corrective action plan which included additional staff and client trainings as well as a thorough review of current policies, practices which may have directly and/or indirectly contributed to such an incident occurring. Additionally, though not rising to the level of a substantiated or unsubstantiated allegation, disciplinary intervention was recommended and carried out in concert with both the University of Colorado's and the ARTS program's policies and procedures.

With the presence of strong comprehensive policies providing clear articulation of expected practices to ensure ongoing compliance with the requirements of §115.276 and demonstration of due diligence in all aspects effecting the detection, deterrence, prevention and reporting of sexual abuse and/or sexual harassment, Peer 1 has demonstrated substantial compliance with all aspects of this standard.

## 115.277 Corrective action for contractors and volunteers

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

**Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.**

Consistent with the requirements set forth in §115.277, ARTS PREA Policy 115.277 accurately reflect the requirements set forth in §115.277(a) and (b) as it pertains to removal of contractor's and/or volunteer's from contact with Peer 1 residents when alleged to have engaged in sexual abuse, notification to law

enforcement, notification to relevant licensing agencies, taking remedial measures up to and including prohibition from further contact with residents for any other violation of the ARTS Zero Tolerance policy (aside from engaging in sexual abuse).

Peer 1 has not had such an occurrence within the facility in the 12 months prior to this audit involving allegations of violations of the ARTS "zero tolerance" policies by a contractor, volunteer or visitor. As such, and with the presence of strong comprehensive policies providing clear articulation of expected practices to ensure ongoing compliance with the requirements of §115.277, has demonstrated substantial compliance with all aspects of this standard.

## 115.278 Disciplinary sanctions for residents

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

**Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.**

ARTS PREA Policy 115.278, "Disciplinary Sanctions for Residents", Procedures (a-g) outline the process by which disciplinary sanctions for ARTS residents, to include Peer 1 residents, can and will be imposed for substantiated incidents of sexual abuse and/or sexual harassment. The aforementioned policy accurately captures and mirrors the requirements of 115.278 (a-f). While the likelihood of a Peer 1 resident remaining in the program following a substantiated incident of sexual abuse and/or sexual harassment is low, the ARTS program has incorporated into their policies and programmatic practices the ability to offer individual and group therapy to the identified resident on resident abuser. Second, it is important to note, as a private contractor providing services to Colorado Department of Corrections, Colorado Division of Criminal Justice (DCJ), et al, ARTS would not be permitted to retain a resident accused of sexual abuse; rather, the appropriate legal entities (DCJ, Denver Police Department, etc.) would remand the alleged abuser until final disposition. Collectively, the ARTS' PREA policies establish a "zero tolerance" environment for all forms of violence, harassment, etcetera. As such, all prohibited behaviors/actions are addressed through Therapeutic Community's tools (pull ups, haircuts, learning experiences, etc.) and via cognitive behavioral therapeutic interventions.

## 115.282 Access to emergency medical and mental health services

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

**Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.**

The ARTS PREA Policy 115.282, Access to Emergency Medical and Mental Health Services", Procedure (a-d), outlines ARTS' stated objectives to provide resident victims of sexual abuse with access to emergency medical treatment and crisis intervention services. ARTS's MOU with the Blue Bench also provides for advocacy and emotional supportive services; furthermore, ARTS's MOU with the Denver Hospital and Health Authority Health Center duties of both ARTS and the "hospital" respectively. In said MOU, sections V and VI respectively, the requirements set forth in 115.282(a)(c)(d) are specifically covered and articulated. Additionally, speaking to §115.282(b), ARTS has set forth written directives (as noted in 115.265) to ensure that notification to appropriate medical and mental health practitioners occurs upon determination that an incident of sexual abuse has transpired and imposes the expectation that staff notification to medical and/or mental health practitioners occurs as soon as possible though not to exceed one hour from the time of discovery of the alleged abuse (ARTS PREA Policy 115.282, Procedure (b)). Additionally, the MOU between the ARTS programs and the Blue Bench provides for emotional supportive counseling, advocacy and follow-up services. As noted previously in §115.265 audit finding narrative, Peer 1's coordinated response plan clearly identifies the protocols, time frames, and parties responsible for notification to ancillary medical, mental health, and supportive services.

## 115.283 Ongoing medical and mental health care for sexual abuse victims and

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

**Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.**

ARTS PREA Policy 115.283, "*Ongoing Medical and Mental Health Care for Victims and Abusers*", Procedures (a-h) captures each of the applicable elements of PREA standard 115.283(a-h) with the notable exceptions of 115.283(d)(e) which would not be applicable as Peer 1 is an all-male facility. The remaining portions of the standard (115.283(a)(b)(c)(f)(g) and (h) are fully articulated in the above referenced policy. The ARTS programs have also entered into memorandums of understanding with the Denver Hospital and Health Authority and the Blue Bench. Both MOU's account for ongoing medical and mental health care services for victims of sexual abuse being provided at no cost to the victim without consideration given for their cooperation, or lack thereof, in any phase of the investigation into the allegation.

## 115.286 Sexual abuse incident reviews

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

**Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.**

ARTS PREA Policy 115.286, "*Sexual Abuse Incident Reviews*", Procedure (a-d) outline ARTS' expectations on the scope, the participants, responsibilities and areas to be reviewed, and functionality of sexual incident review committee and its quorum. Although Peer 1 has not had an allegation of sexual abuse in the twelve months prior to the on-site audit, occurring between September 21, 2015 and September 23, 2015, Peer 1 PREA committee was convened to review the lone allegation that was reported; this being an allegation of sexual harassment of a program participant. As has been previously noted, the allegation, not appearing to be criminal in nature, was administratively investigated by Peer 1 staff members who trained in accordance with §115.234. Following the conclusion of the investigation, and not exceeding the 30-day deadline established via §115.286, Peer 1 PREA committee convened, reviewed and assessed all required and pertinent aspects of the investigation, the investigatory findings, and performance of expected staff duties as expressed, expected and outlined in the ARTS PREA Policy and Procedures. The committee's meeting minutes, findings, and recommendations along with all the investigative documentation have been documented and retained.

## 115.287 Data Collection

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

**Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.**

Peer 1, as directed by ARTS's PREA Policy 115.287, "*Data Collection*", Procedures (a-f)), collects accurate, uniform data for every allegation of sexual abuse at facilities under its direct control and does so by using a set of definitions. The data collected is in accordance with the information required to complete the most recent version of the United States Department of Justice Survey of Sexual Violence. This data is gathered at each ARTS facility, to include Peer 1, and forwarded to the ARTS PREA Coordinator for the respective programs. During the short corrective action period, Peer 1 staff worked diligently to ensure this report was available to the public for review.

This data can be found published in Peer 1's Annual Report which is available for public viewing on the ARTS website, www.artstreatment.org, under the PREA tab on the left hand side of the webpage. With this report published, Peer one is compliant with the requirements of this standard.

## 115.288 Data review for corrective action

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

**Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.**

ARTS PREA Policy 115.288, "Data Review", Procedures (a-d) accurately capture and reflect all of the required elements set forth in §115.288(a-d) and as noted above in 115.287, data collected pursuant to §115.287 has been aggregated, analyzed, and will be made available on the ARTS website in the near future. The ARTS first annual report appropriately reflects the required components of the §115.288. Those required elements being: identifying problem areas (facility and/or agency wide); identification of

corrective actions for each facility and the agency as a whole where needed; and, an assessment on the agency's progress in addressing sexual abuse. As this Peer 1's first Annual report, it reflects the 2012, 2013 and 2014 calendar years.

## 115.289 Data storage, publication, and destruction

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

**Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.**

ARTS, through the ARTS PREA Policy 115.289, "*Data Storage, Publication and Retention*", (Procedures (a-d)), capture each of the requirements of §115.289 and, as has been noted in the previous two standards, ARTS has compiled, aggregated and published data collected for 2012, 2013 and 2014 respectively in the form of an Annual Report. This data can be found published in Peer 1's Annual Report which is available for public viewing on the ARTS website, www.artstreatment.org, under the PREA tab on the left hand side of the webpage.

**AUDITOR CERTIFICATION**

I certify that:

☒ The contents of this report are accurate to the best of my knowledge.

☒ No conflict of interest exists with respect to my ability to conduct an audit of the agency under review, and

☒ I have not included in the final report any personally identifiable information (PII) about any resident or staff member, except where the names of administrative personnel are specifically requested in the report template.

2-16-16

Auditor Signature Date