## Prison Rape Elimination Act (PREA) Audit Report
**Community Confinement Facilities**

- **☑ Final**

### Date of Report
January 31, 2018

### Auditor Information

<table>
<thead>
<tr>
<th>Name</th>
<th>Kenneth Juranek</th>
</tr>
</thead>
<tbody>
<tr>
<td>Email</td>
<td><a href="mailto:dryflylovr@aol.com">dryflylovr@aol.com</a></td>
</tr>
<tr>
<td>Company Name</td>
<td>Click or tap here to enter text.</td>
</tr>
<tr>
<td>Mailing Address:</td>
<td>18601 Green Valley Ranch Blvd #108 Box #104</td>
</tr>
<tr>
<td>City, State, Zip:</td>
<td>Denver, Colo 80249</td>
</tr>
<tr>
<td>Telephone</td>
<td>720-201-3605</td>
</tr>
<tr>
<td>Date of Facility Visit:</td>
<td>September 10-14, 2018</td>
</tr>
</tbody>
</table>

### Agency Information

<table>
<thead>
<tr>
<th>Name of Agency:</th>
<th>PEER 1 Community Therapeutic Community</th>
</tr>
</thead>
<tbody>
<tr>
<td>Governing Authority or Parent Agency (If Applicable):</td>
<td>ARTS (Addiction and Research Treatment Services)</td>
</tr>
<tr>
<td>Physical Address:</td>
<td>3762 W Princeton Circle</td>
</tr>
<tr>
<td>Mailing Address:</td>
<td>Same as above</td>
</tr>
<tr>
<td>City, State, Zip:</td>
<td>Denver, Colorado 80236</td>
</tr>
<tr>
<td>Telephone:</td>
<td>303-761-2885</td>
</tr>
<tr>
<td>Is Agency accredited by any organization?</td>
<td>☐ Yes</td>
</tr>
<tr>
<td>The Agency Is:</td>
<td>☑ State</td>
</tr>
<tr>
<td>☐ Military</td>
<td>☐ Private for Profit</td>
</tr>
<tr>
<td>☐ Private not for Profit</td>
<td>☐ Federal</td>
</tr>
<tr>
<td>☐ Municipal</td>
<td>☐ County</td>
</tr>
<tr>
<td>Agency mission:</td>
<td>Click or tap here to enter text.</td>
</tr>
<tr>
<td>Agency Website with PREA Information:</td>
<td><a href="http://www.artstreatment.edu">www.artstreatment.edu</a></td>
</tr>
</tbody>
</table>

### Agency Chief Executive Officer

<table>
<thead>
<tr>
<th>Name</th>
<th>Kristen Dixion</th>
</tr>
</thead>
<tbody>
<tr>
<td>Title:</td>
<td>Executive Director</td>
</tr>
<tr>
<td>Email</td>
<td><a href="mailto:kristen.dixon@ucdenver.edu">kristen.dixon@ucdenver.edu</a></td>
</tr>
<tr>
<td>Telephone</td>
<td>303-734-5022</td>
</tr>
</tbody>
</table>

### Agency-Wide PREA Coordinator

<table>
<thead>
<tr>
<th>Name</th>
<th>Ken Gaipa</th>
</tr>
</thead>
<tbody>
<tr>
<td>Title:</td>
<td>Director</td>
</tr>
</tbody>
</table>
**Email:** ken.gaipa@ucdenver.edu  
**Telephone:** 720-283-3668

**PREA Coordinator Reports to:** Ken Gaipa

**Number of Compliance Managers who report to the PREA Coordinator:** 1

### Facility Information

**Name of Facility:** PEER 1 Therapeutic Community

**Physical Address:** 3762 W Princeton Circle

**Mailing Address (if different than above):** Click or tap here to enter text.

**Telephone Number:** 303-761-2885

**The Facility Is:**
- [ ] Military
- [ ] Private for Profit
- [x] Private not for Profit
- [ ] Municipal
- [ ] County
- [x] State
- [ ] Federal

**Facility Type:**
- [ ] Community treatment center
- [ ] Halfway house
- [ ] Restitution center
- [ ] Mental health facility
- [x] Alcohol or drug rehabilitation center
- [ ] Other community correctional facility

**Facility Mission:** It is the mission of Addiction Research and Treatment Services to improve the quality of life and productivity of individuals and families affected by substance use and co-occurring mental health disorders through the application of scientifically supported prevention, education and treatment services

**Facility Website with PREA Information:** www.arttreatment.com

**Have there been any internal or external audits of and/or accreditations by any other organization?**

- [x] Yes
- [ ] No

**Signal management Quality Committee conducted site visit on May 11, 2018. No issues per memo.**

### Director

**Name:** Ken Gaipa  
**Title:** Director

**Email:** ken.gaipa@ucdenver.edu  
**Telephone:** 720-283-3668

### Facility PREA Compliance Manager

**Name:** Barbara Sanchez  
**Title:** PREA Coordinator

**Email:** Barbara.sanchez@ucdenver.edu  
**Telephone:** 303-734-3307

### Facility Health Service Administrator
### Facility Characteristics

<table>
<thead>
<tr>
<th>Designated Facility Capacity:</th>
<th>84</th>
</tr>
</thead>
<tbody>
<tr>
<td>Current Population of Facility:</td>
<td>82</td>
</tr>
</tbody>
</table>

| Number of residents admitted to facility during the past 12 months | 119 |
| Number of residents admitted to facility during the past 12 months who were transferred from a different community confinement facility: | 0 |
| Number of residents admitted to facility during the past 12 months whose length of stay in the facility was for 30 days or more: | 105 |
| Number of residents admitted to facility during the past 12 months whose length of stay in the facility was for 72 hours or more: | 116 |
| Number of residents on date of audit who were admitted to facility prior to August 20, 2012: | 0 |

<table>
<thead>
<tr>
<th>Age Range of Population:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adults</td>
</tr>
<tr>
<td>Juveniles</td>
</tr>
<tr>
<td>Youthful residents</td>
</tr>
</tbody>
</table>

| Average length of stay or time under supervision: | 248 |
| Facility Security Level: | Minimum |
| Resident Custody Levels: | N/A it is a free standing facility |

| Number of staff currently employed by the facility who may have contact with residents: | 30 |
| Number of staff hired by the facility during the past 12 months who may have contact with residents: | 4 |
| Number of contracts in the past 12 months for services with contractors who may have contact with residents: | 0 |

### Physical Plant

| Number of Buildings: | 2 |
| Number of Single Cell Housing Units: | 4 |
| Number of Multiple Occupancy Cell Housing Units: | 18 |
| Number of Open Bay/Dorm Housing Units: | 0 |

**Description of any video or electronic monitoring technology (including any relevant information about where cameras are placed, where the control room is, retention of video, etc.):**

PEER 1 has cameras in the stairways of both buildings. These cameras focus on the stairs and laundry room doors. There are a total of 12 cameras and 1 DVR.

There are also 4 cameras located in the PEER 1 administrative building, but there are no residents housed in this building.

The cameras are located in the security office and only the director and supervisor of security have access to log in and check the camera system. The PREA Coordinator also has access to the camera systems.

Video is recorded and available for several months due to the system retaining for longer period due to limited movement.
<table>
<thead>
<tr>
<th>Medical</th>
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<tbody>
<tr>
<td><strong>Type of Medical Facility:</strong></td>
</tr>
<tr>
<td><strong>Forensic sexual assault medical exams are conducted at:</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Number of volunteers and individual contractors, who may have contact with residents, currently authorized to enter the facility:</strong></td>
</tr>
<tr>
<td><strong>Number of investigators the agency currently employs to investigate allegations of sexual abuse:</strong></td>
</tr>
</tbody>
</table>
Audit Findings

Audit Narrative

On July 31, 2018, Peer 1 PREA Coordinator Barbara Sanchez, sent an email advising the auditor that the PREA Audit Notice had been posted within the facilities, she did not specifically note where they were posted, only that they had been posted. The notice advised staff and residents that there would be a PREA on-site audit conducted on September 10-14, 2018, and how to contact the PREA auditor.

On September 4, 2018, the auditor received the pre-audit questionnaire and documents from the Peer 1 Director.

On August 29, 2018, the auditor sent an E-Mail to Just Detentions, which is a nationwide organization that tracks complaints of sexual abuse. On August 31, 2018, a response was received indicating there had been no reports made to their organization.

On September 10, 2018, the PREA auditor Ken Juranek and assistance auditor, Joanie Shoemaker arrived at the facility and were introduced to the management staff. PREA coordinator Barbara Sanchez gave the auditor and auditor assistant a tour of all both Peer 1 buildings (Motivation and Dedication). This tour included residents’ rooms and bathrooms, TV rooms, case manager offices, and the basements. The basement is used for food storage and the laundry rooms.

Later the Director finished the tour and provided the auditors access to the locked staff offices and security office. The auditors went into ever resident’s room and looked at all rooms in both buildings.

Staff can be alone with residents behind a door, but the door has windows, which allowed for privacy, but provided visual for staff.

Peer 1 utilizes two separate buildings (Motivation and Dedication) for their program. These buildings are located on Fort Logan, which is a deactivated Army base. These buildings are Victorian style buildings. Each building has 18 rooms for residents. 18 of these rooms have multiple residents and 4 have single residents. The resident rooms have individual beds, dresser drawers and closets. There is a community bathroom on each floor for residents to use. The bathroom(s) consist of a fixed door, toilet, sink and a shower that has a curtain for privacy. Two of the bathroom doors had locks on them but staff did not have access to keys, but since the audit, the locks have been removed to allow staff access in the event of an emergency.

The Peer 1 PREA Coordinator was informed that staff needs to be able to enter the bathrooms for safety and security reasons.

PREA posters were observed on every floor and each poster gave residents an option of how to report sexual abuse or sexual harassment. The auditors also viewed the audit notifications posted in the common areas and on each floor.

Additionally, the laundry rooms have solid doors with no full window, but there is a fixed camera at the top of the stairs. The camera provides a view of the laundry door to monitor who goes in and out.
After the tour of the facility, the auditors received a resident roster and randomly selected 20 residents to interview. These random interviews were conducted on September 10, 2018, and September 11th, 2018. Additional interviews for residents who identified as gay or bi-sexual were interviewed. There were no other specialized residents interviewed. A total of 20 residents were interviewed.

PEER 1 has 30 staff members, no volunteers and no contractors.

On September 10 and 11, 2018, random staff, the PREA coordinator, PEER 1 director, security, were interviewed. The PEER 1 director was interviewed by phone due to him being out on FMLA leave. Staff on all shifts was interviewed. (Staff was interviewed on the day, swing and graveyard shifts.) 19 staff was interviewed.

A few staff members have multiple duties and were interviewed for more than one of the specialized staff questions. The following specialized staff interviews were conducted: agency head, intake staff, agency contract administrator, human resource, investigators (staff who conduct administrative investigations), staff who perform screening for risk of victimization and abusiveness, and staff on the incident review team. There were 19 interviews conducted. These interviews included 13 random staff; and specialized staff. There is no medical staff at PEER 1.

On September 10th and 11th, 2018, random staff, the PREA coordinator, The PEER 1 director and security were interviewed. The PEER 1 Director was interviewed on September 11th, by phone due to being on FMLA leave. (Staff was interviewed on the day, swing and graveyard shifts.) 19 staff interviews were conducted.

During the post audit there was a discussion of the following:

Residents are not allowed to use the phone the first 30 days and need to get permission to use the phone, which in the event of a PREA allegation, would not guarantee anonymity. It was suggested that PEER 1 program the number of the hotline into the machine to allow residents to fax a complaint as it would not raise suspicions to staff or other residents.

### Facility Characteristics

Peer I is fully licensed by the Colorado Office of Behavioral Health. Peer I contracts with multiple entities, including the Colorado Division of Criminal Justice, Department of Corrections, local probation offices and is in the Signal Behavioral Health Network.

Peer I is a 84-bed Therapeutic Community (TC) that offers long-term, intensive treatment for adult males with chronic substance use disorders, related anti-social behaviors and very limited co-occurring mental health disorders. While in treatment, individuals receive services that not only focus on recovery from substances and maintenance, but treatment that focuses on social functioning, education/vocational skills, and positive community and family ties. Peer I is a highly-structured, scientifically supported treatment model that encompasses progressive phases.

PEER 1 residents commit to a 9-12 month program, which includes a 30 day orientation,
Phase I (Approximately 3-6 months). Addresses issues related to substance use. Develops and strengthens problem-solving skills. Identifies and addresses behavioral problems, and acquires pro-social attitudes and values.

Transitional Phase (Approximately 3-5 months) Re-socialization skills training increase contact with community (employment, school, support, and leisure activities), money management, and employment placement and monitoring.

**Treatment Activities:**

Peer I is a part of ARTS (Addiction Research and Treatment Services), which is within the Division of Substance Dependence, in the Department of Psychiatry at the University of Colorado School of Medicine. Peer I is licensed by the Colorado Department of Human Services (CDHS), Office of Behavioral Health (OBH) ARTS Treatment program, to provide substance abuse treatment.

PEER 1 is a program designed to assist with both alcohol and drug addiction. PEER 1 is a male only facility, clients are admitted from both the Colorado Department of Corrections and local jails.

Services and treatment activities at Peer I rely on cognitive behavioral changes, stages of change, and community reinforcement to help shape pro-social attitudes, behaviors, and enhanced coping skills. Treatment activities include: Extensive Assessment and Treatment, Individual and Group Education, Counseling, Relapse Prevention, Trauma-Informed Treatment, and Alcohol Testing, Peer Run Activities-Groups-Meetings.

PEER 1 occupies two buildings (Motivation and Dedication), with a total occupancy of 84 residents. Both buildings are converted Victorian style homes that sit on Fort Logan, which is an old United States Army base. At the time of the audit there were 82 residents in both buildings.

The Motivation house has a kitchen where the food is prepped and cooked for both houses. During warm weather the residents meet in a common area of the grass area between the houses and eat as a group: inside the house during inclement weather.

PEER 1 is a free standing facility and residents can walk outside, they can sit in the yard area or take walks

PEER 1 has 30 staff that has contact with residents. PEER 1 has no contractors as the work done is completed by employees of Fort Logan, which is a division of the State of Colorado. PEER 1 has no volunteers as all employees are on a paid salary.
PEER 1 is licensed by the Office of Behavioral Health. PEER 1 is considered a Transitional Residential Treatment facility for 84 adult men transitioning from incarceration to the community. PEER 1 supports continuity of care as an essential component to the continued success of clients. This includes stabilizing the clients by providing very limited mental health treatment, developing recovery and maintenance skills from substance abuse, and teaching life skills to support a successful transition from incarceration into the community.

The admission criteria to PEER 1 require an interview by the program staff and all clients must have a substance abuse disorder. PEER 1, works with clients who are currently involved in Therapeutic Community programs within the Colorado Department of Corrections. In addition, PEER 1 serves clients who are considered Condition of Parole status and direct sentence from the judge as an alternative to incarceration.

In the past 12 months the following

119 residents have been admitted to the program.
105 residents have stayed more than 30 days.
116 residents have stayed longer than 72 hours.
The age range exists between 18-70
The average stay for each resident under supervision was 248 days.

Peer 1’s primary focus is treating clients’ substance use disorders, criminogenic needs and some limited mental health issues and sobriety while becoming productive members of the community. PEER 1 provides evidence based groups that focus on cognitive restructuring to help clients understand their thought processes, core beliefs and maladaptive behaviors. In addition to group therapy, all clients meet with an in-house clinical staff member weekly for individual therapy at least twice per month for individual therapy and receive psychiatric medication monitoring from a licensed psychiatrist.

Beyond staff initiated treatment, there is an active peer community component at PEER 1. Residents as they leave or enter rooms, must vocally say a positive thought to strengthen their beliefs in the program.

PEER 1 has 30 staff, including a Clinical Director, who is a Licensed Clinical Social Worker, LAC, MAC and certified Addiction Counselor level III (CAC III) that oversees clinical services at PEER 1. In addition, PEER 1 has case managers, addiction counselors, and a licensed psychiatrist. There are no specialized nurses on site.

All of the PEER 1 security staff has been trained in CPR and first aid.
Summary of Audit Findings

Auditor Note: No standard should be found to be “Not Applicable” or “NA”. A compliance determination must be made for each standard.

Number of Standards Exceeded: 0

Number of Standards Met: 40

Number of Standards Not Met: 0

Summary of Corrective Action (if any)

One area needed corrective action:

During the tour it was observed that there was no way to send an anonymous complaint, as residents are not allowed to use the phone the first 30 days. If they ask to use the phone they are required to write down the phone number, so this would possibly expose them if they complained.

Conclusion- This standard needs correction to ensure residents can send complaints in an anonymous manner.

PREVENTION PLANNING

Standard 115.211: Zero tolerance of sexual abuse and sexual harassment; PREA coordinator

All Yes/No Questions Must Be Answered by The Auditor to Complete the Report

115.211 (a)

- Does the agency have a written policy mandating zero tolerance toward all forms of sexual
abuse and sexual harassment? ☒ Yes ☐ No

- Does the written policy outline the agency’s approach to preventing, detecting, and responding to sexual abuse and sexual harassment? ☒ Yes ☐ No

115.211 (b)

- Has the agency employed or designated an agency-wide PREA Coordinator? ☒ Yes ☐ No
- Is the PREA Coordinator position in the upper-level of the agency hierarchy? ☒ Yes ☐ No
- Does the PREA Coordinator have sufficient time and authority to develop, implement, and oversee agency efforts to comply with the PREA standards in all of its facilities? ☒ Yes ☐ No

Auditor Overall Compliance Determination

☐ Exceeds Standard (Substantially exceeds requirement of standards)
☒ Meets Standard (Substantial compliance; complies in all material ways with the standard for the relevant review period)
☐ Does Not Meet Standard (Requires Corrective Action)

Instructions for Overall Compliance Determination Narrative

PEER 1 has a policy that has a zero tolerance towards any type of abuse between residents and residents or staff-residents. This reporting system includes incidents that have occurred in other facilities. This policy also provides for support for those who have been victims of sexual abuse.

Peer I employs a part time PREA Coordinator. This PREA Coordinator reports directly to the Program Director and have been authorized, in conjunction with the Program Directors, to develop, implement and oversee agency efforts to comply with PREA standards in all facilities. The PREA Coordinator is solely employed to complete PREA related duties. The PREA Coordinator has sufficient time to complete job duties.

The policy for PEER1 lists definitions for all areas of PREA, which include sexual abuse, voyeurism, and sexual harassment.

The policy, which is very extensive, and was sent in an E-Mail to the auditor.

PEER 1 is in compliance with this standard.

Evidence Relied Upon
Pre-Audit Questionnaire
Submitted Policies
Interviews with various individuals
Standard 115.212: Contracting with other entities for the confinement of residents

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.212 (a)

- If this agency is public and it contracts for the confinement of its residents with private agencies or other entities including other government agencies, has the agency included the entity’s obligation to comply with the PREA standards in any new contract or contract renewal signed on or after August 20, 2012? (N/A if the agency does not contract with private agencies or other entities for the confinement of residents.) ☐ Yes ☐ No ☒ NA

115.212 (b)

- Does any new contract or contract renewal signed on or after August 20, 2012 provide for agency contract monitoring to ensure that the contractor is complying with the PREA standards? (N/A if the agency does not contract with private agencies or other entities for the confinement of residents OR the response to 115.212(a)-1 is “NO”.) ☐ Yes ☐ No ☒ NA

115.212 (c)

- If the agency has entered into a contract with an entity that fails to comply with the PREA standards, did the agency do so only in emergency circumstances after making all reasonable attempts to find a PREA compliant private agency or other entity to confine residents? (N/A if the agency has not entered into a contract with an entity that fails to comply with the PREA standards.) ☐ Yes ☐ No ☒ NA

- In such a case, does the agency document its unsuccessful attempts to find an entity in compliance with the standards? (N/A if the agency has not entered into a contract with an entity that fails to comply with the PREA standards.) ☐ Yes ☐ No ☒ NA

Auditor Overall Compliance Determination

☐ Exceeds Standard (Substantially exceeds requirement of standards)

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

☐ Does Not Meet Standard (Requires Corrective Action)

Instructions for Overall Compliance Determination Narrative

Peer 1 per their policy does not enter into any agreement with other agencies. If the situation arose PEER 1 policy indicated they would comply with the following:
The Peer 1 Program is in partnership with other entities such as Community Corrections and the Colorado Department of Corrections will ensure that all contracts and renewals adopt and comply with PREA standards.

The PREA Coordinator or the Program Director will review all new contracts and renewals to ensure that PREA standards are incorporated into the language in all relevant contracts.

The program will make all reasonable efforts to only contract with agencies that are able to comply with the Community Confinement Standards. Only in emergency circumstances will the Peer I and Haven Programs contract with public agencies which are not able to comply with these Standards. The programs will document the unsuccessful efforts to find outside entities that are able to comply.

Subsection (a) This standard is Not Applicable. PEER 1 does not contract from the confinement of its residents with private agencies or other entities including other government agencies for the confinement of residents.

In an interview with the PREA coordinator, she stated that PEER 1 does not contract with a private agency or other agency for the confinement of its residents.

Additionally, the PREA coordinator provided a memo that confirms PEER 1 does not contract with a private or other entity including other government agencies for the confinement of their residents.

Subsection (b) is Not Applicable. PEER 1 does not contract from the confinement of its residents with private agencies or other entities including other government agencies for the confinement of residents.

Subsection (c) This standard is Not Applicable. PEER 1 has not entered into a contract with an entity that fails to comply with the PREA standards. PEER 1 does not contract from the confinement of its residents with private agencies or other entities including other government agencies for the confinement of residents.

PEER 1 is in compliance with this standard.

Evidence Relied Upon
Pre-Audit Questionnaire
Submitted Policies
Interviews with various individuals

**Standard 115.213: Supervision and monitoring**

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.213 (a)

- Does the agency develop for each facility a staffing plan that provides for adequate levels of staffing and, where applicable, video monitoring, to protect residents against sexual abuse?
  ✗ Yes  ☐ No
Does the agency document for each facility a staffing plan that provides for adequate levels of staffing and, where applicable, video monitoring, to protect residents against sexual abuse?  ☒ Yes  ☐ No

Does the agency ensure that each facility’s staffing plan takes into consideration the physical layout of each facility in calculating adequate staffing levels and determining the need for video monitoring?  ☒ Yes  ☐ No

Does the agency ensure that each facility’s staffing plan takes into consideration the composition of the resident population in calculating adequate staffing levels and determining the need for video monitoring?  ☒ Yes  ☐ No

Does the agency ensure that each facility’s staffing plan takes into consideration the prevalence of substantiated and unsubstantiated incidents of sexual abuse in calculating adequate staffing levels and determining the need for video monitoring?  ☒ Yes  ☐ No

Does the agency ensure that each facility’s staffing plan takes into consideration any other relevant factors in calculating adequate staffing levels and determining the need for video monitoring?  ☒ Yes  ☐

115.213 (b)

In circumstances where the staffing plan is not complied with, does the facility document and justify all deviations from the plan? (N/A if no deviations from staffing plan.)  ☐ Yes  ☐ No  ☒ NA

115.213 (c)

In the past 12 months, has the facility assessed, determined, and documented whether adjustments are needed to the staffing plan established pursuant to paragraph (a) of this section?  ☒ Yes  ☐ No

In the past 12 months, has the facility assessed, determined, and documented whether adjustments are needed to prevailing staffing patterns?  ☒ Yes  ☐ No

In the past 12 months, has the facility assessed, determined, and documented whether adjustments are needed to the facility’s deployment of video monitoring systems and other monitoring technologies?  ☒ Yes  ☐ No

In the past 12 months, has the facility assessed, determined, and documented whether adjustments are needed to the resources the facility has available to commit to ensure adequate staffing levels?  ☒ Yes  ☒

Auditor Overall Compliance Determination

☐  Exceeds Standard  (Substantially exceeds requirement of standards)
☒ Meets Standard *(Substantial compliance; complies in all material ways with the standard for the relevant review period)*

☐ Does Not Meet Standard *(Requires Corrective Action)*

Instructions for Overall Compliance Determination Narrative

Peer 1 has a policy that requires a 20:1 ratio of staff to residents. The program has a once a year audit conducted by the ARTS program, which is conducted to ensure adequate staffing. This audit is normally conducted during their budgetary process.

PEER 1 is in compliance with this standard.

Evidence Relied Upon
Pre-Audit Questionnaire
Submitted Policies

Standard 115.215: Limits to cross-gender viewing and searches

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.215 (a)

- Does the facility always refrain from conducting any cross-gender strip or cross-gender visual body cavity searches, except in exigent circumstances or by medical practitioners? ☒ Yes ☐ No

115.215 (b)

- Does the facility always refrain from conducting cross-gender pat-down searches of female residents, except in exigent circumstances? (N/A if less than 50 residents) ☐ Yes ☒ No ☐

- Does the facility always refrain from restricting female residents’ access to regularly available programming or other outside opportunities in order to comply with this provision? (N/A if less than 50 residents) ☐ Yes ☒ No ☒ NA

115.215 (c)

- Does the facility document all cross-gender strip searches and cross-gender visual body cavity searches? ☒ Yes ☐ No

- Does the facility document all cross-gender pat-down searches of female residents? ☒ Yes ☐ No
115.215 (d)

- Does the facility implement policies and procedures that enable residents to shower, perform bodily functions, and change clothing without nonmedical staff of the opposite gender viewing their breasts, buttocks, or genitalia, except in exigent circumstances or when such viewing is incidental to routine cell checks? ☒ Yes ☐ No

- Does the facility require staff of the opposite gender to announce their presence when entering an area where residents are likely to be showering, performing bodily functions, or changing clothing? ☒ Yes ☐ NO

115.215 (e)

- Does the facility always refrain from searching or physically examining transgender or intersex residents for the sole purpose of determining the resident’s genital status? ☒ Yes ☐ No

- If a resident’s genital status is unknown, does the facility determine genital status during conversations with the resident, by reviewing medical records, or, if necessary, by learning that information as part of a broader medical examination conducted in private by a medical practitioner? ☒ Yes ☐ No

115.215 (f)

- Does the facility/agency train security staff in how to conduct cross-gender pat down searches in a professional and respectful manner, and in the least intrusive manner possible, consistent with security needs? ☒ Yes ☐ No

- Does the facility/agency train security staff in how to conduct searches of transgender and intersex residents in a professional and respectful manner, and in the least intrusive manner possible, consistent with security needs? ☒ Yes ☐ No

Auditor Overall Compliance Determination

☐ Exceeds Standard (Substantially exceeds requirement of standards)

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

☐ Does Not Meet Standard (Requires Corrective Action)

Instructions for Overall Compliance Determination Narrative

PEER 1 has a policy which does not allow searches of cross gender residents. The policy is as follows:

(a) The programs will not conduct cross-gender strip searches or cross gender visual body cavity searches except in very exigent circumstances or when being performed by a
medical practitioner. If a staff member requires a search, the supervisor will be notified, who contact the
director, who will make the final decision. The search if approved will be documented.

(b) N/A due to PEER 1 having no female residents so these searches are not conducted.

(c) Existing program policy allows for all clients to perform bodily functions, use the shower
or change clothes without being viewed by a staff member of the opposite gender. Cross-
gender staff members are required to announce their presence in situations where such
viewing may be incidental to routine checks of rooms.

(d) Existing program policy allows for all clients to perform bodily functions, use the shower
or change clothes without being viewed by a staff member of the opposite gender. Cross-
gender staff members are required to announce their presence in situations where such
viewing may be incidental to routine checks of rooms.

(e) The program will not search or physically examine clients for the sole purpose of
determining the genital status of transgender or intersex individuals.

(f) Neither Peer I nor The Haven conduct cross-gender pat-down searches. If a search is necessary
staff is taught to conduct the search in the least intrusive manner. Transgender and intersex clients are
given their choice of pat down searches being conducted by a male or a female staff member.

PEER 1 has a policy that does not allow these types of searches. If a search is required the search will
involve the least intrusive technique, and will be conducted by the gender chosen by the resident.

PEER 1 is in compliance with this standard.

Evidence Relied Upon
Pre-Audit Questionnaire
Submitted Policies
Interviews with staff members

Standard 115.216: Residents with disabilities and residents who are limited
English proficient

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.216 (a)

- Does the agency take appropriate steps to ensure that residents with disabilities have an equal
  opportunity to participate in or benefit from all aspects of the agency’s efforts to prevent, detect,
  and respond to sexual abuse and sexual harassment, including: Residents who are deaf or hard
  of hearing? ☒ Yes ☐ No

- Does the agency take appropriate steps to ensure that residents with disabilities have an equal
  opportunity to participate in or benefit from all aspects of the agency’s efforts to prevent, detect,
  and respond to sexual abuse and sexual harassment, including: Residents who are blind or
  have low vision? ☒ Yes ☐ No
 Does the agency take appropriate steps to ensure that residents with disabilities have an equal opportunity to participate in or benefit from all aspects of the agency’s efforts to prevent, detect, and respond to sexual abuse and sexual harassment, including: Residents who have intellectual disabilities? ☒ Yes ☐ No

 Does the agency take appropriate steps to ensure that residents with disabilities have an equal opportunity to participate in or benefit from all aspects of the agency’s efforts to prevent, detect, and respond to sexual abuse and sexual harassment, including: Residents who have psychiatric disabilities? ☒ Yes ☐ No

 Does the agency take appropriate steps to ensure that residents with disabilities have an equal opportunity to participate in or benefit from all aspects of the agency’s efforts to prevent, detect, and respond to sexual abuse and sexual harassment, including: Residents who have speech disabilities? ☒ Yes ☐ No

 Does the agency take appropriate steps to ensure that residents with disabilities have an equal opportunity to participate in or benefit from all aspects of the agency’s efforts to prevent, detect, and respond to sexual abuse and sexual harassment, including: Other? (if "other," please explain in overall determination notes.) ☒ Yes ☐ No

 Do such steps include, when necessary, ensuring effective communication with residents who are deaf or hard of hearing? ☒ Yes ☐ No

 Do such steps include, when necessary, providing access to interpreters who can interpret effectively, accurately, and impartially, both receptively and expressively, using any necessary specialized vocabulary? ☒ Yes ☐ No

 Does the agency ensure that written materials are provided in formats or through methods that ensure effective communication with residents with disabilities including residents who: Have intellectual disabilities? ☒ Yes ☐ No

 Does the agency ensure that written materials are provided in formats or through methods that ensure effective communication with residents with disabilities including residents who: Have limited reading skills? ☒ Yes ☐ No

 Does the agency ensure that written materials are provided in formats or through methods that ensure effective communication with residents with disabilities including residents who: Are blind or have low vision? ☒ Yes ☐ No

115.216 (b)

 Does the agency take reasonable steps to ensure meaningful access to all aspects of the agency’s efforts to prevent, detect, and respond to sexual abuse and sexual harassment to residents who are limited English proficient? ☒ Yes ☐ No
- Do these steps include providing interpreters who can interpret effectively, accurately, and impartially, both receptively and expressively, using any necessary specialized vocabulary?
  ☒ Yes ☐ No

115.216 (c)

- Does the agency always refrain from relying on resident interpreters, resident readers, or other types of resident assistants except in limited circumstances where an extended delay in obtaining an effective interpreter could compromise the resident's safety, the performance of first-response duties under §115.264, or the investigation of the resident's allegations?
  ☒ Yes ☐ No

Auditor Overall Compliance Determination

☐ Exceeds Standard *(Substantially exceeds requirement of standards)*

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

☐ Does Not Meet Standard *(Requires Corrective Action)*

Instructions for Overall Compliance Determination Narrative

(a) The program will take steps to assure that clients with all types of disabilities and or language barriers have an equal opportunity to participate and benefit from efforts to prevent, detect, and respond to sexual misconduct. Written materials will be provided in formats or methods to ensure effective communication. The PREA video which all clients view upon intake into the program is formatted so that it is shown both in writing and orally. Additionally, The Haven and Peer I are authorized to utilize the services of “The Spring Institute”, which is an approved vendor through the University of Colorado. The Spring Institute provides translation services for ARTS and can be accessed by any ARTS program. The program is not required to take actions that it can demonstrate would result in a fundamental alteration in the nature of a service, program, or activity, or in undue financial and administrative burdens, as those terms are used in regulations promulgated under title II of the Americans With Disabilities Act, 28 CFR 35.164. The Haven and Peer I require that all clients meet the following criteria, for further information regarding eligibility requirements please see Policies related CCCS 3-030 and OBH 21.210.41:

PEER 1 accommodates residents who have disabilities and language barriers. They partner with “The Spring Institute,” who offer translation services.

The program has completed the administrative actions required by title II of the ADA. Specifically, the program retained an ADA compliance consulting firm and performed self-evaluation to identify any potential deficiencies in policies, procedures and practices. As a result, the program has developed a transition plan to implement and mitigate any deficiencies as required by title II of the ADA.
PEER 1 has a policy that allows for all disabilities to participate in programs. Residents must be 18 years of age. They must have a minimal acknowledgement of a substance problem. If a resident requires a translator or an interpreter PEER 1 using “The Spring Institute,” which provides translators, will respond and assist.

Peer 1 does not accept clients who have significant unresolved legal matters which would necessitate continual access to legal systems and would interfere with needed time to participate in treatment activities.

PEER 1 is in compliance with this standard.

Evidence Relied Upon
Pre-Audit Questionnaire
Submitted Policies

**Standard 115.217: Hiring and promotion decisions**

*All Yes/No Questions Must Be Answered by the Auditor to Complete the Report*

**115.217 (a)**

- Does the agency prohibit the hiring or promotion of anyone who may have contact with residents who: Has engaged in sexual abuse in a prison, jail, lockup, community confinement facility, juvenile facility, or other institution (as defined in 42 U.S.C. 1997)? ☒ Yes ☐ No

- Does the agency prohibit the hiring or promotion of anyone who may have contact with residents who: Has been convicted of engaging or attempting to engage in sexual activity in the community facilitated by force, overt or implied threats of force, or coercion, or if the victim did not consent or was unable to consent or refuse? ☒ Yes ☐ No

- Does the agency prohibit the hiring or promotion of anyone who may have contact with residents who: Has been civilly or administratively adjudicated to have engaged in the activity described in the question immediately above? ☒ Yes ☐ No

- Does the agency prohibit the enlistment of services of any contractor who may have contact with residents who: Has engaged in sexual abuse in a prison, jail, lockup, community confinement facility, juvenile facility, or other institution (as defined in 42 U.S.C. 1997)? ☒ Yes ☐ No

- Does the agency prohibit the enlistment of services of any contractor who may have contact with residents who: Has been convicted of engaging or attempting to engage in sexual activity in the community facilitated by force, overt or implied threats of force, or coercion, or if the victim did not consent or was unable to consent or refuse? ☒ Yes ☐ No

- Does the agency prohibit the enlistment of services of any contractor who may have contact with residents who: Has been civilly or administratively adjudicated to have engaged in the activity described in the question immediately above? ☒ Yes ☐ No

115.217 (b)

- Does the agency consider any incidents of sexual harassment in determining whether to hire or promote anyone, or to enlist the services of any contractor, who may have contact with residents? ☒ Yes ☐ No

115.217 (c)

- Before hiring new employees, who may have contact with residents, does the agency: Perform a criminal background records check? ☒ Yes ☐ No

- Before hiring new employees, who may have contact with residents, does the agency: Consistent with Federal, State, and local law, make its best efforts to contact all prior institutional employers for information on substantiated allegations of sexual abuse or any resignation during a pending investigation of an allegation of sexual abuse? ☒ Yes ☐ No

115.217 (d)

- Does the agency perform a criminal background records check before enlisting the services of any contractor who may have contact with residents? ☒ Yes ☐ No

115.217 (e)

- Does the agency either conduct criminal background records checks at least every five years of current employees and contractors who may have contact with residents or have in place a system for otherwise capturing such information for current employees? ☒ Yes ☐ No

115.217 (f)

- Does the agency ask all applicants and employees who may have contact with residents directly about previous misconduct described in paragraph (a) of this section in written applications or interviews for hiring or promotions? ☒ Yes ☐ No

- Does the agency ask all applicants and employees who may have contact with residents directly about previous misconduct described in paragraph (a) of this section in any interviews or written self-evaluations conducted as part of reviews of current employees? ☒ Yes ☐ No

- Does the agency impose upon employees a continuing affirmative duty to disclose any such misconduct? ☒ Yes ☐ No

115.217 (g)

- Does the agency consider material omissions regarding such misconduct, or the provision of materially false information, grounds for termination? ☒ Yes ☐ No
115.217 (h)

- Unless prohibited by law, does the agency provide information on substantiated allegations of sexual abuse or sexual harassment involving a former employee upon receiving a request from an institutional employer for whom such employee has applied to work? (N/A if providing information on substantiated allegations of sexual abuse or sexual harassment involving a former employee is prohibited by law.) ☒ Yes ☐ No ☐ NA

Auditor Overall Compliance Determination

☐ Exceeds Standard (*Substantially exceeds requirement of standards*)

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

☐ Does Not Meet Standard (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

PEER 1 has a zero tolerance against sexual abuse and no one is hired who had engaged in any sexual abuse. All employees go through background checks and previous employers are contacted.

All employees are subjected to a 5 year background after employment.

All applicants are asked about past incidents and any omission or false information will result in termination of employment.

PEER 1 submitted an E-Mail that listed the process, which involves several steps to be hired. Also an application attached that included questions revolving around this standard. Applicants are required to divulge any past incidents which involve any type of sexual behavior. The application includes a specific PREA question requiring a yes or no answer.

PEER 1 is in compliance with this standard.

Evidence Relyed Upon

Pre-Audit Questionnaire

Submitted Policies

Interviews with various individuals

Standard 115.218: Upgrades to facilities and technologies

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.218 (a)
If the agency designed or acquired any new facility or planned any substantial expansion or modification of existing facilities, did the agency consider the effect of the design, acquisition, expansion, or modification upon the agency’s ability to protect residents from sexual abuse? (N/A if agency/facility has not acquired a new facility or made a substantial expansion to existing facilities since August 20, 2012, or since the last PREA audit, whichever is later.)

☐ Yes  ☐ No  ☒ NA

115.218 (b)

If the agency installed or updated a video monitoring system, electronic surveillance system, or other monitoring technology, did the agency consider how such technology may enhance the agency’s ability to protect residents from sexual abuse? (N/A if agency/facility has not installed or updated a video monitoring system, electronic surveillance system, or other monitoring technology since August 20, 2012, or since the last PREA audit, whichever is later.)

☒ Yes  ☐ No  ☐ NA

Auditor Overall Compliance Determination

☐ Exceeds Standard *(Substantially exceeds requirement of standards)*

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

☐ Does Not Meet Standard *(Requires Corrective Action)*

Instructions for Overall Compliance Determination Narrative

PEER 1 policy indicates they will not expand due to the historical buildings they occupy.

Additional cameras were installed to monitor the stairwells and laundry rooms of both buildings, which was a recommendation of the 2015 PREA Audit.

The additional cameras were viewed from the fixed sight as well as the security desk while on sight.

PEER 1 is in compliance with this standard.

Evidence Relied Upon

Pre-Audit Questionnaire

Submitted Policies

Visual viewing by both auditors
Standard 115.221: Evidence protocol and forensic medical examinations

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.221 (a)

- If the agency is responsible for investigating allegations of sexual abuse, does the agency follow a uniform evidence protocol that maximizes the potential for obtaining usable physical evidence for administrative proceedings and criminal prosecutions? (N/A if the agency/facility is not responsible for conducting any form of criminal OR administrative sexual abuse investigations.) ☐ Yes ☐ No ☒ NA

115.221 (b)

- Is this protocol developmentally appropriate for youth where applicable? (N/A if the agency/facility is not responsible for conducting any form of criminal OR administrative sexual abuse investigations.) ☐ Yes ☐ No ☒ NA

- Is this protocol, as appropriate, adapted from or otherwise based on the most recent edition of the U.S. Department of Justice's Office on Violence Against Women publication, “A National Protocol for Sexual Assault Medical Forensic Examinations, Adults/Adolescents,” or similarly comprehensive and authoritative protocols developed after 2011? (N/A if the agency/facility is not responsible for conducting any form of criminal OR administrative sexual abuse investigations.) ☐ Yes ☐ No ☒ NA

115.221 (c)

- Does the agency offer all residents who experience sexual abuse access to forensic medical examinations, whether on-site or at an outside facility, without financial cost, where evidentiary or medically appropriate? ☒ Yes ☐ No

- Are such examinations performed by Sexual Assault Forensic Examiners (SAFEs) or Sexual Assault Nurse Examiners (SANEs) where possible? ☒ Yes ☐ No

- If SAFE.s or SANEs cannot be made available, is the examination performed by other qualified medical practitioners (they must have been specifically trained to conduct sexual assault forensic exams)? ☒ Yes ☐ No

- Has the agency documented its efforts to provide SAFE.s or SANEs? ☒ Yes ☐ No

115.221 (d)

- Does the agency attempt to make available to the victim a victim advocate from a rape crisis center? ☒ Yes ☐ No
If a rape crisis center is not available to provide victim advocate services, does the agency make available to provide these services a qualified staff member from a community-based organization, or a qualified agency staff member?  ☒ Yes  ☐ No

Has the agency documented its efforts to secure services from rape crisis centers?  ☒ Yes  ☐ No

115.221 (e)

As requested by the victim, does the victim advocate, qualified agency staff member, or qualified community-based organization staff member accompany and support the victim through the forensic medical examination process and investigatory interviews?  ☒ Yes  ☐ No

As requested by the victim, does this person provide emotional support, crisis intervention, information, and referrals?  ☒ Yes  ☐ No

115.221 (f)

If the agency itself is not responsible for investigating allegations of sexual abuse, has the agency requested that the investigating entity follow the requirements of paragraphs (a) through (e) of this section? (N/A if the agency/facility is responsible for conducting criminal AND administrative sexual abuse investigations.)  ☒ Yes  ☐ No  ☐ NA

115.221 (g)

Auditor is not required to audit this provision.

115.221 (h)

If the agency uses a qualified agency staff member or a qualified community-based staff member for the purposes of this section, has the individual been screened for appropriateness to serve in this role and received education concerning sexual assault and forensic examination issues in general? (Check N/A if agency attempts to make a victim advocate from a rape crisis center available to victims per 115.221(d) above.)  ☒ Yes  ☐ No  ☐ NA

Auditor Overall Compliance Determination

☐ Exceeds Standard *(Substantially exceeds requirement of standards)*

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

☐ Does Not Meet Standard *(Requires Corrective Action)*
Instructions for Overall Compliance Determination Narrative

PEER 1 does not conduct criminal investigations. If allegations arise that are of criminal nature these are referred to the Denver Police Department Sex Crimes Crime Unit. This unit has detectives assigned who are specially trained in sexual abuse crimes.

All victims of sexual abuse are transported to Denver Health Medical Center, where SANE (Sexual Assault Nurse Exam) nurses are assigned to conduct an examination.

Victims are accompanied by a qualified same gender staff member to the hospital, if desired by victim and permitted by medical personnel.

PEER 1 partners with Blue Bench, which is a program that assists victims with counseling after the incident. Blue Bench also provides support, crisis intervention and referrals throughout the process.

Evidence Relied Upon

Pre-Audit Questionnaire

Submitted Policies

Interviews with various individuals

PEER 1 is in compliance with this standard.

Standard 115.222: Policies to ensure referrals of allegations for investigations

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.222 (a)

- Does the agency ensure an administrative or criminal investigation is completed for all allegations of sexual abuse? ☒ Yes ☐ No

- Does the agency ensure an administrative or criminal investigation is completed for all allegations of sexual harassment? ☒ Yes ☐ No

115.222 (b)

- Does the agency have a policy and practice in place to ensure that allegations of sexual abuse or sexual harassment are referred for investigation to an agency with the legal authority to conduct criminal investigations, unless the allegation does not involve potentially criminal behavior? ☒ Yes ☐ No

- Has the agency published such policy on its website or, if it does not have one, made the policy available through other means? ☒ Yes ☐ No

- Does the agency document all such referrals? ☒ Yes ☐ No
115.222 (c)

- If a separate entity is responsible for conducting criminal investigations, does such publication describe the responsibilities of both the agency and the investigating entity? [N/A if the agency/facility is responsible for conducting criminal investigations. See 115.221(a).]
  - Yes ☒  No ☐  NA ☐

115.222 (d)

- Auditor is not required to audit this provision.

115.222 (e)

- Auditor is not required to audit this provision.

Auditor Overall Compliance Determination

- ☒ Exceeds Standard *(Substantially exceeds requirement of standards)*

- ☐ Meets Standard *(Substantial compliance; complies in all material ways with the standard for the relevant review period)*

- ☐ Does Not Meet Standard *(Requires Corrective Action)*

Instructions for Overall Compliance Determination Narrative

PEER 1 has a policy that mandates all allegations to include those made by residents, staff and third party or by any means to include written, verbal, and electronic, or any other means.

Upon receiving an allegation, staff will separate both parties, instruct both parties to not bathe, drink, change clothes or urinate. The affected area will be roped off allowing no one in the area.

Upon receiving an allegation the supervisor is notified and immediate action will be taken.

If the allegation involves a staff member and the investigation confirms the allegation, the staff member will be suspended until the investigation is over.

Evidence Relied Upon

Pre-Audit Questionnaire

Submitted Policies

Interviews with various individuals

PEER 1 is in compliance with this standard.
TRAINING AND EDUCATION

Standard 115.231: Employee training

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.231 (a)

- Does the agency train all employees who may have contact with residents on: Its zero-tolerance policy for sexual abuse and sexual harassment? ☒ Yes ☐ No

- Does the agency train all employees who may have contact with residents on: How to fulfill their responsibilities under agency sexual abuse and sexual harassment prevention, detection, reporting, and response policies and procedures? ☒ Yes ☐ No

- Does the agency train all employees who may have contact with residents on: Residents’ right to be free from sexual abuse and sexual harassment ☒ Yes ☐ No

- Does the agency train all employees who may have contact with residents on: The right of residents and employees to be free from retaliation for reporting sexual abuse and sexual harassment? ☒ Yes ☐ No

- Does the agency train all employees who may have contact with residents on: The dynamics of sexual abuse and sexual harassment in confinement? ☒ Yes ☐ No

- Does the agency train all employees who may have contact with residents on: The common reactions of sexual abuse and sexual harassment victims? ☒ Yes ☐ No

- Does the agency train all employees who may have contact with residents on: How to detect and respond to signs of threatened and actual sexual abuse? ☒ Yes ☐ No

- Does the agency train all employees who may have contact with residents on: How to avoid inappropriate relationships with residents? ☒ Yes ☐ No

- Does the agency train all employees who may have contact with residents on: How to communicate effectively and professionally with residents, including lesbian, gay, bisexual, transgender, intersex, or gender nonconforming residents? ☒ Yes ☐ No

- Does the agency train all employees who may have contact with residents on: How to comply with relevant laws related to mandatory reporting of sexual abuse to outside authorities? ☒ Yes ☐ No

115.231 (b)

- Is such training tailored to the gender of the residents at the employee’s facility? ☒ Yes ☐ No
Have employees received additional training if reassigned from a facility that houses only male residents to a facility that houses only female residents, or vice versa? ☒ Yes ☐ No

115.231 (c)

Have all current employees who may have contact with residents received such training? ☒ Yes ☐ No

Does the agency provide each employee with refresher training every two years to ensure that all employees know the agency's current sexual abuse and sexual harassment policies and procedures? ☒ Yes ☐ No

In years in which an employee does not receive refresher training, does the agency provide refresher information on current sexual abuse and sexual harassment policies? ☒ Yes ☐ No

115.231 (d)

Does the agency document, through employee signature or electronic verification, that employees understand the training they have received? ☒ Yes ☐ No

Auditor Overall Compliance Determination

☐ Exceeds Standard  (*Substantially exceeds requirement of standards*)

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

☐ Does Not Meet Standard  (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

PEER 1 has a policy that requires employees to include employees, volunteers and contractors, be trained within 30 days of being hired.

Upon initial training and employees acknowledging the training, subsequent training will be conducted at a minimum of every two years.

Employees will be required to read and sign that they have been trained on the above PREA policies and facility procedures. In addition they will need to document their training on their training log. The signed agreement will be kept in each individual’s personnel file.

PEER 1 sent an E-Mail that includes a power point that is mandatory for all employees. The training consists of PREA standards and the expectations of employees when an allegation arises.

Evidence Relied Upon

Pre-Audit Questionnaire
Submitted Policies

Interviews with various individuals

PEER 1 is in compliance with this standard.

Standard 115.232: Volunteer and contractor training

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.232 (a)

- Has the agency ensured that all volunteers and contractors who have contact with residents have been trained on their responsibilities under the agency’s sexual abuse and sexual harassment prevention, detection, and response policies and procedures? ☒ Yes ☐ No

115.232 (b)

- Have all volunteers and contractors who have contact with residents been notified of the agency’s zero-tolerance policy regarding sexual abuse and sexual harassment and informed how to report such incidents (the level and type of training provided to volunteers and contractors shall be based on the services they provide and level of contact they have with residents)? ☒ Yes ☐ No

115.232 (c)

- Does the agency maintain documentation confirming that volunteers and contractors understand the training they have received? ☒ Yes ☐ No

Auditor Overall Compliance Determination

☐ Exceeds Standard  
(Substantially exceeds requirement of standards)

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

☐ Does Not Meet Standard  
(Requires Corrective Action)

Instructions for Overall Compliance Determination Narrative

All contractors and volunteers will receive training within 30 days of commencing a position.

PEER 1 has a policy that requires all volunteers and contractors be trained on PREA within 30 days. The level of training will be dependent on the frequency of the party being on site.

Level 1:
1. Frequency: The Level 1 Volunteer or Contractor is defined as an individual or group who is infrequently in the facility, generally defined as less than one (1) time per month OR less than twelve (12) days per year.

Type of Training: The Level 1 Volunteer or Contractor is required to check in with the front desk and complete the “Visitor Sign In & Out Log”. They are expected to check in with staff on duty in the facility prior to continuing throughout the facility. Staff assures that all relevant policies are followed.

Level 2:

1. Frequency: The Level 2 Volunteer or Contractor is an individual or group who is not often in the facility, generally defined as less than two (2) time per month OR less than twenty-four (24) days per year. The agency’s Zero Tolerance Policy for sexual abuse and sexual harassment.

ii. How to report known or suspected sexual abuse or harassment.

iii. The right of residents to be free from retaliation.

iv. How to avoid inappropriate relationships with residents.

v. How to communicate effectively and professionally with residents, including with residents who are lesbian, gay, bisexual, transgender, intersex or gender-nonconforming.

Level 3

1. Target Group: The Level 3 Volunteer or Contractor is an individual or group who is frequently in the facility, generally defined as more than two times per month OR more than 25 times per year.

Type of Training:

a. This type of volunteer or contractor must check in at the front desk and complete the “Visitor Sign In & Out Log”. They are expected to check in with staff on duty in the facility prior to continuing throughout the facility. Staff will assure that all relevant policies are followed.

b. This type of volunteer or contactor must receive the full PREA training that staff receives. This may be conducted in a group or individual setting.

During the interviews it was discovered that PEER 1 does not have volunteer. The contractors who perform services in their facilities are employed by the state of Colorado and go through separate training for PREA protocol.

Evidence Relied Upon

Pre-Audit Questionnaire

Submitted Policies
Interviews with various individuals

PEER 1 is in compliance with this standard.

**Standard 115.233: Resident education**

*All Yes/No Questions Must Be Answered by the Auditor to Complete the Report*

### 115.233 (a)

- During intake, do residents receive information explaining: The agency’s zero-tolerance policy regarding sexual abuse and sexual harassment? ☒ Yes ☐ No
- During intake, do residents receive information explaining: How to report incidents or suspicions of sexual abuse or sexual harassment? ☒ Yes ☐ No
- During intake, do residents receive information explaining: Their rights to be free from sexual abuse and sexual harassment? ☒ Yes ☐ No
- During intake, do residents receive information explaining: Their rights to be free from retaliation for reporting such incidents? ☒ Yes ☐ No
- During intake, do residents receive information regarding agency policies and procedures for responding to such incidents? ☒ Yes ☐ No

### 115.233 (b)

- Does the agency provide refresher information whenever a resident is transferred to a different facility? ☒ Yes ☐ No

### 115.233 (c)

- Does the agency provide resident education in formats accessible to all residents, including those who: Are limited English proficient? ☒ Yes ☐ No
- Does the agency provide resident education in formats accessible to all residents, including those who: Are deaf? ☒ Yes ☐ No
- Does the agency provide resident education in formats accessible to all residents, including those who: Are visually impaired? ☒ Yes ☐ No
- Does the agency provide resident education in formats accessible to all residents, including those who: Are otherwise disabled? ☒ Yes ☐ No
- Does the agency provide resident education in formats accessible to all residents, including those who: Have limited reading skills? ☒ Yes ☐ No
115.233 (d)

- Does the agency maintain documentation of resident participation in these education sessions?
  ☒ Yes  ☐ No

115.233 (e)

- In addition to providing such education, does the agency ensure that key information is continuously and readily available or visible to residents through posters, resident handbooks, or other written formats?
  ☒ Yes  ☐ No

Auditor Overall Compliance Determination

☐ Exceeds Standard *(Substantially exceeds requirement of standards)*

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

☐ Does Not Meet Standard *(Requires Corrective Action)*

Instructions for Overall Compliance Determination Narrative

PEER 1 has a policy that indicates a zero tolerance against sexual harassment and abuse. During interviews with residents there was an overwhelming indication that this was taken seriously. Residents indicated they were screened and informed of the protocol on PREA.

(a) Upon intake/admission into the residential programs, all clients (regardless of referral source) receive the handout: “Facts You Should Know”. This handout explains that all sexual behavior is prohibited while in community corrections programs and that both Peer I and the Haven have a zero tolerance policy.

Upon admission, clients are also shown the **PREA Community Corrections Offender Education video**, which explains that all clients have the right to be free from sexual abuse and harassment as well as the right from retaliation against reporting.

(b) Peer I and Haven residents do not typically transfer to another facility. If a previous Haven or Peer I resident is readmitted to the program or is regressed from the outpatient therapeutic community a new admission process is initiated and the client receives the same education described in 115.233(a) as described above.

(c) Peer I and the Haven make reasonable efforts to provide resident education in formats accessible to all residents. Admission criteria for the Haven and Peer I require that an individual is able to understand verbal communications in English.

The formats PEER 1 offers are available for residents who are:
1) Limited English Proficiency
2) Deaf
3) Visually Impaired
4) Any other disability
5) Limited Reading Skills

d) Documentation of Resident participation is recorded in the education session at the time of intake and is documented in the Prison Rape Elimination Act (PREA Acknowledgement) which is retained in the client's electronic health record.

PEER 1 has a policy that covers this standard. Their intake process provides each resident with a pamphlet that outlines the PREA guidelines and zero tolerance policy. Peer 1 also requires each new resident to watch a video which also covers PREA guidelines.

PEER 1 assists disabled residents if necessary and all participation is recorded and maintained the residents' health record.

The PREA compliance manager provided a copy of the pamphlet “Facts you should know,” during the audit.

Evidence Relied Upon
Pre-Audit Questionnaire
Submitted Policies
Interviews with various individuals.

PEER 1 is in compliance with this standard.

Standard 115.234: Specialized training: Investigations

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.234 (a)

- In addition to the general training provided to all employees pursuant to §115.231, does the agency ensure that, to the extent the agency itself conducts sexual abuse investigations, its investigators have received training in conducting such investigations in confinement settings? [N/A if the agency does not conduct any form of administrative or criminal sexual abuse investigations. See 115.221(a).] ☒ Yes ☐ No ☐ NA
115.234 (b)

- Does this specialized training include: Techniques for interviewing sexual abuse victims? [N/A if the agency does not conduct any form of administrative or criminal sexual abuse investigations. See 115.221(a.)] ☒ Yes ☐ No ☐ NA

- Does this specialized training include: Proper use of Miranda and Garrity warnings? [N/A if the agency does not conduct any form of administrative or criminal sexual abuse investigations. See 115.221(a.)] ☒ Yes ☐ No ☐ NA

- Does this specialized training include: Sexual abuse evidence collection in confinement settings? [N/A if the agency does not conduct any form of administrative or criminal sexual abuse investigations. See 115.221(a.)] ☒ Yes ☐ No ☐ NA

- Does this specialized training include: The criteria and evidence required to substantiate a case for administrative action or prosecution referral? [N/A if the agency does not conduct any form of administrative or criminal sexual abuse investigations. See 115.221(a.)] ☒ Yes ☐ No ☐ NA

115.234 (c)

- Does the agency maintain documentation that agency investigators have completed the required specialized training in conducting sexual abuse investigations? [N/A if the agency does not conduct any form of administrative or criminal sexual abuse investigations. See 115.221(a.)] ☒ Yes ☐ No ☐ NA

115.234 (d)

- Auditor is not required to audit this provision.

Auditor Overall Compliance Determination

☐ Exceeds Standard (Substantially exceeds requirement of standards)

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

☐ Does Not Meet Standard (Requires Corrective Action)

Instructions for Overall Compliance Determination Narrative

(a) Employees of The Haven and Peer I only investigate non-criminal violations and do not investigate criminal sexual abuse allegations. Investigations which require administrative review will be referred to the appropriate referring body.

(b) Any staff who are identified to conduct such interviews of sexual abuse victims (as it pertains to PREA allegations) will receive specialized training which includes at
minimum, proper use of Miranda and Garrity warnings, sexual abuse evidence collection in confinement settings, and the criteria and evidence required to substantiate a case for administrative action or prosecution referral. Haven staff responsible for investigations will also participate in gender-specific education.

PEER 1 conducts only administrative investigations involving allegations of sexual harassment. If the allegation involves sexual abuse or a criminal element they secure the scene, separate parties and contact the Denver Police Department Sex Crimes Unit, who is the charging authority for the city of Denver.

Although PEER 1 has a section in the policy (b), that indicates staff has received specialized training in the area of Garrity and Miranda warnings, it was made very clear during interviews they don’t conduct these types of interviews. All staff interviewed were knowledgeable and familiar with the process and understood the Denver Police Department would be contacted for any incident involving sexual abuse.

Evidence Relied Upon

Pre-Audit Questionnaire

Submitted Policies

Interviews with various individuals

PEER 1 is in compliance with this standard

Standard 115.235: Specialized training: Medical and mental health care

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.235 (a)

- Does the agency ensure that all full- and part-time medical and mental health care practitioners who work regularly in its facilities have been trained in: How to detect and assess signs of sexual abuse and sexual harassment? ☒ Yes ☐ No

- Does the agency ensure that all full- and part-time medical and mental health care practitioners who work regularly in its facilities have been trained in: How to preserve physical evidence of sexual abuse? ☒ Yes ☐ No

- Does the agency ensure that all full- and part-time medical and mental health care practitioners who work regularly in its facilities have been trained in: How to respond effectively and professionally to victims of sexual abuse and sexual harassment? ☒ Yes ☐ No

- Does the agency ensure that all full- and part-time medical and mental health care practitioners who work regularly in its facilities have been trained in: How and to whom to report allegations or suspicions of sexual abuse and sexual harassment? ☒ Yes ☐ No
115.235 (b)  
- If medical staff employed by the agency conduct forensic examinations, do such medical staff receive appropriate training to conduct such examinations? N/A if agency medical staff at the facility do not conduct forensic exams.) ☐ Yes ☐ No ☒ NA

115.235 (c)  
- Does the agency maintain documentation that medical and mental health practitioners have received the training referenced in this standard either from the agency or elsewhere? ☒ Yes ☐ No

115.235 (d)  
- Do medical and mental health care practitioners employed by the agency also receive training mandated for employees by §115.231? ☒ Yes ☐ No
- Do medical and mental health care practitioners contracted by and volunteering for the agency also receive training mandated for contractors and volunteers by §115.232? [N/A for circumstances in which a particular status (employee or contractor/volunteer) does not apply.] ☐ Yes ☐ No ☒ NA

Auditor Overall Compliance Determination

☐ Exceeds Standard (Substantially exceeds requirement of standards)

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

☐ Does Not Meet Standard (Requires Corrective Action)

Instructions for Overall Compliance Determination Narrative

(a) ARTS may employ medical and mental health care practitioners who work regularly at Peer I or Haven Facilities OR directly with Haven or Peer I clients in another treatment setting (for example, a doctor who is employed by ARTS who provides psychiatric medication management services to Haven or Peer I residents).

(b) Medical staff who are employed by ARTS, The Haven, or Peer I do not provide forensic examinations. All forensic medical examinations are performed at Denver Health Medical Center.

(c) ARTS maintains documentation of medical and mental health practitioner’s training as part of their personnel file at ARTS administration.

(d) Medical and mental health care practitioners also receive the training mandated for employees under 115.231. All training records are retained in the employee’s personnel file.
Evidence Relied Upon
Pre-Audit Questionnaire
Submitted Policies
Interviews with various individuals

PEER 1 is in compliance with this standard.

**SCREENING FOR RISK OF SEXUAL VICTIMIZATION AND ABUSIVENESS**

**Standard 115.241: Screening for risk of victimization and abusiveness**

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.241 (a)

- Are all residents assessed during an intake screening for their risk of being sexually abused by other residents or sexually abusive toward other residents? ☒ Yes ☐ No
- Are all residents assessed upon transfer to another facility for their risk of being sexually abused by other residents or sexually abusive toward other residents? ☒ Yes ☐ No

115.241 (b)

- Do intake screenings ordinarily take place within 72 hours of arrival at the facility? ☒ Yes ☐ No

115.241 (c)

- Are all PREA screening assessments conducted using an objective screening instrument? ☒ Yes ☐ No

115.241 (d)

- Does the intake screening consider, at a minimum, the following criteria to assess residents for risk of sexual victimization: Whether the resident has a mental, physical, or developmental disability? ☒ Yes ☐ No
- Does the intake screening consider, at a minimum, the following criteria to assess residents for risk of sexual victimization: The age of the resident? ☒ Yes ☐ No
- Does the intake screening consider, at a minimum, the following criteria to assess residents for risk of sexual victimization: The physical build of the resident? ☒ Yes ☐ No
- Does the intake screening consider, at a minimum, the following criteria to assess residents for risk of sexual victimization: Whether the resident has previously been incarcerated?  ☒ Yes □ No

- Does the intake screening consider, at a minimum, the following criteria to assess residents for risk of sexual victimization: Whether the resident’s criminal history is exclusively nonviolent?  ☒ Yes □ No

- Does the intake screening consider, at a minimum, the following criteria to assess residents for risk of sexual victimization: Whether the resident has prior convictions for sex offenses against an adult or child?  ☒ Yes □ No

- Does the intake screening consider, at a minimum, the following criteria to assess residents for risk of sexual victimization: Whether the resident is or is perceived to be gay, lesbian, bisexual, transgender, intersex, or gender nonconforming (the facility affirmatively asks the resident about his/her sexual orientation and gender identity AND makes a subjective determination based on the screener’s perception whether the resident is gender non-conforming or otherwise may be perceived to be LGBTI)?  ☒ Yes □ No

- Does the intake screening consider, at a minimum, the following criteria to assess residents for risk of sexual victimization: Whether the resident has previously experienced sexual victimization?  ☒ Yes □ No

- Does the intake screening consider, at a minimum, the following criteria to assess residents for risk of sexual victimization: The resident’s own perception of vulnerability?  ☒ Yes □ No

115.241 (e)

- In assessing residents for risk of being sexually abusive, does the initial PREA risk screening consider, when known to the agency: prior acts of sexual abuse?  ☒ Yes □ No

- In assessing residents for risk of being sexually abusive, does the initial PREA risk screening consider, when known to the agency: prior convictions for violent offenses?  ☒ Yes □ No

- In assessing residents for risk of being sexually abusive, does the initial PREA risk screening consider, when known to the agency: history of prior institutional violence or sexual abuse?  ☒ Yes □ No

115.241 (f)

- Within a set time period not more than 30 days from the resident’s arrival at the facility, does the facility reassess the resident’s risk of victimization or abusiveness based upon any additional, relevant information received by the facility since the intake screening?  ☒ Yes □ No

115.241 (g)

- Does the facility reassess a resident’s risk level when warranted due to a: Referral?  ☒ Yes □ No
- Does the facility reassess a resident’s risk level when warranted due to a: Request? ☒ Yes ☐ No

- Does the facility reassess a resident’s risk level when warranted due to a: Incident of sexual abuse? ☒ Yes ☐ No

- Does the facility reassess a resident’s risk level when warranted due to a: Receipt of additional information that bears on the resident’s risk of sexual victimization or abusiveness? ☒ Yes ☐ No

115.241 (h)

- Is it the case that residents are not ever disciplined for refusing to answer, or for not disclosing complete information in response to, questions asked pursuant to paragraphs (d)(1), (d)(7), (d)(8), or (d)(9) of this section? ☒ Yes ☐ No

115.241 (i)

- Has the agency implemented appropriate controls on the dissemination within the facility of responses to questions asked pursuant to this standard in order to ensure that sensitive information is not exploited to the resident’s detriment by staff or other residents? ☒ Yes ☐ No

Auditor Overall Compliance Determination

☐ Exceeds Standard (Substantially exceeds requirement of standards)

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

☐ Does Not Meet Standard (Requires Corrective Action)

Instructions for Overall Compliance Determination Narrative

PEER 1 has an extensive procedure covering this standard. An initial assessment is conducted within 12 hours of admission, to include a re-screen upon discharge.

They are interviewed using the PREA Victim/Predator screening tool. They conduct a 30 day follow up and do not punish residents if they choose not to answer questions. PEER 1 does not accept residents who have a history of sexual abuse either in a custodial or community sector.

The residents’ private information is protected through the ARTS computer system, which has limited access through permission only.

The information on this file can have a combination of the following:

a. Per PREA this client is identified as a “known predator”.
b. Per PREA this client is identified as a “possible predator”.
c. Per PREA this client is identified as a “known victim”.
d. Per PREA this client is identified as a “possible victim”.

PEER 1 has an extensive policy covering the different combinations of PREA incidents. They conduct an initial interview, an additional one 30 days later.

Any information that is given is protected within the ARTS computer system (and HIPAA compliant Electronic Health Care System) as well as the computer system of the University of Colorado, which has limited access.

Evidence Relied Upon

Pre-Audit Questionnaire

Submitted Policies

Interviews with various individuals

PEER 1 is in compliance with this standard.

**Standard 115.242: Use of screening information**

**All Yes/No Questions Must Be Answered by the Auditor to Complete the Report**

115.242 (a)

- Does the agency use information from the risk screening required by § 115.241, with the goal of keeping separate those residents at high risk of being sexually victimized from those at high risk of being sexually abusive, to inform: Housing Assignments? ☒ Yes ☐ No

- Does the agency use information from the risk screening required by § 115.241, with the goal of keeping separate those residents at high risk of being sexually victimized from those at high risk of being sexually abusive, to inform: Bed assignments? ☒ Yes ☐ No

- Does the agency use information from the risk screening required by § 115.241, with the goal of keeping separate those residents at high risk of being sexually victimized from those at high risk of being sexually abusive, to inform: Work Assignments? ☒ Yes ☐ No

- Does the agency use information from the risk screening required by § 115.241, with the goal of keeping separate those residents at high risk of being sexually victimized from those at high risk of being sexually abusive, to inform: Education Assignments? ☒ Yes ☐ No

- Does the agency use information from the risk screening required by § 115.241, with the goal of keeping separate those residents at high risk of being sexually victimized from those at high risk of being sexually abusive, to inform: Program Assignments? ☒ Yes ☐ No
115.242 (b)

- Does the agency make individualized determinations about how to ensure the safety of each resident? ☒ Yes ☐ No

115.242 (c)

- When deciding whether to assign a transgender or intersex resident to a facility for male or female residents, does the agency consider on a case-by-case basis whether a placement would ensure the resident’s health and safety, and whether a placement would present management or security problems (NOTE: if an agency by policy or practice assigns residents to a male or female facility on the basis of anatomy alone, that agency is not in compliance with this standard)? ☒ Yes ☐ No

- When making housing or other program assignments for transgender or intersex residents, does the agency consider on a case-by-case basis whether a placement would ensure the resident’s health and safety, and whether a placement would present management or security problems? ☒ Yes ☐ No

115.242 (d)

- Are each transgender or intersex resident’s own views with respect to his or her own safety given serious consideration when making facility and housing placement decisions and programming assignments? ☒ Yes ☐ No

115.242 (e)

- Are transgender and intersex residents given the opportunity to shower separately from other residents? ☒ Yes ☐ No

115.242 (f)

- Unless placement is in a dedicated facility, unit, or wing established in connection with a consent decree, legal settlement, or legal judgment for the purpose of protecting lesbian, gay, bisexual, transgender, or intersex residents, does the agency always refrain from placing: lesbian, gay, and bisexual residents in dedicated facilities, units, or wings solely on the basis of such identification or status? ☒ Yes ☐ No

- Unless placement is in a dedicated facility, unit, or wing established in connection with a consent decree, legal settlement, or legal judgment for the purpose of protecting lesbian, gay, bisexual, transgender, or intersex residents, does the agency always refrain from placing: transgender residents in dedicated facilities, units, or wings solely on the basis of such identification or status? ☒ Yes ☐ No

- Unless placement is in a dedicated facility, unit, or wing established in connection with a consent decree, legal settlement, or legal judgment for the purpose of protecting lesbian, gay, bisexual, transgender, or intersex residents, does the agency always refrain from placing: intersex residents in dedicated facilities, units, or wings solely on the basis of such identification or status? ☒ Yes ☐ No
Auditor Overall Compliance Determination

☐ Exceeds Standard *(Substantially exceeds requirement of standards)*

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

☐ Does Not Meet Standard *(Requires Corrective Action)*

Instructions for Overall Compliance Determination Narrative

The Haven and Peer I use information from the risk screening required by § 115.241 to inform housing, bed, in-house work assignments education, and program assignments, with the goal of keeping separate, those residents at high risk of being sexually victimized from those at high risk of being sexually abusive.

Due to the nature of the program structure and the size of the milieus, it is not possible to maintain complete separation between those assessed as “possible predators” and “known” or “possible “victims”.

During interview with residents it was evident that PEER 1 takes this very serious.

During targeted interviews only one resident identified as being gay. This resident indicated he felt safe and had no fears of being targeted. He stated he took nothing from anyone because of his sexual identity.

Due to the nature of the program structure and the size of the milieus,

The Haven and Peer I do not have dedicated facilities, units or wings for lesbian, gay, bisexual, transgender or intersex residents.

a) The layout of the building is a converted army commanders’ house and is not conducive to assigning an entire part to residents who identify as LGBT or intersex.

Peer 1 allows those residents who identify as transgender or intersex to shower separately.

A) PEER 1 had no residents who identified as either transgender or intersex.

Evidence Relied Upon

Pre-Audit Questionnaire

Submitted Policies

Interviews with various individuals

PEER 1 is in compliance with this standard.
Standard 115.251: Resident reporting

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.251 (a)

- Does the agency provide multiple internal ways for residents to privately report: Sexual abuse and sexual harassment? ☒ Yes ☐ No
- Does the agency provide multiple internal ways for residents to privately report: Retaliation by other residents or staff for reporting sexual abuse and sexual harassment? ☒ Yes ☐ No
- Does the agency provide multiple internal ways for residents to privately report: Staff neglect or violation of responsibilities that may have contributed to such incidents? ☒ Yes ☐ No

115.251 (b)

- Does the agency also provide at least one way for residents to report sexual abuse or sexual harassment to a public or private entity or office that is not part of the agency? ☒ Yes ☐ No
- Is that private entity or office able to receive and immediately forward resident reports of sexual abuse and sexual harassment to agency officials? ☒ Yes ☐ No
- Does that private entity or office allow the resident to remain anonymous upon request? ☒ Yes ☐ No

115.251 (c)

- Do staff members accept reports of sexual abuse and sexual harassment made verbally, in writing, anonymously, and from third parties? ☒ Yes ☐ No
- Do staff members promptly document any verbal reports of sexual abuse and sexual harassment? ☒ Yes ☐ No

115.251 (d)

- Does the agency provide a method for staff to privately report sexual abuse and sexual harassment of residents? ☒ Yes ☐ No

Auditor Overall Compliance Determination

☐ Exceeds Standard (Substantially exceeds requirement of standards)
Meets Standard (Substantial compliance; complies in all material ways with the standard for the relevant review period)

Does Not Meet Standard (Requires Corrective Action)

Instructions for Overall Compliance Determination Narrative

(a) Haven and Peer I clients have multiple internal methods which residents may use to privately report sexual harassment, retaliation by other residents or staff for reporting sexual abuse and sexual harassment, and staff neglect or violation of responsibilities that may have contributed to such incidents.

b) These outside contacts included involving the residents’ parole officer, local law enforcement, Colorado Dept of Corrections and a 24 hour rape hotline.

One area needed corrective action:

During the tour it was observed that there was no way to send an anonymous complaint, as residents are not allowed to use the phone the first 30 days. If they ask to use the phone they are required to write down the phone number, so this would possibly expose them if they complained.

The newer solution we are implementing is to have a dedicated phone and phone line in the bathrooms of residential houses. The phone will be enabled to only directly call the PREA DOC Tips Line; no other calls can be made or accepted through these phones.

On January 26, 2019, Assistant Auditor Joanie Shoemaker tested the phone and they connected to the DOC tip-line. The only issue was the phone rang approximately 10 times before it was picked up. PEER 1 will address this to their staff and residents, to ensure they are aware of the 10 rings as DOC controls this and not PEER 1.

This corrective action has been completed.

PEER 1 is in compliance with this standard.

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.252 (a)

- Is the agency exempt from this standard? NOTE: The agency is exempt ONLY if it does not have administrative procedures to address resident grievances regarding sexual abuse. This does not mean the agency is exempt simply because a resident does not have to or is not ordinarily expected to submit a grievance to report sexual abuse. This means that as a matter of explicit policy, the agency does not have an administrative remedies process to address sexual abuse. ☐ Yes ☒ No ☐ NA
115.252 (b)

- Does the agency permit residents to submit a grievance regarding an allegation of sexual abuse without any type of time limits? (The agency may apply otherwise-applicable time limits to any portion of a grievance that does not allege an incident of sexual abuse.) (N/A if agency is exempt from this standard.) ☒ Yes ☐ No ☐ NA

- Does the agency always refrain from requiring a resident to use any informal grievance process, or to otherwise attempt to resolve with staff, an alleged incident of sexual abuse? (N/A if agency is exempt from this standard.) ☒ Yes ☐ No ☐ NA

115.252 (c)

- Does the agency ensure that: A resident who alleges sexual abuse may submit a grievance without submitting it to a staff member who is the subject of the complaint? (N/A if agency is exempt from this standard.) ☒ Yes ☐ No ☐ NA

- Does the agency ensure that: Such grievance is not referred to a staff member who is the subject of the complaint? (N/A if agency is exempt from this standard.) ☒ Yes ☐ No ☐ NA

115.252 (d)

- Does the agency issue a final agency decision on the merits of any portion of a grievance alleging sexual abuse within 90 days of the initial filing of the grievance? (Computation of the 90-day time period does not include time consumed by residents in preparing any administrative appeal.) (N/A if agency is exempt from this standard.) ☒ Yes ☐ No ☐ NA

- If the agency determines that the 90-day timeframe is insufficient to make an appropriate decision and claims an extension of time [the maximum allowable extension of time to respond is 70 days per 115.252(d)(3)], does the agency notify the resident in writing of any such extension and provide a date by which a decision will be made? (N/A if agency is exempt from this standard.) ☒ Yes ☐ No ☐ NA

- At any level of the administrative process, including the final level, if the resident does not receive a response within the time allotted for reply, including any properly noticed extension, may a resident consider the absence of a response to be a denial at that level? (N/A if agency is exempt from this standard.) ☒ Yes ☐ No ☐ NA

115.252 (e)

- Are third parties, including fellow residents, staff members, family members, attorneys, and outside advocates, permitted to assist residents in filing requests for administrative remedies relating to allegations of sexual abuse? (N/A if agency is exempt from this standard.) ☒ Yes ☐ No ☐ NA

- Are those third parties also permitted to file such requests on behalf of residents? (If a third-party files such a request on behalf of a resident, the facility may require as a condition of processing the request that the alleged victim agree to have the request filed on his or her
behalf, and may also require the alleged victim to personally pursue any subsequent steps in the administrative remedy process.) (N/A if agency is exempt from this standard.) ☒ Yes ☐ No ☐ NA

- If the resident declines to have the request processed on his or her behalf, does the agency document the resident’s decision? (N/A if agency is exempt from this standard.) ☒ Yes ☐ No ☐ NA

115.252 (f)

- Has the agency established procedures for the filing of an emergency grievance alleging that a resident is subject to a substantial risk of imminent sexual abuse? (N/A if agency is exempt from this standard.) ☒ Yes ☐ No ☐ NA

- After receiving an emergency grievance alleging a resident is subject to a substantial risk of imminent sexual abuse, does the agency immediately forward the grievance (or any portion thereof that alleges the substantial risk of imminent sexual abuse) to a level of review at which immediate corrective action may be taken? (N/A if agency is exempt from this standard.). ☒ Yes ☐ No ☐ NA

- After receiving an emergency grievance described above, does the agency provide an initial response within 48 hours? (N/A if agency is exempt from this standard.) ☒ Yes ☐ No ☐ NA

- After receiving an emergency grievance described above, does the agency issue a final agency decision within 5 calendar days? (N/A if agency is exempt from this standard.) ☒ Yes ☐ No ☐ NA

- Does the initial response and final agency decision document the agency’s determination whether the resident is in substantial risk of imminent sexual abuse? (N/A if agency is exempt from this standard.) ☒ Yes ☐ No ☐ NA

- Does the initial response document the agency’s action(s) taken in response to the emergency grievance? (N/A if agency is exempt from this standard.) ☒ Yes ☐ No ☐ NA

- Does the agency’s final decision document the agency’s action(s) taken in response to the emergency grievance? (N/A if agency is exempt from this standard.) ☒ Yes ☐ No ☐ NA

115.252 (g)

- If the agency disciplines a resident for filing a grievance related to alleged sexual abuse, does it do so ONLY where the agency demonstrates that the resident filed the grievance in bad faith? (N/A if agency is exempt from this standard.) ☒ Yes ☐ No ☐ NA

Auditor Overall Compliance Determination

☐ Exceeds Standard *(Substantially exceeds requirement of standards)*
☒ Meets Standard *(Substantial compliance; complies in all material ways with the standard for the relevant review period)*

☐ Does Not Meet Standard *(Requires Corrective Action)*

**Instructions for Overall Compliance Determination Narrative**

PEER 1 has a policy that covers this standard.

This policy allows residents to file a grievance that does not have to be given to the staff member who is being accused. The policy allows residents to file grievances with no time limit. They do document in their policy, the longer the time span from the incident may diminish the ability to fully investigate the allegation.

PEER 1 does not require residents to go through the process or attempt to solve a dispute a complaint with staff.

PEER 1 allows several channels to file grievances that include the following:

- The PEER 1 and Haven directors.
- The ARTS grievance representative and director.
- Signal Behavioral Health Network, which is an outside agency and
- DORA, which is a state run office which deals with complaints against employers.

Interviews with residents indicated there had been no need to file grievances for PREA related incidents.

Conclusion: PEER 1 has a policy in place and no residents raised allegations during the audit.

**Evidence Relied Upon**

- Pre-Audit Questionnaire
- Submitted Policies
- Interviews with various individuals

PEER 1 is in compliance with this standard.

**Standard 115.253: Resident access to outside confidential support services**

**All Yes/No Questions Must Be Answered by the Auditor to Complete the Report**

115.253 (a)
- Does the facility provide residents with access to outside victim advocates for emotional support services related to sexual abuse by giving residents mailing addresses and telephone numbers, including toll-free hotline numbers where available, of local, State, or national victim advocacy or rape crisis organizations? ☒ Yes ☐ No

- Does the facility enable reasonable communication between residents and these organizations and agencies, in as confidential a manner as possible? ☒ Yes ☐ No

115.253 (b)

- Does the facility inform residents, prior to giving them access, of the extent to which such communications will be monitored and the extent to which reports of abuse will be forwarded to authorities in accordance with mandatory reporting laws? ☒ Yes ☐ No

115.253 (c)

- Does the agency maintain or attempt to enter into memoranda of understanding or other agreements with community service providers that are able to provide residents with confidential emotional support services related to sexual abuse? ☒ Yes ☐ No

- Does the agency maintain copies of agreements or documentation showing attempts to enter into such agreements? ☒ Yes ☐ No

Auditor Overall Compliance Determination

☐ Exceeds Standard *(Substantially exceeds requirement of standards)*

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

☐ Does Not Meet Standard *(Requires Corrective Action)*

Instructions for Overall Compliance Determination Narrative

PEER 1 has a policy covering this standard:

Their policy states each resident is required to read and sign a PREA packet entitled “Facts You Should Know,” which includes information on outside victim advocates and support groups. This information includes addresses, phone numbers and a toll free hotline number.

There are also copies of the packet throughout the facility and if a resident needs to report, they can use a phone in private that is not recording. Policy also states residents are informed if an allegation is filed; the PREA coordinator will be notified. The PREA coordinator will then assist to contact outside support and allow reasonable access to the group, but will monitor the resident within the community.

Residents are asked to sign a HIPPA release form between them and the outside support agency but they are not mandated to sign.

PEER 1 maintains MOU’s with outside agencies that provide support to victims.
The agency designated by PEER 1 is the Blue Bench. In the event their services are needed, the programs will maintain copies of agreements or documentation showing attempts to enter into such agreements.

During interviews the majority of both staff and residents were aware of Blue Bench as being an outside support group. There were no complaints by residents of having any issues in contacting this entity.

Conclusion- PEER 1 has a current policy covering outside support; in addition they have a current MOU on file with Blue Bench.

Evidence Relied Upon

Pre-Audit Questionnaire

Submitted Policies

Interviews with various individuals

PEER 1 is in compliance with this standard.

**Standard 115.254: Third-party reporting**

**All Yes/No Questions Must Be Answered by the Auditor to Complete the Report**

**115.254 (a)**

- Has the agency established a method to receive third-party reports of sexual abuse and sexual harassment? ☒ Yes ☐ No

- Has the agency distributed publicly information on how to report sexual abuse and sexual harassment on behalf of a resident? ☐ Yes ☒ No

**Auditor Overall Compliance Determination**

☐ Exceeds Standard *(Substantially exceeds requirement of standards)*

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

☐ Does Not Meet Standard *(Requires Corrective Action)*

**Instructions for Overall Compliance Determination Narrative**

PEER 1 has a policy covering this standard which states:

Residents upon admission are required to read and acknowledge the PREA packet, which provides information on how to report sexual abuse to include third party reporting. Residents are given a copy of the brochure covering the reporting rules. In addition to the copy, the rules are posted throughout the facility.
PEER 1 also provides several options to report, which include:

- Speaking in person with a staff member
- Mailing a note or a letter in a sealed envelope to a staff member
- Directly giving a note to a staff member
- Contacting the Blue Bench (crisis hotline: 303-322-7273)
- Notifying the Denver Police Department

ARTS, which is the governing body of PEER 1 has also established a link on their website. This link is accessible to the public and has information for the reporting procedures. This link can be found at www.artstreatment.org.

Interviews with residents indicated they had an understanding of the reporting policy and stated they had not needed the services.

Conclusion- PEER 1 has a policy in place that had residents sign and acknowledge the reporting procedure. They also offer several different methods of reporting to both internal and external sources. PEER 1 is in compliance with this standard

Evidence Relied Upon

- Pre-Audit Questionnaire
- Submitted Policies
- Interviews with various individuals

PEER 1 is in compliance with this standard.

OFFICIAL RESPONSE FOLLOWING A RESIDENT REPORT

Standard 115.261: Staff and agency reporting duties

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.261 (a)

- Does the agency require 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 a facility, whether or not it is part of the agency? ☒ Yes  ☐ No
• Does the agency require all staff to report immediately and according to agency policy any knowledge, suspicion, or information regarding retaliation against residents or staff who reported an incident of sexual abuse or sexual harassment? ☒ Yes ☐ No

• Does the agency require all staff to report immediately and according to agency policy any knowledge, suspicion, or information regarding any staff neglect or violation of responsibilities that may have contributed to an incident of sexual abuse or sexual harassment or retaliation? ☒ Yes ☐ No

115.261 (b)

• Apart from reporting to designated supervisors or officials, does staff always refrain from revealing any information related to a sexual abuse report to anyone other than to the extent necessary, as specified in agency policy, to make treatment, investigation, and other security and management decisions? ☒ Yes ☐ No

115.261 (c)

• Unless otherwise precluded by Federal, State, or local law, are medical and mental health practitioners required to report sexual abuse pursuant to paragraph (a) of this section? ☒ Yes ☐ No

• Are medical and mental health practitioners required to inform residents of the practitioner’s duty to report, and the limitations of confidentiality, at the initiation of services? ☒ Yes ☐ No

115.261 (d)

• If the alleged victim is under the age of 18 or considered a vulnerable adult under a State or local vulnerable person’s statute does the agency report the allegation to the designated State or local services agency under applicable mandatory reporting laws? ☒ Yes ☐ No

115.261 (e)

• Does the facility report all allegations of sexual abuse and sexual harassment, including third-party and anonymous reports, to the facility’s designated investigators? ☒ Yes ☐ No

Auditor Overall Compliance Determination

☐ Exceeds Standard *(Substantially exceeds requirement of standards)*

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

☐ Does Not Meet Standard *(Requires Corrective Action)*
Instructions for Overall Compliance Determination Narrative

PEER 1 has a policy in place that covers this standard.

Employees are trained to report any incident which occurs within or to anyone residing in PEER 1.

This policy also requires employees to report any staff involved PREA incident. The policy also protects against retaliation to residents.

The policy requires staff to report incidents that occur not only within PEER 1 grounds, but those that occur outside their program.

Interviews indicated employees with knowledgeable and familiar with the reporting procedures.

Evidence Relied Upon
Pre-Audit Questionnaire
Submitted Policies
Interviews with various individuals

PEER 1 is in compliance with this standard.

Standard 115.262: Agency protection duties

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.262 (a)

- When the agency learns that a resident is subject to a substantial risk of imminent sexual abuse, does it take immediate action to protect the resident? ☒ Yes ☐ No

Auditor Overall Compliance Determination

☐ Exceeds Standard (Substantially exceeds requirement of standards)

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

☐ Does Not Meet Standard (Requires Corrective Action)

Instructions for Overall Compliance Determination Narrative

PEER 1 has a policy which requires any staff who receives information (from resident, other staff member, other resident, or any 3rd party) report it to a supervisor.

This policy requires staff to separate both parties, develop a plan to ensure the victim is protected.
Other options include change, an increase in visual observation of the victim, a change in work assignments, and if the allegation is substantiated, the offender is discharged from the program and sent returned to custody.

If staff is identified as the potential abuser, the Program Director will notify ARTS Executive Director, University of Colorado Denver- Human Resources and Legal departments as appropriate.

Potential victim will be offered opportunity to access clinical support through the programs clinical staff or mental health provider within 60 hours.

During interviews, staff appeared to be knowledgeable and familiar with the reporting procedures regarding this policy.

Evidence Relied Upon

Pre-Audit Questionnaire

Submitted Policies

Interviews with various individuals

PEER 1 is in compliance with this standard.

**Standard 115.263: Reporting to other confinement facilities**

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

**115.263 (a)**

- Upon receiving an allegation that a resident was sexually abused while confined at another facility, does the head of the facility that received the allegation notify the head of the facility or appropriate office of the agency where the alleged abuse occurred? ☒ Yes ☐ No

**115.263 (b)**

- Is such notification provided as soon as possible, but no later than 72 hours after receiving the allegation? ☒ Yes ☐ No

**115.263 (c)**

- Does the agency document that it has provided such notification? ☒ Yes ☐ No

**115.263 (d)**

- Does the facility head or agency office that receives such notification ensure that the allegation is investigated in accordance with these standards? ☒ Yes ☐ No
Auditor Overall Compliance Determination

☐ Exceeds Standard (Substantially exceeds requirement of standards)
☒ Meets Standard (Substantial compliance; complies in all material ways with the standard for the relevant review period)
☐ Does Not Meet Standard (Requires Corrective Action)

Instructions for Overall Compliance Determination Narrative

PEER 1 has a policy covering this standard, which requires the director to do the following:

The director will notify the director of the reporting agency within 72 hours of the initial notification. This contact will include the person spoken too, their E-Mail and date and time of conversation.

This notification will include any information provided by the victim, but requires re-notification if additional information is received later.

This policy also covers any incident reported to PEER 1 by an outside agency.

If the Program Director receives a notification that a resident was sexually abused while in the care of Peer I, the allegation will be investigated in accordance with all relevant standards.

All information received will be documented in a PREA report.

Interviews with staff indicated they were knowledgeable and familiar with the reporting procedures of this policy.

Evidence Relied Upon
Pre-Audit Questionnaire
Submitted Policies
Interviews with various individuals

PEER 1 is in compliance with this standard.

Standard 115.264: Staff first responder duties

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.264 (a)

- Upon learning of an allegation that a resident was sexually abused, is the first security staff member to respond to the report required to: Separate the alleged victim and abuser?
  ☒ Yes  ☐ No
- Upon learning of an allegation that a resident was sexually abused, is the first security staff member to respond to the report required to: Preserve and protect any crime scene until appropriate steps can be taken to collect any evidence? ☒ Yes  ☐ No

- Upon learning of an allegation that a resident was sexually abused, is the first security staff member to respond to the report required to: Request that the alleged victim not take any actions that could destroy physical evidence, including, as appropriate, washing, brushing teeth, changing clothes, urinating, defecating, smoking, drinking, or eating, if the abuse occurred within a time period that still allows for the collection of physical evidence? ☒ Yes  ☐ No

- Upon learning of an allegation that a resident was sexually abused, is the first security staff member to respond to the report required to: Ensure that the alleged abuser does not take any actions that could destroy physical evidence, including, as appropriate, washing, brushing teeth, changing clothes, urinating, defecating, smoking, drinking, or eating, if the abuse occurred within a time period that still allows for the collection of physical evidence? ☒ Yes  ☐ No

115.264 (b)

- If the first staff responder is not a security staff member, is the responder required to request that the alleged victim not take any actions that could destroy physical evidence, and then notify security staff? ☒ Yes  ☐ No

Auditor Overall Compliance Determination

☐ Exceeds Standard *(Substantially exceeds requirement of standards)*

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

☐ Does Not Meet Standard *(Requires Corrective Action)*

Instructions for Overall Compliance Determination Narrative

PEER 1 has a policy that covers this standard and requires staff to do the following:

Upon learning of an allegation that a resident was sexually abused, the first staff member to respond to the report shall use his or her best judgment to initiate the Coordinated Response plan as described in 115.265.

These steps include ensuring both the victim and abusers are separated. The location for both parties will be determined by the staff member, which generally places the victim in the staff office with an additional staff member.

The crime scene will be protected by placing tape across the door and all residents will be sent to another part of the facility until a complete investigation is conducted.
In the event that evidence collection is available, both parties are instructed to not destroy any possible physical evidence

PEER 1 does not collect evidence as this is conducted by the Denver Police Department.

Operations staff at Peer 1 are trained in security staff duties within 30 days of hire.

During interviews all staff were familiar and knowledgeable with this policy.

Evidence Relied Upon
Pre-Audit Questionnaire
Submitted Policies
Interviews with various individuals

PEER 1 is in compliance with this standard.

Standard 115.265: Coordinated response

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.265 (a)

- Has the facility developed a written institutional plan to coordinate actions among staff first responders, medical and mental health practitioners, investigators, and facility leadership taken in response to an incident of sexual abuse? ☒ Yes  ☐ No

Auditor Overall Compliance Determination

☐ Exceeds Standard (Substantially exceeds requirement of standards)

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

☐ Does Not Meet Standard (Requires Corrective Action)

Instructions for Overall Compliance Determination Narrative

PEER 1 has an extensive policy covering this standard.

The policy requires staff to immediately report any knowledge, suspicion or information of an allegation of sexual abuse or harassment.

Staff does not reveal any information outside of notifying supervisors, investigative and security personnel.
PEER 1 policy mandates that upon learning of an allegation, staff is required to do the following:

A) Separate victim and abuser
B) Secure the scene until the local law enforcement agency (Denver Police) can respond to conduct the investigation.
C) If evidence is available, ensure both the victim and abuser doesn't destroy it by means of brushing teeth, urinating, washing, drinking or smoking.

In regards to the preservation of evidence, PEER 1 has the following policy:

A) Peer I programs, will not enter into or renew any collective bargaining agreement or other agreement that limits Peer I or The Haven’s ability to remove alleged staff sexual abusers from contact with residents pending the outcome of an investigation or of a determination of whether and to what extent discipline is warranted.

In regard to retaliation PEER 1 has a policy that mandates the following:

Peer I will protect all residents and staff who report sexual abuse, harassment, cooperate with investigations of sexual abuse or harassment from retaliation by other residents and staff. The program directors and supervisors are responsible for monitoring for retaliation.

PEER 1 policy mandates a 90 day monitoring for any allegation of abuse. This abuse will be monitored for both residents and staff. The monitoring will focus on any changes or signs of possible retaliation.

During interviews, staffs were knowledgeable and familiar with this policy.

Evidence Relied Upon
Pre-Audit Questionnaire
Submitted Policies
Interviews with various individuals.

PEER 1 is in compliance with this standard

**Standard 115.266: Preservation of ability to protect residents from contact with abusers**

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.266 (a)

- Are both the agency and any other governmental entities responsible for collective bargaining on the agency’s behalf prohibited from entering into or renewing any collective bargaining
agreement or other agreement that limits the agency’s ability to remove alleged staff sexual abusers from contact with any residents pending the outcome of an investigation or of a determination of whether and to what extent discipline is warranted? ☒ Yes ☐ No

115.266 (b)

- Auditor is not required to audit this provision.

**Auditor Overall Compliance Determination**

☐ Exceeds Standard (*Substantially exceeds requirement of standards*)

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

☐ Does Not Meet Standard (*Requires Corrective Action*)

**Instructions for Overall Compliance Determination Narrative**

The Peer I will not enter into or renew any collective bargaining agreement or other agreement that limits the agency’s ability to remove alleged staff sexual abusers from contact with residents pending the outcome of an investigation or a determination of whether and to what extend discipline is warranted.

PEER 1 policy states the following:

Peer I acknowledges that nothing in this standard restricts the program’s ability to enter or renew agreements that govern the conduct of the disciplinary process, as long as such agreements are not inconsistent with the provisions of 115.272 and 115.276 or whether a no-contact assignment that is imposed in the staff member’s personnel file following a determination that the allegation of sexual abuse is not substantiated.

**Evidence Relied Upon**

Pre-Audit Questionnaire

Submitted Policies

PEER 1 is in compliance with this standard

**Standard 115.267: Agency protection against retaliation**

**All Yes/No Questions Must Be Answered by the Auditor to Complete the Report**

115.267 (a)
• Has the agency established a policy to protect all residents and staff who report sexual abuse or sexual harassment or cooperate with sexual abuse or sexual harassment investigations from retaliation by other residents or staff? ☒ Yes ☐ No

• Has the agency designated which staff members or departments are charged with monitoring retaliation? ☒ Yes ☐ No

**115.267 (b)**

• Does the agency employ multiple protection measures, such as housing changes or transfers for resident victims or abusers, removal of alleged staff or resident abusers from contact with victims, and emotional support services for residents or staff who fear retaliation for reporting sexual abuse or sexual harassment or for cooperating with investigations? ☒ Yes ☐ No

**115.267 (c)**

• Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency: Monitor the conduct and treatment of residents or staff who reported the sexual abuse to see if there are changes that may suggest possible retaliation by residents or staff? ☒ Yes ☐ No

• Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency: Monitor the conduct and treatment of residents who were reported to have suffered sexual abuse to see if there are changes that may suggest possible retaliation by residents or staff? ☒ Yes ☐ No

• Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency: Act promptly to remedy any such retaliation? ☒ Yes ☐ No

• Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency: Monitor any resident disciplinary reports? ☒ Yes ☐ No

• Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency: Monitor resident housing changes? ☒ Yes ☐ No

• Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency: Monitor resident program changes? ☒ Yes ☐ No

• Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency: Monitor negative performance reviews of staff? ☒ Yes ☐ No

• Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency: Monitor reassignments of staff? ☒ Yes ☐ No
- Does the agency continue such monitoring beyond 90 days if the initial monitoring indicates a continuing need? ☒ Yes ☐ No

115.267 (d)

- In the case of residents, does such monitoring also include periodic status checks? ☒ Yes ☐ No

115.267 (e)

- If any other individual who cooperates with an investigation expresses a fear of retaliation, does the agency take appropriate measures to protect that individual against retaliation? ☒ Yes ☐ No

115.267 (f)

- Auditor is not required to audit this provision.

Auditor Overall Compliance Determination

☐ Exceeds Standard (Substantially exceeds requirement of standards)

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

☐ Does Not Meet Standard (Requires Corrective Action)

Instructions for Overall Compliance Determination Narrative

Peer I program protect all residents and staff who report sexual abuse or harassment or cooperate with sexual abuse or sexual harassment investigations.

PEER 1 policy is as follows:

(1) Staff: The immediate supervisors of the staff member who are the primary staff charged with monitoring retaliation of line staff. If there is a concern that Supervisor may be the source of the retaliation, program director (or designee not under the direction of the supervisor with whom there is concern of retaliation) will monitor for retaliation of staff.

(2) Residents: The supervisor of the milieu (or designee) will monitor the conduct and treatment of residents who reported the sexual abuse and of residents who were reported to have experienced sexual abuse. If there is concern about the supervisor of the milieu retaliating against resident who reported or experienced the abuse, program director or their designee shall be responsible for monitoring for retaliation.

(3) Others: If there is someone in need of protection against retaliation, such as a volunteer or contractor, the PREA Coordinator (or designee of the Director in the case of conflict of interest or concern regarding retaliation by the PREA Coordinator) will monitor the
(b) Peer I program will employ multiple measures to assure protection from retaliation. These measures may include but is not limited to one or more of the following:

1. Measures for Residents (Victims, abusers, and reporters of sexual abuse) Such measures will be determined on an individualized basis and documented in the PREA Investigation Report.

(a) Housing changes or transfers for resident victims or abusers (transfers to other facilities may require authorization from legal supervisors, however program will assist with obtaining such legal authorization if program’s management team deems it necessary to do so);

(b) Removal of alleged resident or staff abusers from contact with victims;

(c) Emotional support services for residents who fear retaliation for reporting sexual abuse or sexual harassment, or for cooperating with investigations.

2. Measures for Protection of Staff

(a) Staff emotional support services can be accessed through the University’s Employee Assistance Program. Such measures will be determined on an individualized basis and documented in the PREA Investigation report.

(c) For at least 90 days following a report of sexual abuse, The Haven/Peer I supervisors (or designee) will monitor the conduct and treatment of residents or staff who reported the sexual abuse and of residents who were reported to have suffered sexual abuse to see if there are changes. These changes may suggest possible retaliation by residents or staff, and the supervisors shall act promptly to remedy any such retaliation.

(a) Items the programs will monitor include:

1. Any resident disciplinary reports;

2. Housing or program changes,

3. Negative performance reviews or reassignments of staff.

(b) Monitoring may continue beyond 90 days if the initial monitoring indicates a continuing need. Re-evaluation of need for continued monitoring will be conducted every 30 days after the initial 90 day period.

(d) Supervisory staff or PREA Coordinators will conduct periodic status checks with the resident and document such checks with the PEER I/Haven Retaliation Monitoring Form. The frequency of these checks will be individually determined according to the nature of the incident and the preference of the client.

(e) The protections described in this 115.67 shall apply to any individual who cooperates with an investigation who expresses fear of retaliation. ARTS/The Haven/Peer I shall take all
reasonable steps to protect that individual against retaliation. PREA Coordinator will be responsible for assuring that appropriate monitoring has occurred, although primary monitoring may be completed by a designated contact within that individual’s chain of supervision. The definition of “reasonable steps” shall be determined at minimum, by the Management Team at Peer I or The Haven. Additional consultation will occur with ARTS Management, University of Colorado Denver Human Resources and University of Colorado Denver Legal Departments as required.

(f) The Haven and Peer I acknowledge that the obligation to protect against retaliation is removed by the referenced standard if the program determines that the allegation is unfounded, however will make reasonable efforts to prevent and eliminate retaliation as described above.

The policy for PEER 1 is very extensive regarding this standard.

The policy mandates that staff, volunteers / contractors and residents are protected once they make an allegation involving PREA.

The policy mandates once an allegation is made the reporting party is monitored to ensure they are protected from retaliation.

Once retaliation has been alleged PEER 1 will document findings in the PREA Investigation Report:

PEER 1 takes certain measures to ensure the victim is protected to include the following:

1) Residents-
   A) Housing changes, removal of staff if necessary and emotional support.
   B) Staff- Staff emotional support services can be accessed through the University’s Employee Assistance Program.
   C) Others- This policy extends to contractors and volunteers to protect them from retaliation if an allegation arises
   D) For at least 90 days following a report of sexual abuse, The Haven/Peer I supervisors (or designee) will monitor the conduct and treatment of residents or staff who reported the sexual abuse and of residents who were reported to have suffered sexual abuse to see if there are changes.
   E) Supervisory staff or PREA Coordinators will conduct periodic status checks with the resident and document such checks with the PEER I/Haven Retaliation Monitoring Form.
   F) Monitoring may continue beyond 90 days if the initial monitoring indicates a continuing need. Re-evaluation of need for continued monitoring will be conducted every 30 days after the initial 90 day period.
   G) Supervisory staff or PREA Coordinators will conduct periodic status checks with the resident and document such checks with the PEER I/Haven Retaliation Monitoring Form.
H) Peer 1 acknowledges that the obligation to protect against retaliation is removed by the referenced standard if the program determines that the allegation is unfounded, however will make reasonable efforts to prevent and eliminate retaliation as described above.

The policy for this standard is very extensive and covers all victims to include staff, residents and contractors / vendors.

The monitoring continues for 90 days and can be extended if needed.

All documentation will be noted on a monitoring form and PEER 1 reserves the right to remove the protection if the allegation is unfounded. They will however make efforts to protect against retaliation.

Evidence Relied Upon

Pre-Audit Questionnaire

Submitted Policies

PEER 1 is in compliance with this standard.

INVESTIGATIONS

Standard 115.271: Criminal and administrative agency investigations

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.271 (a)

- When the agency conducts its own investigations into allegations of sexual abuse and sexual harassment, does it do so promptly, thoroughly, and objectively? [N/A if the agency/facility is not responsible for conducting any form of criminal OR administrative sexual abuse investigations. See 115.221(a).] ☒ Yes ☐ No ☐ NA

- Does the agency conduct such investigations for all allegations, including third party and anonymous reports? [N/A if the agency/facility is not responsible for conducting any form of criminal OR administrative sexual abuse investigations. See 115.221(a).]
  ☒ Yes ☐ No ☐ NA

115.271 (b)

- Where sexual abuse is alleged, does the agency use investigators who have received specialized training in sexual abuse investigations as required by 115.234? ☒ Yes ☐ No

115.271 (c)

- Do investigators gather and preserve direct and circumstantial evidence, including any available physical and DNA evidence and any available electronic monitoring data? ☒ Yes ☐ No
- Do investigators interview alleged victims, suspected perpetrators, and witnesses?  
  ☒ Yes  ☐ No

- Do investigators review prior reports and complaints of sexual abuse involving the suspected perpetrator?  
  ☒ Yes  ☐ No

### 115.271 (d)

- When the quality of evidence appears to support criminal prosecution, does the agency conduct compelled interviews only after consulting with prosecutors as to whether compelled interviews may be an obstacle for subsequent criminal prosecution?  
  ☐ Yes  ☒ No

### 115.271 (e)

- Do agency investigators assess the credibility of an alleged victim, suspect, or witness on an individual basis and not on the basis of that individual’s status as resident or staff?  
  ☒ Yes  ☐ No

- Does the agency investigate allegations of sexual abuse without requiring a resident who alleges sexual abuse to submit to a polygraph examination or other truth-telling device as a condition for proceeding?  
  ☒ Yes  ☐ No

### 115.271 (f)

- Do administrative investigations include an effort to determine whether staff actions or failures to act contributed to the abuse?  
  ☒ Yes  ☐ No

- Are administrative investigations documented in written reports that include a description of the physical evidence and testimonial evidence, the reasoning behind credibility assessments, and investigative facts and findings?  
  ☒ Yes  ☐ No

### 115.271 (g)

- Are criminal investigations documented in a written report that contains a thorough description of the physical, testimonial, and documentary evidence and attaches copies of all documentary evidence where feasible?  
  ☒ Yes  ☐ No

### 115.271 (h)

- Are all substantiated allegations of conduct that appears to be criminal referred for prosecution?  
  ☒ Yes  ☐ No

### 115.271 (i)
- Does the agency retain all written reports referenced in 115.271(f) and (g) for as long as the alleged abuser is incarcerated or employed by the agency, plus five years? ☒ Yes ☐ No

**115.271 (j)**

- Does the agency ensure that the departure of an alleged abuser or victim from the employment or control of the agency does not provide a basis for terminating an investigation?
  ☒ Yes ☐ No

**115.271 (k)**

- Auditor is not required to audit this provision.

**115.271 (l)**

- When an outside entity investigates sexual abuse, does the facility cooperate with outside investigators and endeavor to remain informed about the progress of the investigation? [N/A if an outside agency does not conduct administrative or criminal sexual abuse investigations. See 115.221(a).] ☒ Yes ☐ No ☐ NA

**Auditor Overall Compliance Determination**

☐ Exceeds Standard (*Substantially exceeds requirement of standards*)

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

☐ Does Not Meet Standard (*Requires Corrective Action*)

**Instructions for Overall Compliance Determination Narrative**

PEER 1 has a very extensive policy regarding this standard which includes the following:

A) Investigations will be conducted in a prompt and thorough manner. These include investigations that involve third party and anonymous reporting.

B) PEER 1 staff does not conduct any investigations involving criminal matters, as this is conducted by the Denver Police Department. These matters are conducted by the Denver Police Department.

C) PEER 1 staff does not collect evidence which stems from a criminal allegation, unless instructed by a law enforcement person. This phase of the investigation is conducted by the Denver Police Department. This includes circumstantial, DNA and any electronic evidence.

D) When quality of evidence appears to support criminal prosecution, The Haven and Peer I will not conduct compelled interviews, but will utilize the resources of the Denver Police Department Sex Crimes Unit to conduct such interviews.
E) Credibility of an alleged victim, suspect, or witness shall be assessed on an individual basis and not be determined by person’s status as a resident or staff. The Peer I/Haven programs do not administer or at any time require the use of a polygraph examination or other truth-telling device as a condition to proceed with an investigation.

F) Administrative Investigations will include the following:

1) An effort or examination to determine whether staff actions or failures contributed to the abuse

(2) Documentation in written reports shall include a description of the physical and testimonial evidence, the reasoning behind credibility assessments, and investigative facts and findings.

G) All gathered information will be placed into a PREA report when feasible.

H) Substantiated allegations of conduct which appear to be criminal will be referred for prosecution in accordance with the coordinated response plan. This will typically be initiated by the Denver Police Sex Crimes Unit, rather than by Peer I.

I) The Peer I/Haven programs will retain all written reports referenced in (f) and (g) for as long as alleged abuser is incarcerated or employed by agency, plus five years. These documents will be retained either in the PREA Coordinators Office, or in a professionally managed, secure offsite storage location (Docuvault).

J) Peer I and The Haven complete all administrative investigations, and support all criminal investigations until such time that a determination of Substantiated, Unsubstantiated, or Unfounded may be made, regardless of the departure of the alleged abuser or victim from the employment or control of The Haven, Peer I, ARTS or the University of Colorado.

K) N/A

L) The Peer I/Haven programs shall cooperate with outside agencies/investigators who are conducting investigations of sexual abuse and shall remain informed about the progress of the investigation. The PREA Coordinator (or designee) shall be the primary point of contact between the outside agencies/investigators and the program once the investigation has been initiated.

As documented above PEER 1 has an extensive policy regarding this standard.

Interviews with staff confirmed their knowledge and understanding of this policy. All staff members understood they would assist with the initial separation of the victim and abuser but the criminal aspect of an allegation would be investigated by the Denver Police Department.

Evidence Relied Upon

Pre-Audit Questionnaire
Submitted Policies
Interviews with various individuals
PEER 1 is in compliance with this standard

**Standard 115.272: Evidentiary standard for administrative investigations**

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.272 (a)

- Is it true that the agency does not impose a standard higher than a preponderance of the evidence in determining whether allegations of sexual abuse or sexual harassment are substantiated? ☒ Yes ☐ No

**Auditor Overall Compliance Determination**

☐ Exceeds Standard *(Substantially exceeds requirement of standards)*

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

☐ Does Not Meet Standard *(Requires Corrective Action)*

**Instructions for Overall Compliance Determination Narrative**

PEER 1 has a policy that applies to this standard which states the following:

As it pertains to PREA Investigations, Peer I conducts administrative investigation and uses no standard higher than a preponderance of the evidence in determining whether the allegations are substantiated. Relevant to this standard, Peer I considers a PREA violation to be substantiated if there is more than 50% of the evidence which indicates that the incident occurred. When criminal activity is suspected, PEER 1 notifies the Denver Police Department Sex Crimes Unit, which is also subject to this evidentiary standard.

During interviews the PREA compliance manager confirmed they conduct administrative interview only and use this policy as a guideline.

Evidence Relied Upon
Pre-Audit Questionnaire
Submitted Policies
Interviews with various individuals.

PEER 1 is in compliance with this standard.
Standard 115.273: Reporting to residents

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.273 (a)

- Following an investigation into a resident’s allegation that he or she suffered sexual abuse in an agency facility, does the agency inform the resident as to whether the allegation has been determined to be substantiated, unsubstantiated, or unfounded? ☒ Yes ☐ No

115.273 (b)

- If the agency did not conduct the investigation into a resident’s allegation of sexual abuse in an agency facility, does the agency request the relevant information from the investigative agency in order to inform the resident? (N/A if the agency/facility is responsible for conducting administrative and criminal investigations.) ☒ Yes ☐ No ☐ NA

115.273 (c)

- Following a resident’s allegation that a staff member has committed sexual abuse against the resident, unless the agency has determined that the allegation is unfounded, or unless the resident has been released from custody, does the agency subsequently inform the resident whenever: The staff member is no longer posted within the resident’s unit? ☒ Yes ☐ No

- Following a resident’s allegation that a staff member has committed sexual abuse against the resident, unless the agency has determined that the allegation is unfounded, or unless the resident has been released from custody, does the agency subsequently inform the resident whenever: The staff member is no longer employed at the facility? ☒ Yes ☐ No

- Following a resident’s allegation that a staff member has committed sexual abuse against the resident, unless the agency has determined that the allegation is unfounded, or unless the resident has been released from custody, does the agency subsequently inform the resident whenever: The agency learns that the staff member has been indicted on a charge related to sexual abuse in the facility? ☒ Yes ☐ No

- Following a resident’s allegation that a staff member has committed sexual abuse against the resident, unless the agency has determined that the allegation is unfounded, or unless the resident has been released from custody, does the agency subsequently inform the resident whenever: The agency learns that the staff member has been convicted on a charge related to sexual abuse within the facility? ☒ Yes ☐ No

115.273 (d)

- Following a resident’s allegation that he or she has been sexually abused by another resident, does the agency subsequently inform the alleged victim whenever: The agency learns that the alleged abuser has been indicted on a charge related to sexual abuse within the facility? ☒ Yes ☐ No
- Following a resident’s allegation that he or she has been sexually abused by another resident, does the agency subsequently inform the alleged victim whenever: The agency learns that the alleged abuser has been convicted on a charge related to sexual abuse within the facility? ☒ Yes ☐ No

115.273 (e)

- Does the agency document all such notifications or attempted notifications? ☒ Yes ☐ No

115.273 (f)

- Auditor is not required to audit this provision.

Auditor Overall Compliance Determination

☒ Exceeds Standard *(Substantially exceeds requirement of standards)*

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

☐ Does Not Meet Standard *(Requires Corrective Action)*

Instructions for Overall Compliance Determination Narrative

PEER 1 has a policy that covers this standard, which is as follows:

A) Following an investigation into a resident’s allegation of sexual abuse suffered in an agency facility, The Peer I/Haven programs shall inform the resident as to whether the allegation has been determined to be substantiated, unsubstantiated, or unfounded. The PREA Coordinator will complete the PREA Resident Notification of Investigation Outcome Form, review with resident, and have resident sign as acknowledgement of receipt.

If the resident is no longer at Peer I, reasonable efforts will be made to provide this document (for example, via mail), however no resident signature is required.

B) If Peer I did not conduct the investigation, the program requests information from investigating entity to share with the resident. When any such information is received, the resident will receive a copy of the record, and the original documents will be retained in the PREA Investigation Binder.

C) Following a resident’s allegation involving a staff member, unless unfounded, the agency will inform the resident whenever:

1. The staff member is no longer posted within the resident’s house;

2. The staff member is no longer employed at Peer I

3. The agency learns that the staff member has been indicted on a charge related to sexual abuse within Peer I
(4) Peer I learns the staff member has been convicted on the charge related to sexual abuse within the facility.

D) Following a resident’s allegation that he or she has been sexually abused by another resident, the agency shall inform the alleged victim whenever:

(1) Peer I/The Haven learns that the alleged abuser has been indicted on a charge related to sexual abuse within the facility or

(2) Peer I/The Haven learns the alleged abuser has been convicted on the charge related to sexual abuse within the facility.

(E) Any such information described in paragraphs (c) and (d) above, may be shared with the resident verbally or in writing by the PREA Coordinator (or designee). If the information is shared in writing, a copy of this letter will be retained in the PREA Binder. If the information is shared verbally, a PREA Case Management Report will be completed reflecting the content of that conversation. This report will be retained in the PREA Binder.

If this information is contained within with another report or document (such as PREA Emergency Grievance Final Decision), then no duplicative letter or case management documentation is required.

(F) Peer I program is not obligated to report under this standard if the resident is released from the Peer I or The Haven’s custody.

As noted above, the policy is extensive and covers all parts of the standard.

During interviews there was no evidence that led to believe this policy was not followed.

Evidence Relied Upon
Pre-Audit Questionnaire
Submitted Policies
Interviews with various individuals

PEER 1 is in compliance with this standard.

**DISCIPLINE**

**Standard 115.276: Disciplinary sanctions for staff**

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.276 (a)

- Are staff subject to disciplinary sanctions up to and including termination for violating agency sexual abuse or sexual harassment policies? ☒ Yes ☐ No
115.276 (b)

- Is termination the presumptive disciplinary sanction for staff who have engaged in sexual abuse? ☒ Yes ☐ No

115.276 (c)

- Are disciplinary sanctions for violations of agency policies relating to sexual abuse or sexual harassment (other than actually engaging in sexual abuse) 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? ☒ Yes ☐ No

115.276 (d)

- Are all terminations for violations of agency sexual abuse or sexual harassment policies, or resignations by staff who would have been terminated if not for their resignation, reported to: Law enforcement agencies unless the activity was clearly not criminal? ☒ Yes ☐ No

- Are all terminations for violations of agency sexual abuse or sexual harassment policies, or resignations by staff who would have been terminated if not for their resignation, reported to: Relevant licensing bodies? ☒ Yes ☐ No

Auditor Overall Compliance Determination

☐ Exceeds Standard (Substantially exceeds requirement of standards)

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

☐ Does Not Meet Standard (Requires Corrective Action)

Instructions for Overall Compliance Determination Narrative

(A) All suspected incidents of staff violating the agencies zero tolerance policies on sexual abuse or sexual harassment will be thoroughly investigated. Upon receipt of any information that staff is involved in any incident of this nature, they may immediately be placed on Administrative Leave, depending on the severity of the incident, and pending the outcome of the investigation. All investigations will be thoroughly documented and provided to the agency executive director, and then to Human Resources, as well as legal/risk management, if warranted, to make a determination regarding sanctions.

(B) Following the determination that an incident of staff-on-resident sexual abuse has occurred, the staff member will be referred through the University of Colorado Denver Human Resources Department’s procedures for termination as pertains to either the State Classified or Exempt Professional guidelines.
(C) When incidents violate program polices but are not abusive in nature, the PREA Committee and program administration will meet to consider the following: the nature and circumstances of the violation against agency policy; the staff member’s disciplinary history; and sanctions that have been applied to other staff for comparable offenses with similar histories. Sanctions other than termination will be discussed with the University of Colorado’s Human Resource Department and may include required training or professional development, demotion, or transfer from facility.

(D) In the case of possible criminal offenses, The Peer I and Haven programs in coordination with the Human Resources Department and Legal Department, will notify all oversight agencies including the Denver Police Department as well as the Office of Behavioral Health. If the staff member holds a professional certification or licensure, the staff member will also be reported to the Department or Regulatory Agencies (DORA). In the case where an employee resigns prior to a termination being issued, all agencies noted above will be contacted.

The policy covers all standards to include termination as a possibility if an allegation against an employee is substantiated. The policy also mandates that services such as licensing and the Denver Police Department should the allegation reach a criminal nature.

During interviews there was no evidence that led to believe this policy was not followed.

Evidence Relied Upon

Pre-Audit Questionnaire

Submitted Policies

Interviews with various individuals.

PEER 1 is in compliance with this standard.

**Standard 115.277: Corrective action for contractors and volunteers**

**All Yes/No Questions Must Be Answered by the Auditor to Complete the Report**

115.277 (a)

- Is any contractor or volunteer who engages in sexual abuse prohibited from contact with residents? ☒ Yes ☐ No
- Is any contractor or volunteer who engages in sexual abuse reported to: Law enforcement agencies unless the activity was clearly not criminal? ☒ Yes ☐ No
- Is any contractor or volunteer who engages in sexual abuse reported to: Relevant licensing bodies? ☒ Yes ☐ No

115.277 (b)
In the case of any other violation of agency sexual abuse or sexual harassment policies by a contractor or volunteer, does the facility take appropriate remedial measures, and consider whether to prohibit further contact with residents? ☒ Yes  ☐ No

Auditor Overall Compliance Determination

☐ Exceeds Standard *(Substantially exceeds requirement of standards)*

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

☐ Does Not Meet Standard *(Requires Corrective Action)*

Instructions for Overall Compliance Determination Narrative

PEER 1 has a policy that covers this standard as follows:

(A) The Haven and Peer I programs have a zero tolerance policy regarding sexually prohibited behaviors. All contract and volunteers are provided training of this policy and pursuant to §115.232. If an allegation is made regarding a contractor or volunteer, an investigation will be initiated per PREA policies. In the case of a criminal incident (sexual abuse), the contracted employee or volunteer will be reported to the Denver Police Department Sex Crimes Unit as well as all oversight agencies and licensing agents. Any contractor or volunteer who engages in sexual abuse shall be prohibited from contact with residents of any ARTS program.

(B) Peer I and the Haven will take appropriate remedial measures, and shall consider whether to prohibit further contact with residents, in the case of any violation of agency sexual harassment policies by a contractor or volunteer. When appropriate and possible through the specific contract, the contracting agency may still be used but different contract employees will be reassigned to the programs. If the allegations are found to be against a contractor and are non-criminal in nature but still in violation of the policies (including consensual sexual acts), administration may take remedial measures but may still consider termination of the contract. If an incident involves a volunteer and is found to be a violation of any program policy (including consensual sexual contact), the volunteer will be prohibited from volunteering at The Haven and Peer I programs.

The policy covers the standard involving contractors and volunteers.

During interviews it was disclosed that PEER 1 has no volunteers.

The contract employees are employed by Fort Logan which is a division of the state of Colorado and are trained on PREA protocol during their training.

During interviews there was no evidence that led to believe this policy was not followed.

Evidence Relied Upon
Pre-Audit Questionnaire

Submitted Policies

Interviews with various individuals.

PEER 1 is in compliance with this standard.

**Standard 115.278: Interventions and disciplinary sanctions for residents**

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.278 (a)
- Following an administrative finding that a resident engaged in resident-on-resident sexual abuse, or following a criminal finding of guilt for resident-on-resident sexual abuse, are residents subject to disciplinary sanctions pursuant to a formal disciplinary process? ☒ Yes ☐ No

115.278 (b)
- Are sanctions commensurate with the nature and circumstances of the abuse committed, the resident's disciplinary history, and the sanctions imposed for comparable offenses by other residents with similar histories? ☒ Yes ☐ No

115.278 (c)
- When determining what types of sanction, if any, should be imposed, does the disciplinary process consider whether a resident’s mental disabilities or mental illness contributed to his or her behavior? ☒ Yes ☐ No

115.278 (d)
- If the facility offers therapy, counseling, or other interventions designed to address and correct underlying reasons or motivations for the abuse, does the facility consider whether to require the offending resident to participate in such interventions as a condition of access to programming and other benefits? ☒ Yes ☐ No

115.278 (e)
- Does the agency discipline a resident for sexual contact with staff only upon a finding that the staff member did not consent to such contact? ☒ Yes ☐ No

115.278 (f)
- For the purpose of disciplinary action does a report of sexual abuse made in good faith based upon a reasonable belief that the alleged conduct occurred NOT constitute falsely reporting an incident or lying, even if an investigation does not establish evidence sufficient to substantiate the allegation? ☒ Yes ☐ No
115.278 (g)

- Does the agency always refrain from considering non-coercive sexual activity between residents to be sexual abuse? (N/A if the agency does not prohibit all sexual activity between residents.)
  ☒ Yes  ☐ No  ☐ NA

Auditor Overall Compliance Determination

☐ Exceeds Standard *(Substantially exceeds requirement of standards)*

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

☐ Does Not Meet Standard *(Requires Corrective Action)*

Instructions for Overall Compliance Determination Narrative

PEER 1 has a policy that covers this standard as follows:

(A) Following the determination that an incident of resident-on-resident sexual abuse has occurred, the incident will be reviewed by the PREA committee members and program management in order to determine and implement the appropriate sanctions.

(B) PREA Committee Members will consider the following: the resident’s disciplinary history by report and from the resident’s file, and sanctions issued to other residents with similar incidents and histories.

(C) PREA Committee Members will also consider the resident’s mental health diagnosis, trauma history, and/or cognitive abilities when considering sanctions.

(D) In cases of criminal assault or harassment the resident will be discharged from the program and proper authorities including oversight agencies and law enforcement will be contacted. If the violation is not found to be criminal in nature and the PREA committee members and administrative staff deems that is not an offense that would warrant termination/discharge from the program, then the program will institute sanctions that will consequence the behavior while providing therapeutic behavioral modification through individual and group therapy, milieu tools and assignments or other interventions as appropriate.

(E) If the victim in a sexual assault or harassment incident is a program staff member who was not a consenting participant, the resident will receive sanctions commensurate to the behavior and pursuant to paragraphs a-d. Services for the staff member will be provided through the Employee Assistance Program and Human Resources. If it is deemed that the staff was a consenting party, the resident will not be sanctioned but will be provided therapy services commensurate to a level of care available in the community to include but not limited to: individual and group therapy, cognitive behavioral therapeutic interventions, therapy related to relationship issues, and other interventions as appropriate. Staff members must uphold counseling ethical standards and are considered in a position of trust and authority. Unless staff did not consent/was not a willing participant, staff will be
referred to administration and Human Resources for termination or other sanctions. All oversight agencies and licensing agencies will also be notified of the incident via a critical incident report. All reports will be kept in administrative offices and not in the resident’s chart.

(F) All reports will be thoroughly investigated and if it is determined that no incident has occurred yet the report was made in good faith, there will be no consequences to the resident for falsely reporting. If the report was made falsely, then the client may face discharge from the program or additional charges for falsifying their report.

(G) Peer 1 residential program uphold strict policies that prohibit all sexual activity between residents regardless of consent. If an incident is investigated and found to be consensual it will not be considered a violation of PREA policies, however, may still result in sanctions up to and including discharge from the program for non-compliance to program policies.

PEER 1 has an extensive policy covering this policy, they strictly enforce the conduct of residents and if a violation occurs, they conduct an investigation. If validated, they have options to discharge the resident and return them to custody. If the allegation involves criminal behavior, they contact the Denver Police Department to conduct an investigation.

Evidence Rel lied Upon
Pre-Audit Questionnaire
Submitted Policies
Interviews with various individuals

PEER 1 is in compliance with this standard.

MEDICAL AND MENTAL CARE

Standard 115.282: Access to emergency medical and mental health services

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.282 (a)

- Do resident victims of sexual abuse receive timely, unimpeded access to emergency medical treatment and crisis intervention services, the nature and scope of which are determined by medical and mental health practitioners according to their professional judgment?
  ❑ Yes ❑ No

115.282 (b)
If no qualified medical or mental health practitioners are on duty at the time a report of recent sexual abuse is made, do security staff first responders take preliminary steps to protect the victim pursuant to § 115.262? ☒ Yes ☐ No

Do security staff first responders immediately notify the appropriate medical and mental health practitioners? ☒ Yes ☐ No

115.282 (c)

Are resident victims of sexual abuse offered timely information about and timely access to emergency contraception and sexually transmitted infections prophylaxis, in accordance with professionally accepted standards of care, where medically appropriate? ☒ Yes ☐ No

115.282 (d)

Are treatment services provided to the victim without financial cost and regardless of whether the victim names the abuser or cooperates with any investigation arising out of the incident? ☒ Yes ☐ No

Auditor Overall Compliance Determination

☐ Exceeds Standard (Substantially exceeds requirement of standards)

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

☐ Does Not Meet Standard (Requires Corrective Action)

Instructions for Overall Compliance Determination Narrative

(A) After the scene is secure and no longer than within one hour of staff notification of an incident, the first responder will notify the Supervisor or the Program Director of the incident. The Supervisor will provide direction for medical referral for treatment, and will refer the victim to Denver Health Medical Center Emergency Department to be transported by program staff or by ambulance depending upon the severity of injuries. (Medical staff is not on site at either Peer I or the Haven.) The PREA Coordinator will also assure that the Denver Health Emergency Department is aware that a sexual assault has occurred and that the SANE team must be notified. The PREA Coordinator will also contact the Mental Health Therapist at the Haven and the Senior Counseling Staff at Peer I to assist with the mental health treatment and services as needed. All services delivered in accordance with this section will be done in accordance with professionally accepted standards of care.

(B) After the scene is secure and no longer than within one hour of staff notification of an incident, the first responder will notify the Supervisor or the Program Director of the incident. The Supervisor will provide direction for medical referral for treatment, and will refer the victim to Denver Health Medical Center Emergency Department to be transported by program staff or by ambulance depending upon the severity of injuries. (Medical staff is not on site at
either Peer I or the Haven.) The PREA Coordinator will also assure that the Denver Health Emergency Department is aware that a sexual assault has occurred and that the SANE team must be notified. The PREA Coordinator will also contact the Mental Health Therapist at the Haven and the Senior Counseling Staff at Peer I to assist with the mental health treatment and services as needed. All services delivered in accordance with this section will be done in accordance with professionally accepted standards of care.

(C) Services will be provided by the SANE Nurse at the Denver Health Medical Center Emergency Department who will provide information to the client regarding emergency contraception and sexually transmitted infections prophylaxis, in accordance with professionally accepted standards of care, where medically appropriate. In addition to above outlined procedures, and if necessary, the victim will receive on-going medical services through the Sheridan Health Services, an agency partnership, and may receive referrals to outside agencies, such as the Blue Bench, for specialized services. All services delivered in accordance with this section will be done in accordance with professionally accepted standards of care.

(D) Services will be provided by the SANE Nurse at the Denver Health Medical Center Emergency Department. The program directors, in conjunction with the University Risk Management Team and the Department of Criminal Justice will assure payment for services is obtained. The victim will not incur any financial costs arising out of the incident regardless of whether the victim names the abuser or cooperates with any investigation arising out of the incident. All services delivered in accordance with this section will be done in accordance with professionally accepted standards of care.

PEER 1 has a policy that covers the entire standard. It provides the victim access to a SANE (Sexual Assault Nurse Exam).

The policy mandates one hour notification after being informed of a PREA incident. It also mandates the SANE department at Denver Health is notified, a member of the PEER 1 staff present during the exam, if clinically appropriate.

Policy mandates victims have access to outside agencies for support that fall within accepted standards of care.

During interviews staff was knowledgeable and familiar with this policy.

Evidence Relied Upon

Pre-Audit Questionnaire
Submitted Policies
Interviews with various individuals

PEER 1 is in compliance with this standard.

Standard 115.283: Ongoing medical and mental health care for sexual abuse victims and abusers
All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.283 (a)
- Does the facility offer medical and mental health evaluation and, as appropriate, treatment to all residents who have been victimized by sexual abuse in any prison, jail, lockup, or juvenile facility? ☒ Yes ☐ No

115.283 (b)
- Does the evaluation and treatment of such victims include, as appropriate, follow-up services, treatment plans, and, when necessary, referrals for continued care following their transfer to, or placement in, other facilities, or their release from custody? ☒ Yes ☐ No

115.283 (c)
- Does the facility provide such victims with medical and mental health services consistent with the community level of care? ☒ Yes ☐ No

115.283 (d)
- Are resident victims of sexually abusive vaginal penetration while incarcerated offered pregnancy tests? (N/A if all-male facility.) ☑ Yes ☐ No ☒ NA

115.283 (e)
- If pregnancy results from the conduct described in paragraph § 115.283(d), do such victims receive timely and comprehensive information about and timely access to all lawful pregnancy-related medical services? (N/A if all-male facility.) ☐ Yes ☐ No ☒ NA

115.283 (f)
- Are resident victims of sexual abuse while incarcerated offered tests for sexually transmitted infections as medically appropriate? ☒ Yes ☐ No

115.283 (g)
- Are treatment services provided to the victim without financial cost and regardless of whether the victim names the abuser or cooperates with any investigation arising out of the incident? ☒ Yes ☐ No
- Does the facility attempt to conduct a mental health evaluation of all known resident-on-resident abusers within 60 days of learning of such abuse history and offer treatment when deemed appropriate by mental health practitioners? ☒ Yes ☐ No

Auditor Overall Compliance Determination

☐ Exceeds Standard (Substantially exceeds requirement of standards)

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

☐ Does Not Meet Standard (Requires Corrective Action)

Instructions for Overall Compliance Determination Narrative

. PEER 1 has a policy that covers this standard:

Peer 1 program at screening and intake, assess each client’s history of abuse. If a client has been a victim of sexual abuse in prison, jail, lockup, or juvenile facility, prior to entering the programs, admission staff will refer the client for a mental health evaluation and medical services as needed. Additionally, all clients receive an initial physical examination within 4 weeks of being admitted into the programs.

(A) All clients who have been victims of sexual abuse/assault in prison, jail, lockup, or juvenile facility, prior to entering the programs, will have service plans that address this issue and provide plans for follow up care and referrals as needed.

(B) Peer 1 has senior counseling staff. When appropriate clients may receive services from these staff and based on their professional expertise they will refer clients for additional care as needed. For follow up and on-going medical care, the programs will refer clients to Sheridan Health Services, located on the same campus as the facilities.

(C) N/A as Peer 1 is an all-male facility.

(D) N/A as Peer 1 is an all-male facility.

(E) Victims of sexual abuse will be referred to Sheridan Health Services for detection and treatment of sexually transmitted infections.

(F) Treatment of the victim will be provided without cost to the victim. Clients will receive case management services to assure they are covered by Medicaid, CHIP+ or other insurance; however, the program directors will work with the Department of Criminal Justice and other referring agents to assure that the victim does not incur any charges.

(G) Intake staff assesses clients per PREA standards to determine if clients have a history of being a victim or a perpetrator of sexual abuse. The Haven and Peer 1 programs do not admit persons who have been convicted of sex offenses. If the client has already been admitted into treatment and a disclosure is made regarding their participation in abuse, a
A care coordination meeting will occur to determine risk to clients and a plan for services will be initiated. The Peer 1 program reserves the right to reject after acceptance if the abuser does not appear appropriate for these programs due to their history.

PEER 1 policy is very extensive in this standard. They mandate all residents be interviewed and if any resident they provide the medical screening necessary.

PEER 1 does not house female residents so Sections (C) and (D) don't apply.

PEER 1 does not accept clients who have a conviction history of sexual abuse.

Evidence Relied Upon
Pre-Audit Questionnaire
Submitted Policies
Interviews with various individuals
PEER 1 is in compliance with this standard.

DATA COLLECTION AND REVIEW

**Standard 115.286: Sexual abuse incident reviews**

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.286 (a)

- Does the facility conduct a sexual abuse incident review at the conclusion of every sexual abuse investigation, including where the allegation has not been substantiated, unless the allegation has been determined to be unfounded? ☒ Yes ☐ No

115.286 (b)

- Does such review ordinarily occur within 30 days of the conclusion of the investigation? ☒ Yes ☐ No

115.286 (c)

- Does the review team include upper-level management officials, with input from line supervisors, investigators, and medical or mental health practitioners? ☒ Yes ☐ No

115.286 (d)

- Does the review team: Consider whether the allegation or investigation indicates a need to change policy or practice to better prevent, detect, or respond to sexual abuse? ☒ Yes ☐ No
- Does the review team: Consider whether the incident or allegation was motivated by race; ethnicity; gender identity; lesbian, gay, bisexual, transgender, or intersex identification, status, or perceived status; gang affiliation; or other group dynamics at the facility? ☒ Yes ☐ No

- Does the review team: Examine the area in the facility where the incident allegedly occurred to assess whether physical barriers in the area may enable abuse? ☒ Yes ☐ No

- Does the review team: Assess the adequacy of staffing levels in that area during different shifts? ☒ Yes ☐ No

- Does the review team: Assess whether monitoring technology should be deployed or augmented to supplement supervision by staff? ☒ Yes ☐ No

- Does the review team: Prepare a report of its findings, including but not necessarily limited to determinations made pursuant to §§ 115.286(d)(1) - (d)(5), and any recommendations for improvement and submit such report to the facility head and PREA compliance manager? ☒ Yes ☐ No

115.286 (e)

- Does the facility implement the recommendations for improvement, or document its reasons for not doing so? ☒ Yes ☐ No

Auditor Overall Compliance Determination

☐ Exceeds Standard (Substantially exceeds requirement of standards)

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

☐ Does Not Meet Standard (Requires Corrective Action)

Instructions for Overall Compliance Determination Narrative

(A) Peer I conducts sexual abuse incident reviews at the conclusion of every sexual abuse investigation, including where the allegation has not been substantiated, unless the allegation has been determined to be unfounded. This notification occurs in writing and is evidenced by the Program Director’s signature on the PREA Incident Report Form. The program will assemble a review team within 30 days of the conclusion of all sexual abuse investigations.

(B) The review team will be compiled of supervisors, shift lead workers, investigators, and medical and mental health practitioners as indicated by the incident.

(C) The review team will examine all aspects of the reporting and investigating process: in order to determine if there is a need to change procedures to better prevent, detect, or respond to sexual abuse allegations. The review team will also help to determine if the incident was motivated by race, ethnicity, gender identity, lesbian, gay, bisexual, transgender, or intersex identification, status, or
perceived status, or gang affiliation, or was motivated or otherwise caused by other group dynamics at the facility. This part of the policy also looks at staffing levels at the time of the incident.

(D) A report of all findings, including the factors listed in PREA standard 115.286, will be prepared using the **PREA Incident Review Team Report**. The report shall be used in determining if change in policy and procedure is necessary, as well as, any recommendations for improvement. The report will then be submitted to both the program director and PREA Coordinator, as evidenced by the signatures on the document.

(E) The program will implement the recommendations for change or will document its reason(s) for not doing so.

PEER 1 conducts a review at the conclusion of every investigation. The review looks at all aspects to include possible changes in procedures, staffing level or if the incident occurred due to race, ethnicity or sexual preference.

The review conclusion is then documented on a PREA Incident Team Report.

The results of the investigation are secured in a filing cabinet in the PREA coordinator’s office and kept confidential.

During her interview the PREA coordinator and PEER 1 manager were knowledgeable and familiar with this policy and the necessary steps needed to complete the investigation.

Evidence Relied Upon
Pre-Audit Questionnaire
Submitted Policies
Interviews with various individuals

PEER 1 is in compliance with this standard.

**Standard 115.287: Data collection**

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.287 (a)
- Does the agency collect accurate, uniform data for every allegation of sexual abuse at facilities under its direct control using a standardized instrument and set of definitions? ☒ Yes ☐ No

115.287 (b)
- Does the agency aggregate the incident-based sexual abuse data at least annually?
  ☒ Yes ☐ No

115.287 (c)
- Does the incident-based data include, at a minimum, the data necessary to answer all questions from the most recent version of the Survey of Sexual Violence conducted by the Department of Justice? ☒ Yes ☐ No

115.287 (d)

- Does the agency maintain, review, and collect data as needed from all available incident-based documents, including reports, investigation files, and sexual abuse incident reviews? ☒ Yes ☐ No

115.287 (e)

- Does the agency also obtain incident-based and aggregated data from every private facility with which it contracts for the confinement of its residents? (N/A if agency does not contract for the confinement of its residents.) ☐ Yes ☐ No ☒ NA

115.287 (f)

- Does the agency, upon request, provide all such data from the previous calendar year to the Department of Justice no later than June 30? (N/A if DOJ has not requested agency data.) ☐ Yes ☐ No ☒ NA

Auditor Overall Compliance Determination

☐ Exceeds Standard (Substantially exceeds requirement of standards)

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

☐ Does Not Meet Standard (Requires Corrective Action)

Instructions for Overall Compliance Determination Narrative

(A) PEER 1 will collect accurate, uniform data for every allegation of sexual abuse at each program utilizing a standardized instrument and set of definitions. This information will be recorded using the PREA Incident Report for most data points. Demographic data is readily accessible through the electronic health record system.

(B) The PREA Coordinator or Designee shall aggregate the incident-based sexual abuse data at least annually, on a cycle which runs from January-December of each year.

(C) The incident based data collected shall include, at a minimum, the data necessary to answer all questions from the most recent version of the Survey of Sexual Violence conducted by the Department of Justice.

(D) The agency shall maintain, review and collect data as needed from all available incident-based documents including reports, investigation files, and sexual abuse incident reviews.
All PREA Reporting Documents are retained in a PREA Binder in the office of the PREA Coordinator, and/or stored as electronic files and/or stored in secure offsite storage accessible to the PREA Coordinator and/or Program Director.

(E) Peer I does not contract with private facilities for the confinement of residents.

(F) Upon request to the Program Director or PREA Coordinator, Peer I will provide all such data from the previous calendar year to the Department of Justice no later than June 30th.

PEER 1 logs information on each incident and secure the files in a cabinet in the PREA coordinators office.

They review the information annually and provide such data when requested.

Evidence Relied Upon
Pre-Audit Questionnaire
Submitted Policies
Interviews with various individuals

PEER 1 is in compliance with this standard.

**Standard 115.288: Data review for corrective action**

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.288 (a)

- Does the agency review data collected and aggregated pursuant to § 115.287 in order to assess and improve the effectiveness of its sexual abuse prevention, detection, and response policies, practices, and training, including by: Identifying problem areas? ☒ Yes ☐ No

- Does the agency review data collected and aggregated pursuant to § 115.287 in order to assess and improve the effectiveness of its sexual abuse prevention, detection, and response policies, practices, and training, including by: Taking corrective action on an ongoing basis? ☒ Yes ☐ No

- Does the agency review data collected and aggregated pursuant to § 115.287 in order to assess and improve the effectiveness of its sexual abuse prevention, detection, and response policies, practices, and training, including by: Preparing an annual report of its findings and corrective actions for each facility, as well as the agency as a whole? ☒ Yes ☐ No

115.288 (b)

- Does the agency’s annual report include a comparison of the current year’s data and corrective actions with those from prior years and provide an assessment of the agency’s progress in addressing sexual abuse? ☒ Yes ☐ No
115.288 (c)

- Is the agency’s annual report approved by the agency head and made readily available to the public through its website or, if it does not have one, through other means? ☒ Yes ☐ No

115.288 (d)

- Does the agency indicate the nature of the material redacted where it redacts specific material from the reports when publication would present a clear and specific threat to the safety and security of a facility? ☒ Yes ☐ No

Auditor Overall Compliance Determination

☐ Exceeds Standard *(Substantially exceeds requirement of standards)*

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

☐ Does Not Meet Standard *(Requires Corrective Action)*

Instructions for Overall Compliance Determination Narrative

(A) PEER 1 will collect accurate, uniform data for every allegation of sexual abuse at each program utilizing a standardized instrument and set of definitions. This information will be recorded using the PREA Incident Report for most data points. Demographic data is readily accessible through the electronic health record system.

(B) The PREA Coordinator or Designee shall aggregate the incident-based sexual abuse data at least annually, on a cycle which runs from January-December of each year.

(C) The incident based data collected shall include, at a minimum, the data necessary to answer all questions from the most recent version of the Survey of Sexual Violence conducted by the Department of Justice.

(D) The agency shall maintain, review and collect data as needed from all available incident-based documents including reports, investigation files, and sexual abuse incident reviews. All PREA Reporting Documents are retained in a PREA Binder in the office of the PREA Coordinator, and/or stored as electronic files and/or stored in secure offsite storage accessible to the PREA Coordinator and/or Program Director.

(E) Peer I does not contract with private facilities for the confinement of residents.

(F) Upon request to the Program Director or PREA Coordinator, of Peer 1 provide all such data from the previous calendar year to the Department of Justice no later than June 30th.

PEER 1 has a policy covering this standard:
The policy mandates the collection of accurate and uniformed information for every allegation. PEER 1 maintains these findings in a secure cabinet in the PREA compliance managers’ office.

Peer 1 does not contract with other facilities due to their residents mainly coming from a confinement setting.

They aggregate the data yearly and report these findings upon request to the DOJ.

Minor correction: Page 2 of this policy indicates the policy is 115.286 and it should be 115.288.

Evidence Relied Upon
Pre-Audit Questionnaire
Submitted Policies

PEER 1 is in compliance with this standard.

**Standard 115.289: Data storage, publication, and destruction**

**All Yes/No Questions Must Be Answered by the Auditor to Complete the Report**

**115.289 (a)**
- Does the agency ensure that data collected pursuant to § 115.287 are securely retained? ☒ Yes ☐ No

**115.289 (b)**
- Does the agency make all aggregated sexual abuse data, from facilities under its direct control and private facilities with which it contracts, readily available to the public at least annually through its website or, if it does not have one, through other means? ☒ Yes ☐ No

**115.289 (c)**
- Does the agency remove all personal identifiers before making aggregated sexual abuse data publicly available? ☒ Yes ☐ No

**115.289 (d)**
- Does the agency maintain sexual abuse data collected pursuant to § 115.287 for at least 10 years after the date of the initial collection, unless Federal, State, or local law requires otherwise? ☒ Yes ☐ No

**Auditor Overall Compliance Determination**

☐ Exceeds Standard *(Substantially exceeds requirement of standards)*
☒ Meets Standard (Substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (Requires Corrective Action)

Instructions for Overall Compliance Determination Narrative

(a) The Peer 1 program shall ensure that data collected pursuant to § 115.287 (Data Collection) are securely retained. Data collected relevant to specific, individual allegations is retained in a The PREA Investigation Reports Binder, which is stored in a locked cabinet in the PREA Coordinator’s Office.

(b) The Peer 1 program publishes aggregated sexual abuse data, from their facilities, readily available to the public annually through the website www.artstreatment.org, on the PREA page, which is easily accessible via the landing page. Program data for Peer 1 and The Haven will be reported and published separately.

(c) Peer 1 will remove all personal identifiers prior to publishing aggregated sexual abuse data. If data to be published is inherently identifying due to the low volume of sexual abuse allegations, Peer 1 and the Haven will consult with regulating bodies (OBH, DCJ, SIGNAL Behavioral Health Network) and ARTS Management and/or legal counsel prior to publishing any data.

(d) The program shall maintain sexual abuse data collected pursuant to § 115.287 (Data Collection) for at least 10 years after the date of the initial collection unless Federal, State or local law requires otherwise. Electronic data will be secured on a secure server accessible to, at minimum, PREA Coordinators and Program Directors. Paper copies of the respective program’s data (The Haven/Peer 1) will be maintained in the PREA Coordinator’s office.

As stated in 115.287, PEER 1 maintains the protected data in a secured area; their website allows the public to view the data of both incidents and previous PREA audit findings.

They maintain their findings and only authorized personnel (PREA manager and the director) have access to this information.

Interviews with both the PREA manager and director confirmed their knowledge and practice of this standard.

Evidence Relied Upon

Pre-Audit Questionnaire

Submitted Policies

Interviews with various individuals

PEER 1 is in compliance with this standard.

AUDITING AND CORRECTIVE ACTION
Standard 115.401: Frequency and scope of audits

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.401 (a)

- During the prior three-year audit period, did the agency ensure that each facility operated by the agency, or by a private organization on behalf of the agency, was audited at least once? ([Note: The response here is purely informational. A “no” response does not impact overall compliance with this standard.] ☐ Yes ☒ No)

115.401 (b)

- Is this the first year of the current audit cycle? ([Note: a “no” response does not impact overall compliance with this standard.] ☐ Yes ☒ No)

- If this is the second year of the current audit cycle, did the agency ensure that at least one-third of each facility type operated by the agency, or by a private organization on behalf of the agency, was audited during the first year of the current audit cycle? (N/A if this is not the second year of the current audit cycle.) ☐ Yes ☒ No ☒ NA

- If this is the third year of the current audit cycle, did the agency ensure that at least two-thirds of each facility type operated by the agency, or by a private organization on behalf of the agency, were audited during the first two years of the current audit cycle? (N/A if this is not the third year of the current audit cycle.) ☐ Yes ☒ No ☒ NA

115.401 (h)

- Did the auditor have access to, and the ability to observe, all areas of the audited facility? ☒ Yes ☐ No

115.401 (i)

- Was the auditor permitted to request and receive copies of any relevant documents (including electronically stored information)? ☒ Yes ☐ No

115.401 (m)

- Was the auditor permitted to conduct private interviews with inmates, residents, and detainees? ☒ Yes ☐ No

115.401 (n)

- Were residents permitted to send confidential information or correspondence to the auditor in the same manner as if they were communicating with legal counsel? ☒ Yes ☐ No
Auditor Overall Compliance Determination

☐ Exceeds Standard (Substantially exceeds requirement of standards)
☒ Meets Standard (Substantial compliance; complies in all material ways with the standard for the relevant review period)
☐ Does Not Meet Standard (Requires Corrective Action)

Instructions for Overall Compliance Determination Narrative

Regarding the other parts to the standard please see below:

Auditors were allowed access to all areas to include bedrooms, kitchens, basements, and administrative offices.

PEER 1 administrators allowed auditors access to both staff and residents without interruptions.

PEER 1 staff were very accommodating in allowing auditors access to their facility, they were transparent with their documentation.

On May 11, 2018, The Signal Quality Management Committee conducted an on-site visit and reported no issues that needed to be addressed.

PEER 1 is in compliance with this standard.

Standard 115.403: Audit contents and findings

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.403 (f)

- The agency has published on its agency website, if it has one, or has otherwise made publicly available, all Final Audit Reports within 90 days of issuance by auditor. The review period is for prior audits completed during the past three years PRECEDING THIS AGENCY AUDIT. In the case of single facility agencies, the auditor shall ensure that the facility’s last audit report was published. The pendency of any agency appeal pursuant to 28 C.F.R. § 115.405 does not excuse noncompliance with this provision. (N/A if there have been no Final Audit Reports issued in the past three years, or in the case of single facility agencies that there has never been a Final Audit Report issued.) ☒ Yes ☐ No ☐ NA

Auditor Overall Compliance Determination

☐ Exceeds Standard (Substantially exceeds requirement of standards)
☒ Meets Standard *(Substantial compliance; complies in all material ways with the standard for the relevant review period)*

☐ Does Not Meet Standard *(Requires Corrective Action)*

**Instructions for Overall Compliance Determination Narrative**

PEER 1 posted the last audit (2015) on the website and is available to the public for review.
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.

Auditor Instructions:

Type your full name in the text box below for Auditor Signature. This will function as your official electronic signature. Auditors must deliver their final report to the PREA Resource Center as a searchable PDF format to ensure accessibility to people with disabilities. Save this report document into a PDF format prior to submission. Auditors are not permitted to submit audit reports that have been scanned. See the PREA Auditor Handbook for a full discussion of audit report formatting requirements.

Kenneth L Juranek  
January 31, 2019

Auditor Signature  
Date

1 See additional instructions here: https://support.office.com/en-us/article/Save-or-convert-to-PDF-d85416c5-7d77-4fd6-a216-6f4bf7c7c110.