

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

☐ Interim ☒ Final

Date of Interim Audit Report: Click or tap here to enter text. ☒ N/A

If no Interim Audit Report, select N/A

Date of Final Audit Report: January 18, 2022

Auditor Information

Name: Natasha Mitchell	Email: nshaferdu@gmail.com
Company Name: J&F Collaboration and Consulting, LLC	
Mailing Address: PO Box 110993	City, State, Zip: Aurora, CO
Telephone: 720-371-2172	Date of Facility Visit: Click or tap here to enter text.

Agency Information

Name of Agency: University of Colorado Anschutz/The Haven			
Governing Authority or Parent Agency <i>(If Applicable)</i> : Regents of the University of Colorado			
Physical Address: 3630 W. Princeton Circle		City, State, Zip: Denver, CO 80236	
Mailing Address: 3732 W, Princeton Circle		City, State, Zip: Denver, CO 80236	
The Agency Is:	<input type="checkbox"/> Military	<input type="checkbox"/> Private for Profit	<input type="checkbox"/> Private not for Profit
<input type="checkbox"/> Municipal	<input type="checkbox"/> County	<input checked="" type="checkbox"/> State	<input type="checkbox"/> Federal
Agency Website with PREA Information: www.artstreatment.com			

Agency Chief Executive Officer

Name: Kristen Dixon	
Email: Kristen.dixon@cuanschutz.edu	Telephone: 303-734-5022

Agency-Wide PREA Coordinator

Name: Toni Wright	
Email: toni.wright@cuanschutz.edu	Telephone: 303-734-3376
PREA Coordinator Reports to: Daniele Wolff	Number of Compliance Managers who report to the PREA Coordinator: 0

Facility Information

Name of Facility: The Haven

Physical Address: 3630 W. Princeton Circle

City, State, Zip: Denver, CO 80236

Mailing Address (if different from above):

Click or tap here to enter text.

City, State, Zip: Click or tap here to enter text.

The Facility Is:

☐ Military

☐ Private for Profit

☐ Private not for Profit

☐ Municipal

☐ County

☒ State

☐ Federal

Facility Website with PREA Information: www.artstreatment.com

Has the facility been accredited within the past 3 years? ☐ Yes ☒ No

If the facility has been accredited within the past 3 years, select the accrediting organization(s) – select all that apply (N/A if the facility has not been accredited within the past 3 years):

☐ ACA

☐ NCCHC

☐ CALEA

☐ Other (please name or describe: Click or tap here to enter text.

☒ N/A

If the facility has completed any internal or external audits other than those that resulted in accreditation, please describe:

Click or tap here to enter text.

Facility Director

Name: Daniele Wolff

Email: daniele.wolff@cuanschultz.edu

Telephone: 303-734-3346

Facility PREA Compliance Manager

Name: Toni Wright

Email: toni.wright@cuanschultz.edu

Telephone: 303-734-3376

Facility Health Service Administrator ☒ N/A

Name: Click or tap here to enter text.

Email: Click or tap here to enter text.

Telephone: Click or tap here to enter text.

Facility Characteristics

Designated Facility Capacity:

20

Current Population of Facility:

12

Average daily population for the past 12 months:

16

Has the facility been over capacity at any point in the past 12 months?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Which population(s) does the facility hold?	<input checked="" type="checkbox"/> Females <input type="checkbox"/> Males <input type="checkbox"/> Both Females and Males	
Age range of population:	18+/ no maximum age limit	
Average length of stay or time under supervision	1 year	
Facility security levels/resident custody levels	Minimum/ Therapeutic Community	
Number of residents admitted to facility during the past 12 months	28	
Number of residents admitted to facility during the past 12 months whose length of stay in the facility was for 72 hours or more:	27	
Number of residents admitted to facility during the past 12 months whose length of stay in the facility was for 30 days or more:	20	
Does the audited facility hold residents for one or more other agencies (e.g. a State correctional agency, U.S. Marshals Service, Bureau of Prisons, U.S. Immigration and Customs Enforcement)?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Select all other agencies for which the audited facility holds residents: Select all that apply (N/A if the audited facility does not hold residents for any other agency or agencies):	<input type="checkbox"/> Federal Bureau of Prisons <input type="checkbox"/> U.S. Marshals Service <input type="checkbox"/> U.S. Immigration and Customs Enforcement <input type="checkbox"/> Bureau of Indian Affairs <input type="checkbox"/> U.S. Military branch <input type="checkbox"/> State or Territorial correctional agency <input type="checkbox"/> County correctional or detention agency <input type="checkbox"/> Judicial district correctional or detention facility <input type="checkbox"/> City or municipal correctional or detention facility (e.g. police lockup or city jail) <input type="checkbox"/> Private corrections or detention provider <input type="checkbox"/> Other - please name or describe: Click or tap here to enter text. <input checked="" type="checkbox"/> N/A	
Number of staff currently employed by the facility who may have contact with residents:	15	
Number of staff hired by the facility during the past 12 months who may have contact with residents:	6	
Number of contracts in the past 12 months for services with contractors who may have contact with residents:	0	
Number of individual contractors who have contact with residents, currently authorized to enter the facility:	0	
Number of volunteers who have contact with residents, currently authorized to enter the facility:	0	

Physical Plant

Number of buildings:

Auditors should count all buildings that are part of the facility, whether residents are formally allowed to enter them or not. In situations where temporary structures have been erected (e.g., tents) the auditor should use their discretion to determine whether to include the structure in the overall count of buildings. As a general rule, if a temporary structure is regularly or routinely used to hold or house residents, or if the temporary structure is used to house or support operational functions for more than a short period of time (e.g., an emergency situation), it should be included in the overall count of buildings.

2

Number of resident housing units:

Enter 0 if the facility does not have discrete housing units. DOJ PREA Working Group FAQ on the definition of a housing unit: How is a "housing unit" defined for the purposes of the PREA Standards? The question has been raised in particular as it relates to facilities that have adjacent or interconnected units. The most common concept of a housing unit is architectural. The generally agreed-upon definition is a space that is enclosed by physical barriers accessed through one or more doors of various types, including commercial-grade swing doors, steel sliding doors, interlocking sally port doors, etc. In addition to the primary entrance and exit, additional doors are often included to meet life safety codes. The unit contains sleeping space, sanitary facilities (including toilets, lavatories, and showers), and a dayroom or leisure space in differing configurations. Many facilities are designed with modules or pods clustered around a control room. This multiple-pod design provides the facility with certain staff efficiencies and economies of scale. At the same time, the design affords the flexibility to separately house residents of differing security levels, or who are grouped by some other operational or service scheme. Generally, the control room is enclosed by security glass, and in some cases, this allows residents to see into neighboring pods. However, observation from one unit to another is usually limited by angled site lines. In some cases, the facility has prevented this entirely by installing one-way glass. Both the architectural design and functional use of these multiple pods indicate that they are managed as distinct housing units.

1

Number of single resident cells, rooms, or other enclosures:

2

Number of multiple occupancy cells, rooms, or other enclosures:

9

Number of open bay/dorm housing units:

0

Does the facility have a video monitoring system, electronic surveillance system, or other monitoring technology (e.g. cameras, etc.)?

☒ Yes ☐ No

Has the facility installed or updated a video monitoring system, electronic surveillance system, or other monitoring technology in the past 12 months?

☐ Yes ☒ No

Medical and Mental Health Services and Forensic Medical Exams

Are medical services provided on-site?

☐ Yes ☒ No

Are mental health services provided on-site?

☒ Yes ☐ No

<p>Where are sexual assault forensic medical exams provided? Select all that apply.</p>	<input type="checkbox"/> On-site <input type="checkbox"/> Local hospital/clinic <input type="checkbox"/> Rape Crisis Center <input checked="" type="checkbox"/> Other (please name or describe: Denver Health Medical Center)	
Investigations		
Criminal Investigations		
<p>Number of investigators employed by the agency and/or facility who are responsible for conducting CRIMINAL investigations into allegations of sexual abuse or sexual harassment:</p>	<p>0</p>	
<p>When the facility received allegations of sexual abuse or sexual harassment (whether staff-on-resident or resident-on-resident), CRIMINAL INVESTIGATIONS are conducted by: Select all that apply.</p>	<input type="checkbox"/> Facility investigators <input type="checkbox"/> Agency investigators <input checked="" type="checkbox"/> An external investigative entity	
<p>Select all external entities responsible for CRIMINAL INVESTIGATIONS: Select all that apply (N/A if no external entities are responsible for criminal investigations)</p>	<input type="checkbox"/> Local police department <input type="checkbox"/> Local sheriff's department <input type="checkbox"/> State police <input type="checkbox"/> A U.S. Department of Justice component <input checked="" type="checkbox"/> Other (please name or describe: Denver Sex Crimes Unit) <input type="checkbox"/> N/A	
Administrative Investigations		
<p>Number of investigators employed by the agency and/or facility who are responsible for conducting ADMINISTRATIVE investigations into allegations of sexual abuse or sexual harassment?</p>	<p>1</p>	
<p>When the facility receives allegations of sexual abuse or sexual harassment (whether staff-on-resident or resident-on-resident), ADMINISTRATIVE INVESTIGATIONS are conducted by: Select all that apply</p>	<input checked="" type="checkbox"/> Facility investigators <input type="checkbox"/> Agency investigators <input type="checkbox"/> An external investigative entity	
<p>Select all external entities responsible for ADMINISTRATIVE INVESTIGATIONS: Select all that apply (N/A if no external entities are responsible for administrative investigations)</p>	<input type="checkbox"/> Local police department <input type="checkbox"/> Local sheriff's department <input type="checkbox"/> State police <input type="checkbox"/> A U.S. Department of Justice component <input type="checkbox"/> Other (please name or describe: Click or tap here to enter text.) <input checked="" type="checkbox"/> N/A	

Summary of Audit Findings

The summary should include the number and list of standards exceeded, number of standards met, and number and list of standards not met.

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

Standards Exceeded

Number of Standards Exceeded: 2
List of Standards Exceeded: 115.241, 115.251

Standards Met

Number of Standards Met: 38

Standards Not Met

Number of Standards Not Met: Click or tap here to enter text.
List of Standards Not Met: Click or tap here to enter text.

Post-Audit Reporting Information

General Audit Information	
Onsite Audit Dates	
1. Start date of the onsite portion of the audit:	November 4, 2021
2. End date of the onsite portion of the audit:	November 9, 2021
Outreach	
3. Did you attempt to communicate with community-based organization(s) or victim advocates who provide services to this facility and/or who may have insight into relevant conditions in the facility?	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
a. If yes, identify the community-based organizations or victim advocates with whom you corresponded:	The Blue Bench
Audited Facility Information	
4. Designated Facility Capacity:	20
5. Average daily population for the past 12 months:	16
6. Number of inmate/resident/detainee housing units: DOJ PREA Working Group FAQ on the definition of a housing unit: How is a "housing unit" defined for the purposes of the PREA Standards? The question has been raised in particular as it relates to facilities that have adjacent or interconnected units. The most common concept of a housing unit is architectural. The generally agreed-upon definition is a space that is enclosed by physical barriers accessed through one or more doors of various types, including commercial-grade swing doors, steel sliding doors, interlocking sally port doors, etc. In addition to the primary entrance and exit, additional doors are often included to meet life safety codes. The unit contains sleeping space, sanitary facilities (including toilets, lavatories, and showers), and a dayroom or leisure space in differing configurations. Many facilities are designed with modules or pods clustered around a control room. This multiple-pod design provides the facility with certain staff efficiencies and economies of scale. At the same time, the design affords the flexibility to separately house inmates of differing security levels, or who are grouped by some other operational or service scheme. Generally, the control room is enclosed by security glass, and in some cases, this allows residents to see into neighboring pods. However, observation from one unit to another is usually limited by angled site lines. In some cases, the facility has prevented this entirely by installing one-way glass. Both the architectural design and functional use of these multiple pods indicate that they are managed as distinct housing units.	1
7. Does the facility ever hold youthful inmates or youthful/juvenile detainees?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> N/A for the facility type audited (i.e., Community Confinement Facility or Juvenile Facility)

Audited Facility Population on Day One of the Onsite Portion of the Audit	
<i>Inmates/Residents/Detainees</i>	
8. Enter the total number of inmates/residents/detainees housed at the facility as of the first day of the onsite portion of the audit:	12
9. Enter the total number of youthful inmates or youthful/juvenile detainees housed at the facility on the first day of the onsite portion of the audit:	0
10. Enter the total number of inmates/residents/detainees with a physical disability housed at the facility as of the first day of the onsite portion of the audit:	0
11. Enter the total number of inmates/residents/detainees with a cognitive or functional disability (including intellectual disability, psychiatric disability, or speech disability) housed at the facility as of the first day of the onsite portion of the audit:	0
12. Enter the total number of inmates/residents/detainees who are Blind or have low vision (visually impaired) housed at the facility on the first day of the onsite portion of the audit:	0
13. Enter the total number of inmates/residents/detainees who are Deaf or hard-of-hearing housed at the facility on the first day of the onsite portion of the audit:	0
14. Enter the total number of inmates/residents/detainees who are Limited English Proficient (LEP) housed at the facility as of the first day of the onsite portion of the audit:	0
15. Enter the total number of inmates/residents/detainees who identify as lesbian, gay, or bisexual housed at the facility as of the first day of the onsite portion of the audit:	0
16. Enter the total number of inmates/residents/detainees who identify as transgender, or intersex housed at the facility as of the first day of the onsite portion of the audit:	0
17. Enter the total number of inmates/residents/detainees who reported sexual abuse in this facility who are housed at the facility as of the first day of the onsite portion of the audit:	0
18. Enter the total number of inmates/residents/detainees who reported sexual harassment in this facility who are housed at the facility as of the first day of the onsite portion of the audit:	0
19. Enter the total number of inmates/residents/detainees who disclosed prior sexual victimization during risk screening housed at the facility as of the first day of the onsite portion of the audit:	3
20. Enter the total number of inmates/residents/detainees who are or were ever placed in segregated housing/isolation for risk of sexual victimization housed at the facility as of the first day of the onsite portion of the audit:	0
21. Enter the total number of inmates/residents/detainees who are or were ever placed in segregated housing/isolation for having reported sexual abuse in this facility as of the first day of the onsite portion of the audit:	0
22. Enter the total number of inmates/residents detained	0

solely for civil immigration purposes housed at the facility as of the first day of the onsite portion of the audit:	
23. Provide any additional comments regarding the population characteristics of inmates/residents/detainees in the facility as of the first day of the onsite portion of the audit (e.g., groups not tracked, issues with identifying certain populations). <i>Note: as this text will be included in the audit report, please do not include any personally identifiable information or other information that could compromise the confidentiality of any persons in the facility.</i>	Click or tap here to enter text.
Staff, Volunteers, and Contractors <i>Include all full- and part-time staff employed by the facility, regardless of their level of contact with inmates/residents/detainees</i>	
24. Enter the total number of STAFF, including both full- and part-time staff employed by the facility as of the first day of the onsite portion of the audit:	15
25. Enter the total number of CONTRACTORS assigned to the facility as of the first day of the onsite portion of the audit who have contact with inmates/residents/detainees:	0
26. Enter the total number of VOLUNTEERS assigned to the facility as of the first day of the onsite portion of the audit who have contact with inmates/residents/detainees:	0
27. Provide any additional comments regarding the population characteristics of staff, volunteers, and contractors who were in the facility as of the first day of the onsite portion of the audit. <i>Note: as this text will be included in the audit report, please do not include any personally identifiable information or other information that could compromise the confidentiality of any persons in the facility.</i>	The Haven is a 20-bed residential Modified Therapeutic Community (MTC) that provides treatment for adult women with chronic substance use disorders and co-occurring mental health disorders.
Interviews	
Inmate/Resident/Detainee Interviews	
<i>Random Inmate/Resident/Detainee Interviews</i>	
28. Enter the total number of RANDOM INMATES/RESIDENTS/DETAINEES who were interviewed:	8
29. Select which characteristics you considered when you selected random inmate/resident/detainee interviewees:	<input type="checkbox"/> Age <input type="checkbox"/> Race <input type="checkbox"/> Ethnicity (e.g., Hispanic, Non-Hispanic) <input type="checkbox"/> Length of time in the facility <input type="checkbox"/> Housing assignment <input type="checkbox"/> Gender <input type="checkbox"/> Other (describe) Click or tap here to enter text. <input checked="" type="checkbox"/> None (explain) Interviewed all of the clients that did not fall into the special characterization category.

30. How did you ensure your sample of random inmate/resident/detainee interviewees was geographically diverse?	This auditor interviewed all twelve of the clients residing at the facility during the on-site audit.
31. Were you able to conduct the minimum number of random inmate/resident/detainee interviews?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
a. If no, explain why it was not possible to interview the minimum number of random inmate/resident/detainee interviews:	The client population was twelve and three of the clients were interviewed using the special characteristic category.
32. Provide any additional comments regarding selecting or interviewing random inmates/residents/detainees (e.g., any populations you oversampled, barriers to completing interviews, barriers to ensuring representation, etc.). <i>Note: as this text will be included in the audit report, please do not include any personally identifiable information or other information that could compromise the confidentiality of any persons in the facility.</i>	Click or tap here to enter text.

Targeted Inmate/Resident/Detainee Interviews

33. Enter the total number of TARGETED INMATES/RESIDENTS/DETAINEES who were interviewed: <i>As stated in the PREA Auditor Handbook, the breakdown of targeted interviews is intended to guide auditors in interviewing the appropriate cross-section of inmates/residents/detainees who are the most vulnerable to sexual abuse and sexual harassment. When completing questions regarding targeted inmate/resident/detainee interviews below, remember that an interview with one inmate/resident/detainee may satisfy multiple targeted interview requirements. These questions are asking about the number of interviews conducted using the targeted inmate/resident/detainee protocols.</i> <i>For example, if an auditor interviews an inmate who has a physical disability, is being held in segregated housing due to risk of sexual victimization, and disclosed prior sexual victimization, that interview would be included in the totals for each of those questions. Therefore, in most cases, the sum of all the following responses to the targeted inmate/resident/detainee interview categories will exceed the total number of targeted inmates/residents/detainees who were interviewed.</i> <i>If a particular targeted population is not applicable in the audited facility, enter "0".</i>	3
34. Enter the total number of interviews conducted with youthful inmates or youthful/juvenile detainees using the "Youthful Inmates" protocol:	0
a. If 0, select why you were unable to conduct at least the minimum required number of targeted inmates/residents/detainees in this category:	<input checked="" type="checkbox"/> Facility said there were "none here" during the onsite portion of the audit and/or the facility was unable to provide a list of these inmates/residents/detainees. <input type="checkbox"/> The inmates/residents/detainees in this targeted category declined to be interviewed.

b. If 0, discuss your corroboration strategies to determine if this population exists in the audited	The auditor interviewed the Program Director and PREA Coordinator prior to conducting client interviews; the interviews
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facility (e.g., based on information obtained from the PAQ; documentation reviewed onsite; and discussions with staff and other inmates/residents/detainees).	indicated there was no one residing in the facility that met this special characteristic. This information was corroborated through a random review of the facility risk screening tool as well as interviews with clients and their perceptions of other clients. <input type="checkbox"/>
35. Enter the total number of interviews conducted with inmates/residents/detainees with a physical disability using the “Disabled and Limited English Proficient Inmates” protocol:	0
a. If 0, select why you were unable to conduct at least the minimum required number of targeted inmates/residents/detainees in this category:	<input checked="" type="checkbox"/> Facility said there were “none here” during the onsite portion of the audit and/or the facility was unable to provide a list of these inmates/residents/detainees. <input type="checkbox"/> The inmates/residents/detainees in this targeted category declined to be interviewed.
b. If 0, discuss your corroboration strategies to determine if this population exists in the audited facility (e.g., based on information obtained from the PAQ; documentation reviewed onsite; and discussions with staff and other inmates/residents/detainees).	The auditor interviewed the Program Director and PREA Coordinator prior to conducting client interviews; the interviews indicated there was no one residing in the facility that met this special characteristic. This information was corroborated through a random review of the facility risk screening tool as well as interviews with clients and their perceptions of other clients. <input type="checkbox"/>
36. Enter the total number of interviews conducted with inmates/residents/detainees with a cognitive or functional disability (including intellectual disability, psychiatric disability, or speech disability) using the “Disabled and Limited English Proficient Inmates” protocol:	0
a. If 0, select why you were unable to conduct at least the minimum required number of targeted inmates/residents/detainees in this category:	<input checked="" type="checkbox"/> Facility said there were “none here” during the onsite portion of the audit and/or the facility was unable to provide a list of these inmates/residents/detainees. <input type="checkbox"/> The inmates/residents/detainees in this targeted category declined to be interviewed.
b. If 0, discuss your corroboration strategies to determine if this population exists in the audited facility (e.g., based on information obtained from the PAQ; documentation reviewed onsite; and discussions with staff and other inmates/residents/detainees).	The auditor interviewed the Program Director and PREA Coordinator prior to conducting client interviews; the interviews indicated there was no one residing in the facility that met this special characteristic. This information was corroborated through a random review of the facility risk screening tool as well as interviews with clients and their perceptions of other clients. <input type="checkbox"/>
37. Enter the total number of interviews conducted with inmates/residents/detainees who are Blind or have low vision (visually impaired) using the “Disabled and Limited English Proficient Inmates” protocol:	0
a. If 0, select why you were unable to conduct at least the minimum required number of targeted inmates/residents/detainees in this category:	<input checked="" type="checkbox"/> Facility said there were “none here” during the onsite portion of the audit and/or the facility was unable to provide a list of these inmates/residents/detainees. <input type="checkbox"/> The inmates/residents/detainees in this targeted category declined to be interviewed.
b. If 0, discuss your corroboration strategies to determine if this population exists in the audited facility (e.g., based on information obtained from the PAQ; documentation reviewed onsite; and discussions with staff and other inmates/residents/detainees).	The auditor interviewed the Program Director and PREA Coordinator prior to conducting client interviews; the interviews indicated there was no one residing in the facility that met this special characteristic. This information was corroborated through a random review of the facility risk screening tool as well as interviews with clients and their perceptions of other clients. <input type="checkbox"/>

38. Enter the total number of interviews conducted with inmates/residents/detainees who are Deaf or hard-of-hearing using the “Disabled and Limited English Proficient Inmates” protocol:	0
a. If 0, select why you were unable to conduct at least the minimum required number of targeted inmates/residents/detainees in this category:	<input checked="" type="checkbox"/> Facility said there were “none here” during the onsite portion of the audit and/or the facility was unable to provide a list of these inmates/residents/detainees. <input type="checkbox"/> The inmates/residents/detainees in this targeted category declined to be interviewed.
b. If 0, discuss your corroboration strategies to determine if this population exists in the audited facility (e.g., based on information obtained from the PAQ; documentation reviewed onsite; and discussions with staff and other inmates/residents/detainees).	The auditor interviewed the Program Director and PREA Coordinator prior to conducting client interviews; the interviews indicated there was no one residing in the facility that met this special characteristic. This information was corroborated through a random review of the facility risk screening tool as well as interviews with clients and their perceptions of other clients. <input type="checkbox"/>
39. Enter the total number of interviews conducted with inmates/residents/detainees who are Limited English Proficient (LEP) using the “Disabled and Limited English Proficient Inmates” protocol:	0
a. If 0, select why you were unable to conduct at least the minimum required number of targeted inmates/residents/detainees in this category:	<input checked="" type="checkbox"/> Facility said there were “none here” during the onsite portion of the audit and/or the facility was unable to provide a list of these inmates/residents/detainees. <input type="checkbox"/> The inmates/residents/detainees in this targeted category declined to be interviewed.
b. If 0, discuss your corroboration strategies to determine if this population exists in the audited facility (e.g., based on information obtained from the PAQ; documentation reviewed onsite; and discussions with staff and other inmates/residents/detainees).	The auditor interviewed the Program Director and PREA Coordinator prior to conducting client interviews; the interviews indicated there was no one residing in the facility that met this special characteristic. This information was corroborated through a random review of the facility risk screening tool as well as interviews with clients and their perceptions of other clients. <input type="checkbox"/>
40. Enter the total number of interviews conducted with inmates/residents/detainees who identify as lesbian, gay, or bisexual using the “Transgender and Intersex Inmates; Gay, Lesbian, and Bisexual Inmates” protocol:	0
a. If 0, select why you were unable to conduct at least the minimum required number of targeted inmates/residents/detainees in this category:	<input checked="" type="checkbox"/> Facility said there were “none here” during the onsite portion of the audit and/or the facility was unable to provide a list of these inmates/residents/detainees. <input type="checkbox"/> The inmates/residents/detainees in this targeted category declined to be interviewed.
b. If 0, discuss your corroboration strategies to determine if this population exists in the audited facility (e.g., based on information obtained from the PAQ; documentation reviewed onsite; and discussions with staff and other inmates/residents/detainees).	The auditor interviewed the Program Director and PREA Coordinator prior to conducting client interviews; the interviews indicated there was no one residing in the facility that met this special characteristic. This information was corroborated through a random review of the facility risk screening tool as well as interviews with clients and their perceptions of other clients. <input type="checkbox"/>
41. Enter the total number of interviews conducted with inmates/residents/detainees who identify as transgender or intersex “Transgender and Intersex Inmates; Gay, Lesbian, and Bisexual Inmates” protocol:	0

<p>a. If 0, select why you were unable to conduct at least the minimum required number of targeted inmates/residents/detainees in this category:</p>	<p><input checked="" type="checkbox"/> Facility said there were “none here” during the onsite portion of the audit and/or the facility was unable to provide a list of these inmates/residents/detainees.</p> <p><input type="checkbox"/> The inmates/residents/detainees in this targeted category declined to be interviewed.</p>
<p>b. If 0, discuss your corroboration strategies to determine if this population exists in the audited facility (e.g., based on information obtained from the PAQ; documentation reviewed onsite; and discussions with staff and other inmates/residents/detainees).</p>	<p>The auditor interviewed the Program Director and PREA Coordinator prior to conducting client interviews; the interviews indicated there was no one residing in the facility that met this special characteristic. This information was corroborated through a random review of the facility risk screening tool as well as interviews with clients and their perceptions of other clients. <input type="checkbox"/></p>
<p>42. Enter the total number of interviews conducted with inmates/residents/detainees who reported sexual abuse in this facility using the “Inmates who Reported a Sexual Abuse” protocol:</p>	<p>0</p>
<p>a. If 0, select why you were unable to conduct at least the minimum required number of targeted inmates/residents/detainees in this category:</p>	<p><input checked="" type="checkbox"/> Facility said there were “none here” during the onsite portion of the audit and/or the facility was unable to provide a list of these inmates/residents/detainees.</p> <p><input type="checkbox"/> The inmates/residents/detainees in this targeted category declined to be interviewed.</p>
<p>b. If 0, discuss your corroboration strategies to determine if this population exists in the audited facility (e.g., based on information obtained from the PAQ; documentation reviewed onsite; and discussions with staff and other inmates/residents/detainees).</p>	<p>The auditor interviewed the Program Director and PREA Coordinator prior to conducting client interviews; the interviews indicated there was no one residing in the facility that met this special characteristic. This information was corroborated through a random review of the facility risk screening tool as well as interviews with clients and their perceptions of other clients. <input type="checkbox"/></p>
<p>43. Enter the total number of interviews conducted with inmates/residents/detainees who disclosed prior sexual victimization during risk screening using the “Inmates who Disclosed Sexual Victimization during Risk Screening” protocol:</p>	<p>3</p>
<p>a. If 0, select why you were unable to conduct at least the minimum required number of targeted inmates/residents/detainees in this category:</p>	<p><input type="checkbox"/> Facility said there were “none here” during the onsite portion of the audit and/or the facility was unable to provide a list of these inmates/residents/detainees.</p> <p><input type="checkbox"/> The inmates/residents/detainees in this targeted category declined to be interviewed.</p>
<p>b. If 0, discuss your corroboration strategies to determine if this population exists in the audited facility (e.g., based on information obtained from the PAQ; documentation reviewed onsite; and discussions with staff and other inmates/residents/detainees).</p>	<p>Click or tap here to enter text.</p>
<p>44. Enter the total number of interviews conducted with inmates/residents/detainees who are or were ever placed in segregated housing/isolation for risk of sexual victimization using the “Inmates Placed in Segregated Housing (for Risk of Sexual Victimization/Who Alleged to have Suffered Sexual Abuse)” protocol:</p>	<p>0</p>
<p>a. If 0, select why you were unable to conduct at least the minimum required number of targeted inmates/residents/detainees in this category:</p>	<p><input checked="" type="checkbox"/> Facility said there were “none here” during the onsite portion of the audit and/or the facility was unable to provide a list of these inmates/residents/detainees.</p> <p><input type="checkbox"/> The inmates/residents/detainees in this targeted category declined to be interviewed.</p>

<p>b. If 0, discuss your corroboration strategies to determine if this population exists in the audited facility (e.g., based on information obtained from the PAQ; documentation reviewed onsite; and discussions with staff and other inmates/residents/detainees).</p>	<p>The Haven is a community confinement facility and during the site review the auditor did not observe an isolation of seclusion area.□□</p>
<p>45. Provide any additional comments regarding selecting or interviewing random inmates/residents/detainees (e.g., any populations you oversampled, barriers to completing interviews, barriers to ensuring representation, etc.).</p> <p><i>Note: as this text will be included in the audit report, please do not include any personally identifiable information or other information that could compromise the confidentiality of any persons in the facility.</i></p>	<p>Click or tap here to enter text.</p>
<p align="center">Staff, Volunteer, and Contractor Interviews</p>	
<p align="center"><i>Random Staff Interviews</i></p>	
<p>46. Enter the total number of RANDOM STAFF who were interviewed:</p>	<p>2</p>
<p>47. Select which characteristics you considered when you selected RANDOM STAFF interviewees (select all that apply):</p>	<p> <input type="checkbox"/> Length of tenure in the facility <input checked="" type="checkbox"/> Shift assignment <input checked="" type="checkbox"/> Work assignment <input type="checkbox"/> Rank (or equivalent) <input type="checkbox"/> Other (describe) Click or tap here to enter text. <input type="checkbox"/> None (explain) Click or tap here to enter text. </p>
<p>48. Were you able to conduct the minimum number of RANDOM STAFF interviews?</p>	<p><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p>
<p>a. If no, select the reasons why you were not able to conduct the minimum number of RANDOM STAFF interviews (select all that apply):</p>	<p> <input type="checkbox"/> Too many staff declined to participate in interviews <input type="checkbox"/> Not enough staff employed by the facility to meet the minimum number of random staff interviews (Note: select this option if there were not enough staff employed by the facility or not enough staff employed by the facility to interview for both random and specialized staff roles). <input type="checkbox"/> Not enough staff available in the facility during the onsite portion of the audit to meet the minimum number of random staff interviews. <input type="checkbox"/> Other (describe) Click or tap here to enter text. </p>
<p>b. Describe the steps you took to select additional RANDOM STAFF interviewees and why you were still unable to meet the minimum number of random staff interviews:</p>	<p>The facility employs a total of 15 staff with many of them in the role of a specialized staff member.</p>
<p>49. Provide any additional comments regarding selecting or interviewing random staff (e.g., any populations you oversampled, barriers to completing interviews, etc.).</p> <p><i>Note: as this text will be included in the audit report, please do not include any personally identifiable information or other information that could compromise the confidentiality of any persons in the facility.</i></p>	<p>Click or tap here to enter text.</p>

Specialized Staff, Volunteers, and Contractor Interviews

Staff in some facilities may be responsible for more than one of the specialized staff duties. Therefore, more than one interview protocol may apply to an interview with a single staff member and that interview would satisfy multiple specialized staff interview requirements.

50. Enter the total number of staff in a SPECIALIZED STAFF role who were interviewed (excluding volunteers and contractors):	5
51. Were you able to interview the Agency Head?	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
a. If no, explain why it was not possible to interview the Agency Head:	Click or tap here to enter text.
52. Were you able to interview the Warden/Facility Director/Superintendent or their designee?	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
a. If no, explain why it was not possible to interview the Warden/Facility Director/Superintendent or their designee:	Click or tap here to enter text.
53. Were you able to interview the PREA Coordinator?	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
a. If no, explain why it was not possible to interview the PREA Coordinator:	Click or tap here to enter text.
54. Were you able to interview the PREA Compliance Manager?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> N/A (N/A if the agency is a single facility agency or is otherwise not required to have a PREA Compliance Manager per the Standards)
a. If no, explain why it was not possible to interview the PREA Compliance Manager:	Click or tap here to enter text.

<p>55. Select which SPECIALIZED STAFF roles were interviewed as part of this audit (select all that apply):</p>	<p> <input type="checkbox"/> Agency contract administrator <input checked="" type="checkbox"/> Intermediate or higher-level facility staff responsible for conducting and documenting unannounced rounds to identify and deter staff sexual abuse and sexual harassment <input type="checkbox"/> Line staff who supervise youthful inmates (if applicable) <input type="checkbox"/> Education and program staff who work with youthful inmates (if applicable) <input type="checkbox"/> Medical staff <input checked="" type="checkbox"/> Mental health staff <input type="checkbox"/> Non-medical staff involved in cross-gender strip or visual searches <input checked="" type="checkbox"/> Administrative (human resources) staff <input checked="" type="checkbox"/> Sexual Assault Forensic Examiner (SAFE) or Sexual Assault Nurse Examiner (SANE) staff <input checked="" type="checkbox"/> Investigative staff responsible for conducting administrative investigations <input type="checkbox"/> Investigative staff responsible for conducting criminal investigations <input checked="" type="checkbox"/> Staff who perform screening for risk of victimization and abusiveness <input checked="" type="checkbox"/> Staff who supervise inmates in segregated housing/residents in isolation <input checked="" type="checkbox"/> Staff on the sexual abuse incident review team <input checked="" type="checkbox"/> Designated staff member charged with monitoring retaliation <input checked="" type="checkbox"/> First responders, both security and non-security staff <input checked="" type="checkbox"/> Intake staff <input type="checkbox"/> Other (describe) Click or tap here to enter text. </p>
<p>56. Did you interview VOLUNTEERS who may have contact with inmates/residents/detainees in this facility?</p>	<p><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p>
<p>a. Enter the total number of VOLUNTEERS who were interviewed:</p>	<p>The facility is currently off-limits to volunteers and has been for 18 months due to COVID-19.</p>
<p>b. Select which specialized VOLUNTEER role(s) were interviewed as part of this audit (select all that apply):</p>	<p> <input type="checkbox"/> Education/programming <input type="checkbox"/> Medical/dental <input type="checkbox"/> Mental health/counseling <input type="checkbox"/> Religious <input type="checkbox"/> Other </p>
<p>57. Did you interview CONTRACTORS who may have contact with inmates/residents/detainees in this facility?</p>	<p><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p>
<p>a. Enter the total number of CONTRACTORS who were interviewed:</p>	<p>The facility does not have a contract with any contract providers.</p>
<p>b. Select which specialized CONTRACTOR role(s) were interviewed as part of this audit (select all that apply):</p>	<p><input type="checkbox"/> Security/detention</p>

	<input type="checkbox"/> Education/programming <input type="checkbox"/> Medical/dental <input type="checkbox"/> Food service <input type="checkbox"/> Maintenance/construction <input type="checkbox"/> Other
58. Provide any additional comments regarding selecting or interviewing specialized staff (e.g., any populations you oversampled, barriers to completing interviews, etc.). <i>Note: as this text will be included in the audit report, please do not include any personally identifiable information or other information that could compromise the confidentiality of any persons in the facility.</i>	Click or tap here to enter text.
Site Review and Documentation Sampling	
Site Review	
<p><i>PREA Standard 115.401(h) states, "The auditor shall have access to, and shall observe, all areas of the audited facilities." In order to meet the requirements in this Standard, the site review portion of the onsite audit must include a thorough examination of the entire facility. The site review is not a casual tour of the facility. It is an active, inquiring process that includes talking with staff and inmates to determine whether, and the extent to which, the audited facility's practices demonstrate compliance with the Standards. Note: discussions related to testing critical functions are expected to be included in the relevant Standard-specific overall determination narratives.</i></p>	
59. Did you have access to all areas of the facility?	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
a. If no, explain what areas of the facility you were unable to access and why.	Click or tap here to enter text.
Was the site review an active, inquiring process that included the following:	
60. Reviewing/examining all areas of the facility in accordance with the site review component of the audit instrument?	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
a. If no, explain why the site review did not include reviewing/examining all areas of the facility.	Click or tap here to enter text.
61. Testing and/or observing all critical functions in the facility in accordance with the site review component of the audit instrument (e.g., intake process, risk screening process, PREA education)?	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
a. If no, explain why the site review did not include testing and/or observing all critical functions in the facility.	Click or tap here to enter text.
62. Informal conversations with inmates/residents/detainees during the site review (encouraged, not required)?	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
63. Informal conversations with staff during the site review (encouraged, not required)?	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
64. Provide any additional comments regarding the site review (e.g., access to areas in the facility, observations, tests of critical functions, or informal conversations). <i>Note: as this text will be included in the audit report, please do not include any personally identifiable information or other information that could compromise the confidentiality of any persons in the facility.</i>	Click or tap here to enter text.

Documentation Sampling

Where there is a collection of records to review—such as staff, contractor, and volunteer training records; background check records; supervisory rounds logs; risk screening and intake processing records; inmate education records; medical files; and investigative files—auditors must self-select for review a representative sample of each type of record.

65. In addition to the proof documentation selected by the agency or facility and provided to you, did you also conduct an auditor-selected sampling of documentation?

☒ Yes ☐ No

66. Provide any additional comments regarding selecting additional documentation (e.g., any documentation you oversampled, barriers to selecting additional documentation, etc.).

Note: as this text will be included in the audit report, please do not include any personally identifiable information or other information that could compromise the confidentiality of any persons in the facility.

The Haven maintains electronic documents. The auditor sat with the PREA Coordinator as well as the staff member responsible for conducting the intake process to review documents. □□

Sexual Abuse and Sexual Harassment Allegations and Investigations in this Facility

Sexual Abuse and Sexual Harassment Allegations and Investigations Overview

Remember the number of allegations should be based on a review of all sources of allegations (e.g., hotline, third-party, grievances) and should not be based solely on the number of investigations conducted.

Note: For question brevity, we use the term “inmate” in the following questions. Auditors should provide information on inmate, resident, or detainee sexual abuse allegations and investigations, as applicable to the facility type being audited.

67. Total number of SEXUAL ABUSE allegations and investigations overview during the 12 months preceding the audit, by incident type:

Instructions: If you are unable to provide information for one or more of the fields below, enter an “X” in the field(s) where information cannot be provided.

	# of sexual abuse allegations	# of criminal investigations	# of administrative investigations	# of allegations that had both criminal and administrative investigations
<u>Resident-on-resident</u> sexual abuse	0	0	0	0
<u>Staff-on-resident</u> sexual abuse	0	0	0	0
Total	0	0	0	0

a. If you were unable to provide any of the information above, explain why this information could not be provided.

The facility received one staff on client report that involved a local law enforcement investigation. The investigation was conducted within the facility as if it were a PREA allegation.

68. Total number of SEXUAL HARASSMENT allegations and investigations overview during the 12 months preceding the audit, by incident type:

Instructions: If you are unable to provide information for one or more of the fields below, enter an "X" in the field(s) where information cannot be provided.

	# of sexual harassment allegations	# of criminal investigations	# of administrative investigations	# of allegations that had both criminal and administrative investigations
<u>Resident-on-resident</u> sexual harassment	2	0	2	0
<u>Staff-on-resident</u> sexual harassment	0	0	0	0
Total	2	0	2	0

a. If you were unable to provide any of the information above, explain why this information could not be provided.

Click or tap here to enter text.

Sexual Abuse and Sexual Harassment Investigation Outcomes

Sexual Abuse Investigation Outcomes

Note: these counts should reflect where the investigation is currently (i.e., if a criminal investigation was referred for prosecution and resulted in a conviction, that investigation outcome should only appear in the count for "convicted.") Do not double count. Additionally, for question brevity, we use the term "inmate" in the following questions. Auditors should provide information on inmate, resident, and detainee sexual abuse investigation files, as applicable to the facility type being audited.

69. Criminal SEXUAL ABUSE investigation outcomes during the 12 months preceding the audit:

Instructions: If you are unable to provide information for one or more of the fields below, enter an "X" in the field(s) where information cannot be provided.

	Ongoing	Referred for Prosecution	Indicted/Court Case Filed	Convicted/Adjudicated	Acquitted
<u>Resident-on-resident</u> sexual abuse	0	0	0	0	0
<u>Staff-on-resident</u> sexual abuse	0	0	0	0	0
Total	0	0	0	0	0

a. If you were unable to provide any of the information above, explain why this information could not be provided.

Click or tap here to enter text.

70. Administrative SEXUAL ABUSE investigation outcomes during the 12 months preceding the audit:

Instructions: If you are unable to provide information for one or more of the fields below, enter an "X" in the field(s) where information cannot be provided.

	Ongoing	Unfounded	Unsubstantiated	Substantiated
<u>Resident-on-resident</u> sexual harassment	0	0	0	0
<u>Staff-on-resident</u> sexual abuse	0	0	0	0
Total	0	0	0	0

a. If you were unable to provide any of the information above, explain why this information could not be provided.

Click or tap here to enter text.

Sexual Harassment Investigation Outcomes

Note: these counts should reflect where the investigation is currently. Do not double count. Additionally, for question brevity, we use the term "inmate" in the following questions. Auditors should provide information on inmate, resident, and detainee sexual harassment investigation files, as applicable to the facility type being audited.

71. Criminal SEXUAL HARASSMENT investigation outcomes during the 12 months preceding the audit:

Instructions: If you are unable to provide information for one or more of the fields below, enter an "X" in the field(s) where information cannot be provided.

	Ongoing	Referred for Prosecution	Indicted/Court Case Filed	Convicted/Adjudicated	Acquitted
<u>Resident-on-resident</u> sexual harassment	0	0	0	0	0
<u>Staff-on-resident</u> sexual harassment	0	0	0	0	0
Total	Click or tap here to enter text.	Click or tap here to enter text.	Click or tap here to enter text.	Click or tap here to enter text.	Click or tap here to enter text.

a. If you were unable to provide any of the information above, explain why this information could not be provided.

Click or tap here to enter text.

72. Administrative SEXUAL HARASSMENT investigation outcomes during the 12 months preceding the audit:

Instructions: If you are unable to provide information for one or more of the fields below, enter an "X" in the field(s) where information cannot be provided.

	Ongoing	Unfounded	Unsubstantiated	Substantiated
<u>Resident-on-resident</u> sexual harassment	0	0	0	2
<u>Staff-on-resident</u> sexual harassment	0	0	0	0
Total	0	0	0	2

a. If you were unable to provide any of the information above, explain why this information could not be provided.

Click or tap here to enter text.

Sexual Abuse and Sexual Harassment Investigation Files Selected for Review

Sexual Abuse Investigation Files Selected for Review

73. Enter the total number of SEXUAL ABUSE investigation files reviewed/sampled:	0
a. If 0, explain why you were unable to review any sexual abuse investigation files:	The facility did not have an incident of sexual abuse in the last 12 months or in the three years since the last audit.
74. Did your selection of SEXUAL ABUSE investigation files include a cross-section of criminal and/or administrative investigations by findings/outcomes?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> N/A (N/A if you were unable to review any sexual abuse investigation files)

Resident-on-resident sexual abuse investigation files

75. Enter the total number of INMATE-ON-INMATE SEXUAL ABUSE investigation files reviewed/sampled:	0
76. Did your sample of INMATE-ON-INMATE SEXUAL ABUSE investigation files include criminal investigations?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> N/A (N/A if you were unable to review any inmate-on-inmate sexual abuse investigation files)
77. Did your sample of INMATE-ON-INMATE SEXUAL ABUSE investigation files include administrative investigations?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> N/A (N/A if you were unable to review any inmate-on-inmate sexual abuse investigation files)

Staff-on-resident sexual abuse investigation files

78. Enter the total number of STAFF-ON-INMATE SEXUAL ABUSE investigation files reviewed/sampled:	0
79. Did your sample of STAFF-ON-INMATE SEXUAL ABUSE investigation files include criminal investigations?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> N/A (N/A if you were unable to review any staff-on-inmate sexual abuse investigation files)
80. Did your sample of STAFF-ON-INMATE SEXUAL ABUSE investigation files include administrative investigations?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> N/A (N/A if you were unable to review any staff-on-inmate sexual abuse investigation files)

Sexual Harassment Investigation Files Selected for Review

81. Enter the total number of SEXUAL HARASSMENT investigation files reviewed/sampled:	2
a. If 0, explain why you were unable to review any sexual harassment investigation files:	Click or tap here to enter text.
82. Did your selection of SEXUAL HARASSMENT investigation files include a cross-section of criminal and/or administrative investigations by findings/outcomes?	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A (N/A if you were unable to review any sexual harassment investigation files)

Inmate-on-inmate sexual harassment investigation files

83. Enter the total number of RESIDENT-ON-RESIDENT SEXUAL HARASSMENT investigation files reviewed/sampled:	2
84. Did your sample of RESIDENT-ON-RESIDENT SEXUAL HARASSMENT investigation files include criminal investigations?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> N/A (N/A if you were unable to review any inmate-on-inmate sexual harassment investigation files)

85. Did your sample of INMATE-ON-INMATE SEXUAL HARASSMENT investigation files include administrative investigations?	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A (N/A if you were unable to review any inmate-on-inmate sexual harassment investigation files)
Staff-on-inmate sexual harassment investigation files	
86. Enter the total number of STAFF-ON-RESIDENT SEXUAL HARASSMENT investigation files reviewed/sampled:	0
87. Did your sample of STAFF-ON-RESIDENT SEXUAL HARASSMENT investigation files include criminal investigations?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> N/A (N/A if you were unable to review any staff-on-inmate sexual harassment investigation files)
88. Did your sample of STAFF-ON-RESIDENT SEXUAL HARASSMENT investigation files include administrative investigations?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> N/A (N/A if you were unable to review any staff-on-inmate sexual harassment investigation files)
89. Provide any additional comments regarding selecting and reviewing sexual abuse and sexual harassment investigation files. <i>Note: as this text will be included in the audit report, please do not include any personally identifiable information or other information that could compromise the confidentiality of any persons in the facility.</i>	Click or tap here to enter text.
Support Staff Information	
DOJ-certified PREA Auditors Support Staff	
90. Did you receive assistance from any DOJ-CERTIFIED PREA AUDITORS at any point during this audit? <i>Remember: the audit includes all activities from the pre-onsite through the post-onsite phases to the submission of the final report. Make sure you respond accordingly.</i>	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
a. If yes, enter the TOTAL NUMBER OF DOJ-CERTIFIED PREA AUDITORS who provided assistance at any point during the audit:	Click or tap here to enter text.
Non-certified Support Staff	
91. Did you receive assistance from any NON-CERTIFIED SUPPORT STAFF at any point during this audit? <i>Remember: the audit includes all activities from the pre-onsite through the post-onsite phases to the submission of the final report. Make sure you respond accordingly.</i>	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
a. If yes, enter the TOTAL NUMBER OF NON-CERTIFIED SUPPORT STAFF who provided assistance at any point during the audit:	1
Auditing Arrangements and Compensation	
92. Who paid you to conduct this audit?	<input checked="" type="checkbox"/> The audited facility or its parent agency <input type="checkbox"/> My state/territory or county government (if you audit as part of a consortium or circular auditing arrangement, select this option)

- | | |
|--|--|
| | <input type="checkbox"/> A third-party auditing entity (e.g., accreditation body, consulting firm)
<input type="checkbox"/> Other |
|--|--|

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

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

Documents Reviewed:

- Facility PAQ
- Policy Zero Tolerance of Sexual Abuse and Sexual Harassment: PREA Coordinator
- Baseline Core Security Audit Report

115.211(a)-1

The agency has a written policy mandating zero tolerance toward all forms of sexual abuse and sexual harassment in facilities it operates directly or under contract.

- (a) An agency shall have a written policy mandating zero tolerance toward all forms of sexual abuse and sexual harassment and outlining the agency's approach to preventing, detecting, and responding to such conduct.
- (b) An agency shall employ or designate an upper-level, agency-wide PREA coordinator, with sufficient time and authority to develop, implement, and oversee agency efforts to comply with the PREA standards in all of its community confinement facilities.

The Peer I and Haven Programs do not tolerate any type sexual abuse, harassment, or inappropriate sexual behavior or conduct of any kind between staff and clients or between clients and clients in their environments. The Programs believe that employees, volunteers and contractors must contribute to a culture of zero tolerance for sexual abuse to achieve safety, security and fairness for everyone involved. Individuals employed or contracted by the programs are expected to follow all policies and procedures, including but not limited to:

- Reporting known or suspected incidents of sexual assault and harassment that occur within the Peer I and Haven Programs and facilities
- Reporting suspicions of staff sexual misconduct between a colleague and an individual under community corrections supervision
- Reporting incidents of sexual assault that may have occurred in other institutional settings that are revealed by offenders now under the care of Peer I and Haven Programs
- Providing support to clients who have been victims of sexual abuse or harassment.
- Informing clients of their rights to be protected against sexual abuse while under the care of Peer I and Haven Programs.
- Ensuring that all incidents are properly investigated and addressed.

115.211(a)-3

The policy includes definitions of prohibited behaviors regarding sexual abuse and sexual harassment.

The Peer I and Haven Programs recognize that there are many behaviors which could put clients or staff at risk. The Peer I and Haven programs recognize all forms of sexual abuse and sexual harassment specified by the PREA Standards for Community Confinement Facilities as defined in §115.6. See Attachment 1 for full definitions of the terms sexual abuse and sexual harassment.

Sexual abuse includes—

- (1) Sexual abuse of an inmate, detainee, or resident by another inmate, detainee, or resident; and
- (2) Sexual abuse of an inmate, detainee, or resident by a staff member, contractor, or volunteer.

Sexual abuse of an inmate, detainee, or resident by another inmate, detainee, or resident includes any of the following acts, if the victim does not consent, is coerced into such act by overt or implied threats of violence, or is unable to consent or refuse:

- (1) Contact between the penis and vulva or the penis and the anus, including penetration, however slight;
- (2) Contact between the mouth and the penis, vulva, or anus;

- (3) Penetration of the anal or genital opening of another person, however slight, by a hand, finger, object, or other instrument; and
- (4) Any other intentional touching, either directly or through the clothing, of the genitalia, anus, groin, breast, inner thigh, or the buttocks of another person, excluding contact incidental to a physical altercation.

Sexual abuse of an inmate, detainee, or resident by a staff member, contractor, or volunteer includes any of the following acts, with or without the consent of the inmate, detainee, or resident:

- (1) Contact between the penis and the vulva or the penis and the anus, including penetration, however slight;
- (2) Contact between the mouth and the penis, vulva, or anus;
- (3) Contact between the mouth and any body part where the staff member, contractor, or volunteer has the intent to abuse, arouse, or gratify sexual desire;
- (4) Penetration of the anal or genital opening, however slight, by a hand, finger, object, or other instrument, that is unrelated to official duties, or where the staff member, contractor, or volunteer has the intent to abuse, arouse, or gratify sexual desire;
- (5) Any other intentional contact, whether directly or through the clothing, of or with the genitalia, anus, groin, breast, inner thigh, or the buttocks, that is unrelated to official duties, or where the staff member, contractor, or volunteer has the intent to abuse, arouse, or gratify sexual desire;
- (6) Any attempt, threat, or request by a staff member, contractor, or volunteer to engage in the activities described in paragraphs (1)-(5) of this section;
- (7) Any display by a staff member, contractor, or volunteer of his or her uncovered genitalia, buttocks, or breast in the presence of an inmate, detainee, or resident, and
- (8) Voyeurism by a staff member, contractor, or volunteer.
Voyeurism by a staff member, contractor, or volunteer means an invasion of privacy of an inmate, detainee or resident by staff for reasons unrelated to official duties, such as peering at an inmate who is using a toilet in his or her cell to perform bodily functions; requiring an inmate to expose his or her buttocks, genitals, or breasts; or taking images of all or part of an inmates naked body or of an inmate performing bodily functions.

Sexual Harassment includes—

- (1) Repeated and unwelcome sexual advances, requests for sexual favors or verbal comments, gestures, or actions of a derogatory or offensive sexual nature by one inmate, detainee, or resident directed toward another; and
- (2) Repeated verbal comments or gestures of a sexual nature to an inmate, detainee, or resident by a staff member, contractor, or volunteer, including demeaning references to gender, sexually suggestive or derogatory comments about body or clothing, or obscene language or gestures.

115.211(b)

The PREA coordinator has sufficient time and authority to develop, implement, and oversee agency efforts to comply with the PREA standards in all of its community confinement facilities.

The Haven and Peer I each employ a PREA Coordinator. These PREA Coordinators report directly to the Program Directors 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. PREA Coordinators are either solely employed to complete PREA related duties OR serve as PREA Coordinator in conjunction with other job duties. PREA Coordinators have sufficient time to complete job duties.

Interviews:

- PREA Coordinator
- Facility Director

During an interview with the PREA Coordinator she reported she has sufficient time and authority to build upon and oversee the agency's efforts to comply with the PREA standards at the facilities under the agency's jurisdiction. She indicated the previous PREA Coordinator did a great job of establishing systems and once she took over she was responsible for overseeing the systems that were already in place, and staying current with changes that would require the agency to modify their policies and procedures. The PREA Coordinator reports directly to the Havens Program Director and works closely with the Program Director of the Haven program.

Conclusion:

Based upon the review and analysis of the available evidence, the auditor has determined the agency and facility is in compliance with this standard requiring a zero-tolerance policy toward sexual abuse and sexual harassment and the designation of a PREA Coordinator and PREA Compliance Manager. No corrective action is required.

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.) ☐ 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

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

Documents reviewed:

- Facility PAQ
- Policy Contracting with other Entities for the Confinement of Residents

University of Colorado Anschutz-The Haven does not contract with other agencies for the confinement of clients residing in their program. The Haven is fully licensed by the Colorado Office of Behavioral Health and contracts with multiple entities, including the Division of Criminal Justice, Department of Corrections, local probation offices and Signal Behavioral Health Network. As a part of their contractual agreement, The Haven has agreed to allow the respective agencies to monitor their program to a number of state and federal standards to include the community confinement PREA standards.

Interviews:

- PREA Coordinator

Conclusion:

Based upon the review and analysis of the available evidence, the auditor has determined the agency is fully compliant with this standard regarding contracting with other entities for the confinement of clients. No corrective action is required.

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 facility have a documented staffing plan that provides for adequate levels of staffing and, where applicable, video monitoring, to protect residents against sexual abuse? ☒ Yes ☐ No
- In calculating adequate staffing levels and determining the need for video monitoring, does the staffing plan take into consideration: The physical layout of each facility? ☒ Yes ☐ No
- In calculating adequate staffing levels and determining the need for video monitoring, does the staffing plan take into consideration: The composition of the resident population? ☒ Yes ☐ No
- In calculating adequate staffing levels and determining the need for video monitoring, does the staffing plan take into consideration: The prevalence of substantiated and unsubstantiated incidents of sexual abuse? ☒ Yes ☐ No
- In calculating adequate staffing levels and determining the need for video monitoring, does the staffing plan take into consideration: Any other relevant factors? ☒ Yes ☐ No

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

Documents Reviewed:

- Facility PAQ
- Policy Supervision and Monitoring
- Walkthrough Form

(a) For each facility, the agency shall develop and document a staffing plan that provides for adequate Documents Reviewed:

115.213(a)-1

For each facility, the agency develops and documents a staffing plan that provides for adequate levels of staffing, and, where applicable, video monitoring to protect residents against sexual abuse.

(a) For each facility, the agency shall develop and document a staffing plan that provides for adequate levels of staffing, and, where applicable, video monitoring, to protect residents against sexual abuse. In calculating adequate staffing levels and determining the need for video monitoring, agencies shall take into consideration:

- (1) The physical layout of each facility;
- (2) The composition of the resident population;
- (3) The prevalence of substantiated and unsubstantiated incidents of sexual abuse; and
- (4) Any other relevant factors.

(b) In circumstances where the staffing plan is not complied with, the facility shall document and justify all deviations from the plan.

(c) Whenever necessary, but no less frequently than once each year, the facility shall assess, determine, and document whether adjustments are needed to:

- (1) The staffing plan established pursuant to paragraph (a) of this section;
- (2) Prevailing staffing patterns;
- (3) The facility's deployment of video monitoring systems and other monitoring technologies; and
- (4) The resources the facility has available to commit to ensure adequate staffing levels.

PROCEDURE:

The Peer I and Haven programs will maintain appropriate staffing patterns in compliance with Colorado Community Corrections Standard 4-240. CCCS indicate that, at minimum, a **50:1 ratio** be maintained. When calculating adequate staffing levels, each program takes into consideration the physical layout of each facility; the composition of the resident population; the prevalence of substantiated and unsubstantiated incidents of sexual abuse; the successful operation of the TC structure with adequate clinical and security staffing is also taken into account. Video monitoring is used in addition to, not in lieu of, physical staff presence in the facilities.

115.213(b)-1

Each time the staffing plan is not complied with, the facility documents and justifies all deviations from the staffing plan.

In circumstances where the staffing plan is not complied with, management team members from each facility will report to their immediate supervisor about the nature of the deviations from the plan during regularly scheduled supervisions. If a pattern of lack of compliance is evidenced, these issues will be addressed at ARTS level management meetings to discuss opportunities for increased compliance.

Interviews:

- Executive Director
- PREA Coordinator
- Facility Director
- Supervisors

The PREA Coordinator and the Facility Director acknowledged there is collaboration in the development of and review of the staffing plan. During the review process the team will conduct a walk through to assess vulnerable areas and address the placement of video monitoring equipment and installation plans for the future. The facility does not deviate from the staffing plan, which in compliance with the standards established by the Division of Criminal Justice. When there is a need to address staffing issues every staff member employed by the facility can provide coverage and the Program Director or their designee will hold someone over or request a staff member adjust their schedule to arrive early meet the staffing ratios.

DCJ has a standard that there has to be two (2) head counts and three (3) walk through, the purpose is to identify issues and have interaction with clients to prevent issues. If there are additional needs the staff will conduct more head counts or walk through, and they are all unannounced. Head counts and "walk throughs" are documented. The facility provided walk through documentation, which demonstrates the facility conducts their rounds at variable times throughout the day.

Conclusion:

Based upon the review and analysis of the available evidence, the auditor has determined the facility is in compliance with this standard regarding supervision and monitoring. No corrective action required.

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 the facility does not have female residents.)
☒ Yes ☐ No ☐ NA

- 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 the facility does not have female 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? (N/A if the facility does not have female residents). ☒ Yes ☐ No ☐ NA

115.215 (d)

- Does the facility have policies 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 have procedures that enables 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

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

Documents Reviewed:

- Facility PAQ
- Policy Limits to Cross-Gender Viewing and Searches
- Pat Search Documentation

115.215(a)-1

The facility conducts cross-gender strip or cross-gender visual body cavity searches of residents.

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 believes that a cross-gender strip search is required, he or she will immediately contact their direct supervisor, who will contact the program director. The program director will decide what constitutes an exigent situation and a cross-gender search will only be done upon the program director's approval. This search will be documented in an internal incident report, which will be retained in the resident's electronic health record. Cross gender visual body cavity searches by ARTS employees will never be authorized for female residents.

115.215(b)-1 The facility does not permit cross-gender pat-down searches of female residents, absent exigent circumstances.

Peer I and the Haven do not permit cross-gender pat down searches of female residents. In all routine circumstances, there is a female staff available at The Haven or Haven Mother's house who would be able to conduct such a search. Neither Peer I nor The Haven restricts residents' access to regularly available programming or other outside opportunities in order to comply with this provision. There are female staff on shift at all times at The Haven residential facilities, all of whom are trained to complete searches. In the event that a Peer I resident identified as female and requested that searches be conducted by a female staff, female Peer I staff or a Haven staff would conduct the search in a manner that did not restrict participation in programing our outside activities.

115.215(c)-1 Facility policy requires that all cross-gender strip searches and cross-gender visual body cavity searches be documented.

The program documents all searches, regardless of the gender identity of the resident and/or staff participating in the search. Records of these searches are documented in the resident's electronic health record.

115.215(d)-1 The facility has implemented policies and procedures that enable residents to shower, perform bodily functions, and change clothing without non-medical 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 (this includes viewing via video camera).

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. Visitors, contractors, volunteers and other non-staff individuals are either escorted by staff or trained to appropriately announce their presence when in these areas.

Interviews:

- Executive Director
- Facility Director
- Random Staff
- Random Residents

Staff and client interviews indicate staff are prohibited from conducting cross-gender pat searches. Interviews with the clients indicated they have never been searched by a staff member of the opposite gender nor have they observed or heard another client being searched by a staff member of the opposite gender. Pat searches are assigned randomly and they are also conducted when the client is allowed the privilege of leaving the facility to engage in community programming (i.e., work, appointments, etc.).

The search procedures and practices are trauma informed. The staff are trained to use the back of their hands to conduct a pat search; additionally the staff will have the client remove their socks and shoes. Pat searches are completed at a minimum five times per month.

The clients report they share rooms with each other and per facility rules and expectation is they are required to exit their rooms fully clothed and change their clothes in the bathroom. The clients consistently state they hear and observe staff announce their presence when the staff are conducting rounds and head counts. Additionally, the clients report the staff will knock when their room door is secure; the staff will announce their presence and wait for a verbal response from the clients prior to entering their rooms. They also report the staff does not have a practice of entering the bathroom while when it is occupied. The clients are expected to verbally respond during the checks. Every client interviewed report that they have adequate privacy and feel confident that the staff are conducting their duties per policy.

The clients also report they have the ability to complete their hygiene at the designated time per policy and everyone has the ability to shower one at a time. Most clients report they have never seen more than one person showering at the same time, and in the rare instance that there are two people in the bathroom, there are security measures to increase their privacy.

Conclusion:

Based upon the review and analysis of the available evidence, the auditor has determined the facility is compliant with this standard regarding limits to cross-gender viewing and searches. No corrective action is required.

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

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

Documents Reviewed:

- Facility PAQ
- Policy Residents with Disabilities and Residents who are Limited English Proficient

115.216(a)-1 The agency has established procedures to provide disabled residents 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.

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:

- a. Any person who is 18 years old or older, or who has been emancipated, and has an admitted substance abuse problem.
- b. The individual must be able to understand verbal communications.
- c. The individual must be medically, physically able and psychologically stable in order to fully participate in treatment.
- d. The individual must demonstrate at least minimal motivation, e.g. acknowledgment of a substance abuse problem and a desire to stop using drugs/alcohol, i.e., Contemplation stage of change.
- e. The individual must score a Level 4 on the SOA-R (if utilized) and meet 111.5 Level of Care on the ASAM. Substance abuse history must be severe enough to meet criteria for the Therapeutic Community treatment modality.
- f. Individuals must not have a need for a medical setting detoxification. Clients cannot be taking benzodiazepines or amphetamines to treat a psychological disorder such as anxiety or ADHD.
- g. Clients using narcotic pain medication for long term treatment of pain management must be switched to some other non-narcotic medication or receiving services through a methadone clinic.
- h. Individuals with minimal risk of escape and/or escape history.
- i. Individuals who are not currently involved with legal matters that would involve continual access to legal systems and would interfere with their time spent in treatment.

115.216(b)-1 The agency has established procedures to provide residents with limited English proficiency 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.

The program will ensure meaningful access to all aspects in order to prevent, detect, and respond to sexual abuse and sexual harassment to residents who are limited English proficient, including steps to provide interpreters who can interpret effectively, accurately, and impartially, both receptively and expressively, using any necessary specialized vocabulary. Residents must have the ability to interact

with other residents and staff in order to participate fully in the program. Therefore, clients without adequate English language skills to communicate without an interpreter would not be considered to be appropriate for placement at Peer I or The Haven. Peer I and The Haven understand that a client's ability to communicate in English in the therapeutic community setting may not be someone's preferred language, particularly in a situation requiring response to trauma. In these situations, The Haven and Peer I will utilize the translation and/or interpretive services provided by The Spring Institute as described above.

115.216(c)-1 Agency policy prohibits use of 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.

The program does not rely on other clients to interpret, read or provide other types of interpretive assistance unless it is an emergency 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.

Interviews:

- Executive Director
- PREA Coordinator
- Random

During the on-site audit all of the clients resident at the Haven were English proficient. During interviews with clients the auditor attempted to assess if anyone had a slight or obvious disability, and determined that of the clients interviewed no one presented with any signs that indicated they had a disability that required additional supports. Every client effectively communicated their understanding of PREA the agency zero tolerance policy and how to make a report. During the onsite audit the auditor had the ability to review risk screening documentation and of those reviewed on-site, there was no one with documentation that indicated they had a disability.

The clients at the Haven indicated they received periodic PREA education and PREA information is posted throughout the facility. The clients stated they also received PREA information at their previous institutions and upon their arrival at the Haven they were provided PREA information that was specific to the agency/facility. The clients were proficient in explaining their understanding of PREA and acknowledged that they had the right to be free from sexual abuse and sexual harassment. The clients explained the facility/agency has a rule that prohibits sexual misconduct that involves staff and other clients, and the potential consequence for violating the rule could result in an unsuccessful termination from the program.

Conclusion:

Based upon the review and analysis of the available evidence, the auditor has determined the facility is fully compliant with this standard regarding residents with disabilities and residents who are limited English Proficient. No corrective action is required.

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 who may have contact with residents? ☒ Yes ☐ No
- Does the agency consider any incidents of sexual harassment in determining whether 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)

- 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

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

Documents Reviewed:

- Facility PAQ
- Policy Hiring and Promotion Decisions
- Web based application
- New Hire and 5-year Background Clearance

115.217(a)-1 Agency policy prohibits hiring or promoting anyone who may have contact with residents and prohibits enlisting the services of any contractor who may have contact with residents who:

(1) 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);

(2) 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; or

(3) Has been civilly or administratively adjudicated to have engaged in the activity described in paragraph (a)(2) of this section.

As part of the Peer I and The Haven's zero tolerance and hiring policies, no one is hired or considered for promotion who has engaged in sexual abuse in prison, jail, lock up, community confinement facility, juvenile facility, or other institution (as defined in 42 U.S.C. § 1997). Anyone discovered to have 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 will not be considered for employment. This includes any civil or administrative adjudication.

115.217(b)-1 Agency policy requires the consideration of 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.

The Haven and Peer 1 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.

115.217(c)-1 Agency policy requires that before it hires any new employees who may have contact with residents, it (a) conducts criminal background record checks, and (b) consistent with federal, state, and local law, makes 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.

Before hiring new employees who may have contact with residents Addictions Research and Treatment services and/or Haven & Peer I conduct thorough background screening.

- (1) As part of the program's hiring policy all applicants being considered for employment, volunteer, or contract worker complete a basic information sheet which is forwarded to the Division of Criminal Justice who conduct CCIC/NCIC criminal history checks and report the findings to the Program Director.
- (2) The programs make reasonable efforts to contact all prior institutional employers to gather information on allegations of sexual abuse or any resignation during a pending investigation of an allegation of sexual abuse.

115.217(c)-2 In the past 12 months, the number of persons hired who may have contact with residents who have had criminal background record checks:

Before hiring new employees who may have contact with residents, the agency shall:

- (1) Perform a criminal background records check; and
- (2) 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.

115.217(e)-1 Agency policy requires that either criminal background record checks be conducted at least every five years for current employees and contractors who may have contact with residents or that a system is in place for otherwise capturing such information for current employees.

The Department of Criminal Justice has implemented a system where all Community Corrections employees are re-checked within every five years of employment with The Haven and Peer I programs. Programs are responsible for notifying DCJ when these 5-year background checks are due. Current employees are required to sign their on-going affirmative duty to immediately report to their supervisors any contact with legal entities. It is the stated duty of all employees, volunteers, or contract workers to disclose any such sexual misconduct.

115.217(f)-1

The program asks directly about any previous sexual misconduct. This is done as part of the pre-screening process and any written applications, interviews for promotion, self-evaluations, and reviews of current employees. This includes both current employees and applicants as well as those who may be up for promotion.

115.217(g)-1 Agency policy states that material omissions regarding such misconduct, or the provision of materially false information, shall be grounds for termination.

Any omission or provision of false information shall be grounds for termination and this is clearly stated as part of the pre-screening and new hire process on forms which potential and new employees sign.

115.217(h)-1

When ARTS and/or The Haven/Peer I receive a request from an institutional employer regarding an employee who has substantiated allegations of sexual misconduct, the Program Director and/or ARTS Director will be notified. Because ARTS employees are employed through the University of Colorado Denver, ARTS is required to consult with (at minimum) University Human Resources to determine what, if any, information they are able to share with an institutional employer regarding substantiated

allegations of sexual misconduct. These cases will be evaluated on an individual basis, as there are a broad range of behaviors which may be categorized as “sexual misconduct”. ARTS will share information to the fullest extent possible allowed by all applicable local, state and federal laws.

Interviews:

- PREA Coordinator
- Human Resources Representative

According to the facility PAQ, the facility hired six employees in the past 12 months. Reviewed documentation showed that the new employees that have contact with the clients had a criminal background check completed prior to their official employment with the facility. The auditor received background clearance documentation for the staff and reviewed documentation for additional staff members, which verified the facility/agency has a practice of conducting a background check. Interviews with the Human Resource staff member corroborated the background check process and reported that she maintains all of the staff members personnel files, which includes their application, reference check and background clearance check.

The agency/facility policy prohibits hiring or promoting persons in the categories enumerated in this standard. The agencies practice is to obtain sexual harassment information when engaging the services of a contractor through the application process by providing potential candidates with supplemental questions during the application process. When a person is considered for employment, criminal background checks are conducted through the Colorado Bureau of Investigation background check. The facility/agency also performs criminal background checks every 5 years on current employees of all classification levels.

The University of Colorado Anschutz policy requires the agency to provide information on substantiated allegations of sexual abuse or sexual harassment involving a former employee upon receiving prior consent from the former employee. An interview with the Human Resources staff member indicates a former employee would need to sign a consent form to allow the agency to disclose their employment information for potential new institutional employers. Absent a signed consent the agency will not release any information.

Conclusion:

Based upon the review and analysis of the available evidence, the auditor has determined the facility is in compliance with this standard regarding hiring and promotion decisions. No corrective action is required.

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

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

Documents Reviewed:

- Facility PAQ
- Policy Upgrades to Facilities and Technologies

(a) The Haven and Peer I will consider resident safety (such as protection from sexual abuse), when designing or acquiring any new facilities. Substantial expansion and modification are not likely to occur with existing buildings due to the historic nature of the facilities. However, Program Directors will take resident safety into consideration when making technological improvements to the facilities as described below.

(b) The programs will consider how the installation of video monitoring systems, electronic surveillance systems, or any other types of monitoring technology can enhance the programs ability to protect clients from sexual abuse. Please refer to policy 115.213(c) for further information regarding the process of evaluation, consideration and timely review of the video and/or electronic surveillance systems.

Interviews:

- Executive Director
- Facility Program Director
- PREA Coordinator

According to the PAQ, the facility has not made any substantial expansion or modification since the last PREA audit; this was by the Program Director and the PREA Coordinator. Consideration is given to

generally accepted practices with regards to staffing, identifying for blind spots and the client population being served. The Haven has a video monitoring system which captures and records video that is periodically reviewed. The cameras are strategically installed in the highest risk areas (i.e., basement, medication distribution office, building entrance/exit). The video monitoring system is also used in post incident investigations, as well as regular on-going quality control reviews by facility supervisors and administrators.

According to the Executive Director the agency continues to work collaboratively with the state to update the current monitoring system to a more modern system. The agency is currently has a lease with the state; therefore, any modifications requires the state facility management department to approve those changes.

Conclusion:

Based upon the review and analysis of the available evidence, the auditor has determined the agency and facility is fully compliant with this standard regarding upgrades to facilities and technologies. No corrective action is required.

RESPONSIVE PLANNING

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 evidentiarily 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 SAFEs 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 SAFEs 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? (N/A if agency *always* makes a victim advocate from a rape crisis center available to victims.) ☒ Yes ☐ No ☐ NA
- 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 agency 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? (N/A if agency *always* makes a victim advocate from a rape crisis center available to victims.) ☐ 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

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

Documents Reviewed:

- Facility PAQ
- Policy Upgrades to facilities and technology

115.221(a)-1 115.221(b)-1 The agency/facility is responsible for conducting administrative or criminal sexual abuse investigations (including resident-on-resident sexual abuse or staff sexual misconduct).

The protocol was adapted from or otherwise based on the most recent edition of the DOJ'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.

(a) Uniform Evidence Protocol

(1) The Haven and Peer I do not conduct criminal investigations of allegations of sexual abuse, including resident on resident sexual abuse or staff sexual misconduct. The Haven and Peer I follow the Uniform Evidence Protocol for Administrative investigations.

(2) Haven and Peer I programs will refer all criminal investigations of sexual abuse to the proper authorities, including but not limited to The Denver Police Sex Crimes Unit. When abuse occurs at The Haven or Peer I, the first responder acts in accordance with §115.264 by separating any victim from the abuser, preserving and protecting the crime scene, assuring that the alleged victim and the abuser do

not take actions that could destroy physical evidence. The first responder will contact the program director and the local (Denver) law enforcement agency, if criminal activity is suspected. Per standards, the first responder will document the incident as well as their efforts, including the time that the director and law enforcement were notified.

(b) The Peer I and the Haven do not serve youth as primary clients. Women at the Haven Mother's House often have infants in residence with them. In the event that the victim is a child, the Colorado Child Abuse and Neglect Hotline (1-844-264-5437) will be notified and staff will follow the directions they are given at the time of the report. If a sexual assault medical forensic examination is required of an adult resident of Peer I or the Haven, all applicable laws, protocols and best practices will be upheld by Denver Health Medical Center.

115.221(c)-1 The facility offers to all residents who experience sexual abuse access to forensic medical examinations.

All victims of sexual abuse who require forensic medical examinations will be taken to Denver Health Medical Center located at 777 Bannock Street, Denver, 303-436-6000. A mental health therapist or qualified same gender staff member will accompany victims to the hospital, if desired by victim and permitted by medical personnel. If they cannot accompany them to the hospital the mental health therapist or designated qualified staff member will meet the client at the hospital. The agency staff member will assure that prior to checking into the hospital a SANE nurse has been requested. Denver Health and Hospitals procedure is to have all victims of assault or abuse meet with the SANE team. Denver Health and Hospital SANE nurses understand the Haven and Peer I programs and are aware of PREA standards. The Blue Bench will also be immediately notified, and per MOU, they will send an advocate to Denver Health Medical Center to stay with the victim, if the victim wants this support. The agency will document the time the client arrived at the hospital and coordinate services with the SANE team as appropriate. The Denver Health SANE nurses will advise the police of findings.

115.221(d)-1 The facility attempts to make available to the victim a victim advocate from a rape crisis center, either in person or by other means.

The Haven and Peer I programs make available to clients the services of The Blue Bench, which provides a continuum of care for survivors of sexual assault from immediately after the assault, through medical and legal logistics, to counseling. The Haven also provides mental health counseling which is offered on site with an agency therapist. The Haven and Peer I assure that the client receives support and is accompanied by staff as requested by the victim in attending all off site appointments through The Blue Bench or other community services as needed and at no cost to the victim. The agency therapist and or individual counselor will coordinate care with other entities with proper releases of information.

Interviews:

- Executive Director
- PREA Coordinator

The facility PAQ indicates administrative investigations are conducted internally by the PREA Coordinator. When the facility receives a PREA allegation and it requires external reporting the report is considered critical and the Executive Director must be notified. Criminal investigations are conducted by the Denver Police Department Sex Crimes Unit. The police department follows a uniform evidence protocol consistent with law enforcement agencies sexual abuse crimes unit protocols. The agency follows a uniform evidence protocol for first responders that maximize the potential for obtaining usable

physical evidence for both administrative investigations and criminal prosecution. Every staff member could articulate their first responder duties, which demonstrated they understand the need to separate the client from the offender and secure the scene to protect and preserve evidence.

According to the facility PAQ and during the interview with the PREA Coordinator, clients who report sexual abuse victimization would be transported or arrangements would be made to transport the client to the local hospital (i.e., Denver Health) to receive medical treatment and a forensic examination. The facility does not have on-site medical personnel; therefore, clients receive all medical care at the hospital or a clinic of their choice. Forensic medical exams would be offered without financial cost to the client, which is consistent with the level of care for all community members.

The PAQ indicates the facility did not receive an allegation of sexual abuse that would have required a client to be transported to an outside medical facility for a SANE exam.

The PREA Coordinator has established a relationship with the Blue Bench, which is a local community rape crisis and advocacy center. There is an agreement that the Blue Bench will provide clients with direct access to outside victim support services and advocacy assistance to victims who make an allegation of sexual abuse while they are residing at the Haven. The Blue Bench agrees to provide emotional support, crisis intervention, support information, and outside referrals for the clients.

Conclusion: Based upon the review and analysis of the available evidence, the auditor has determined the facility is fully compliant with this standard regarding evidence protocol and forensic medical examinations. No corrective action is required.

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 the policy 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

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

Documents Reviewed:

- Facility PAQ
- Policy Upgrades to facilities and technology

115.222(a)-1 The agency ensures that an administrative or criminal investigation is completed for all allegations of sexual abuse and sexual harassment (including resident-on-resident sexual abuse or staff sexual misconduct).

(a) Peer I and the Haven assure that an administrative or criminal investigation is completed for all allegations of sexual abuse and sexual harassment. All reports are taken regardless of their source (from resident, from staff, from a third party) or the method of communication used (in writing, electronic, verbal, or any other source).

(1) The Staff member who initially receives the report is responsible for following the First Responder Duties which include:

(a) Immediately separating the alleged victim and the alleged perpetrator. Typically the alleged victim is placed in the staff office with the support of a staff, and the alleged perpetrator is

placed in another room. If there is only one staff on, staff will stay with the victim. If there are two or more staff available, one staff will stay with each the alleged perpetrator and the alleged victim. If a second staff office is available, the alleged perpetrator & staff support will stay in that room. If there is not a second staff office available, the first responder will designate an appropriate room for the alleged perpetrator, such as a TV room within the facility.

- (b) Both the alleged victim and the alleged perpetrator are instructed not to eat, bathe, drink, change clothes, urinate, defecate, smoke or brush their teeth.
 - (c) The area in which the alleged offense is immediately closed off, with signage or tape clearly posted to protect the crime scene and deter staff, clients, and others from compromising the scene.
 - (d) Staff will immediately notify their supervisor about the incident.
 - (e) All contact times will be noted in a log.
 - (f) Staff will thoroughly complete the First Responder Form and email it to their supervisor.
- (2) Notification of the Program Director
- (a) The program director is immediately notified by the supervisor of any staff sexual misconduct or sexual assault allegation that involves either residents or staff.
 - (b) The supervisor notified the Program Director (or designee) within 24 hours of receipt of an allegation of sexual harassment. If notification is not immediate, Supervisor will take reasonable steps to assure the safety of the resident in the intervening period and document these measures in a report to the PREA Coordinator for inclusion in the PREA Incident Report
- (3) Coordinated Responses
- (i) In the event of Staff on Resident Sexual Assault Allegation or Resident on Resident sexual assault allegation, the appropriate coordinated Response Flow Chart will be followed.
 - (ii) In the event that the alleged incident does not require criminal investigation, the Administrative Investigation Procedures will be followed in accordance with the Administrative Investigation Flow Chart. If, at any time during the course of an administrative investigation, an investigator or other staff has cause to believe that a criminal act has occurred, the Administrative investigation will be immediately suspended and the process for Criminal investigation, including notification of the Denver Police Sex Crimes Unit, will occur.

115.222(b)-1 The agency has a policy that requires that allegations of sexual abuse or sexual harassment be referred for investigation to an agency with the legal authority to conduct criminal investigations, including the agency if it conducts its own investigations, unless the allegation does not involve potentially criminal behavior.

Peer I and The Haven do not have legal authority to conduct criminal investigations. Peer I and The Haven refer for investigation all allegations that involve potentially criminal behavior to the Denver Police Department Sex Crimes Unit. Peer I and The Haven follow all procedures outlined in the Denver Police Department Sex Crimes Unit PREA Procedures. Information regarding the programs' zero tolerance and reporting procedures are described for both programs at the Addictions Research and Treatment Services website, www.artstreatment.org.

Interviews:

- Executive Director
- Investigative Staff

Interviews:

- Executive Director
- PREA Coordinator

The facility PAQ indicates the Have had two sexual harassment allegations and zero sexual abuse allegations. Both reports had an administrative investigation that was conducted by the PREA Coordinator. Neither report was referred to the Denver Police Department because neither allegation was potentially criminal. Every allegation reported to the facility would have an administrative investigation. Any allegation that involves a possible criminal violation would be reported to the Denver Police Department Sex Crimes Unit and the PREA Coordinator would monitor the progress of the investigation and fully cooperate with the investigator.

The agency's policy regarding the referral of allegations of sexual abuse or sexual harassment for a criminal investigation is published on the agency website at <https://www.artstreatment.com/prea/>.

Conclusion:

Based upon the review and analysis of the available evidence, the auditor has determined the facility is in compliance with this standard regarding policies to ensure referrals of allegations for investigations. No corrective action is required.

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

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

Documents Reviewed:

- Facility PAQ
- Policy Employee training
- Training Curriculum
- Training Records

115.231(a)-1

The agency trains all employees who may have contact with residents on the following matters (check all that apply and indicate where in the training curriculum this information is covered):

(1) Agency's zero-tolerance policy for sexual abuse and sexual harassment;

- (2) How to fulfill their responsibilities under agency sexual abuse and sexual harassment prevention, detection, reporting, and response policies and procedures;
- (3) The right of residents to be free from sexual abuse and sexual harassment;
- (4) The right of residents and employees to be free from retaliation for reporting sexual abuse and sexual harassment;
- (5) The dynamics of sexual abuse and sexual harassment in confinement;
- (6) The common reactions of sexual abuse and sexual harassment victims;
- (7) How to detect and respond to signs of threatened and actual sexual abuse;
- (8) How to avoid inappropriate relationships with residents;
- (9) How to communicate effectively and professionally with residents, including lesbian, gay, bisexual, transgender, intersex, or gender-nonconforming residents; and
- (10) How to comply with relevant laws related to mandatory reporting of sexual abuse to outside authorities.

The Haven and Peer I train all employees who may have contact with residents on items 115.231 (a)1-10 described above. Training includes the PowerPoint Slides "PREA Training for Community Corrections" and/or the "PREA Training for Community Corrections Text Adaptation". These documents are retained in the facility's shared network drive under the titles used here. Staff receive the initial PREA Training within 30 days of hire from the PREA Coordinator or qualified designee.

115.231(b)-1 Training is tailored to the gender of the residents at the facility

Peer I serves male clients and The Haven serves female clients. The training materials discussed in section (a) above contain gender specific content. If a staff transitions from Peer I or the Haven, they will receive another PREA training from the PREA Coordinator of the facility to which they are transitioned.

115.231(c)-1 The number of staff currently employed by the facility, who may have contact with residents, who were trained or retrained on the PREA requirements enumerated above:

a) PREA Trainings

- 1) Initial trainings to achieve compliance with the PREA Standards were conducted on 5/30/2012 for Peer I staff and 11/14/12 for all Haven Staff. The PREA coordinator along with management staff ensures all newly employed staff, interns, contractors, or volunteers, at the Peer I and Haven Programs, are required as part of their Orientation (within 30 days of hire), to receive training in the agency's policy of zero tolerance toward all forms of sexual abuse, sexual harassment and sexual misconduct. Staff will review PREA standards which are located on the shared drive and in the PREA notebook.
- 2) Updated trainings for all staff on PREA standards will occur via staff in-services at least one time per year. Full review of the T4T Training (either PowerPoint or word document) will occur during even years (2012, 2014, etc). A refresher of the current sexual abuse and sexual harassment policies will occur during odd years (2015, 2017, etc.). Trainings will be conducted by the director, PREA Coordinators or management staff who have been trained in the PREA training for trainers. Trainings may occur throughout the year, on any year, regarding cultural diversity, gender responsive treatment, substance use disorders, co-occurring mental health disorders and other topics relevant to this standard. Such trainings are documented in staff's individual personnel files. As trainings are typically only offered once per year, staff who were not present on the day of the training may not be listed on the training sign-in sheet. All staff are responsible for reviewing material that was covered during the training, however they do not receive training documentation for these missed sessions.

115.231(d)-1 The agency documents that employees who may have contact with residents understand the training they have received through employee signature or electronic verification.

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.

Interviews:

- PREA Coordinator
- Random Staff

The Haven is a therapeutic facility which complies with the community confinement PREA standards. The facility serves an all-female population that is operated by all-female staff. A review of the training curriculum indicates the training is tailored towards staff that work with both male clients in a therapeutic setting. The policies provide clear guidance for staff supervision and the type of programming that the staff are responsible for facilitating and monitoring, which is intended to support the clients recovery and to create a safe environment.

There are fifteen (15) staff currently employed by the facility, who may have contact with clients. All new hires will participate in an initial PREA training and current staff will participate in training biannually. Additionally, the staff are kept abreast of the PREA requirements and any updates or changes through visual aids/posters that are strategically posted throughout the facility and through verbal communication during staff meetings.

The auditor reviewed a sample of training records and logs with staff signatures for new and tenured staff. The staff signatures acknowledged attending and understanding the provided training. The forms are maintained in the employees electronic training file, which the PREA Coordinator shared with the auditor during the on-site audit.

Conclusion:

Based upon the review and analysis of the available evidence, the auditor has determined the facility is in compliance with the standard regarding employee training. No corrective action is required.

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

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

Documents Reviewed:

- Facility PAQ
- Policy Volunteer and contractor training
- Training records

115.232(a)-1 All volunteers and contractors who have contact with residents have been trained on their responsibilities under the agency's policies and procedures regarding sexual abuse/harassment prevention, detection, and response.

Within 30 days of commencing a volunteer or contract position, all volunteers and contractors who have contact with residents will be trained on their responsibility under the Peer I/The Haven's sexual abuse and sexual harassment, prevention, detection and response policies and procedures.

115.232(b)-2 The level and type of training provided to volunteers and contractors is based on the services they provide and level of contact they have with residents.

The level and type of training provided to volunteers and contractors shall be based on the services they provide and the frequency/volume of contact they have with residents. All volunteers and contractors who have contact with residents are notified of the agency's Zero Tolerance Policy regarding sexual abuse and sexual harassment, and informed of how to report such harassment.

Interviews:

- PREA Coordinator
- Contractors

The Haven currently does not have any contractors or volunteers that have access to the client. All volunteer services have been prohibited since the national pandemic. In any instance that the facility would enter into an agreement with the contractor or volunteer for services, the facility will provide the individual with an orientation and formal training; and periodic refresher trainings. Once volunteer services are initiated again, all of the providers that had previous approval to enter the facility will have to go through the entire application process, and before they are allowed to have contact with clients they will have to complete the orientation and training requirements.

Conclusion:

Based upon the review and analysis of the available evidence, the auditor has determined the facility is in compliance with this standard regarding volunteer and contractor training. No corrective action is required.

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

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

Documents Reviewed:

- Facility PAQ
- Policy Resident education
- Signed Acknowledgments
- Zero tolerance and hotline posters

115.233(a)-1 & 115.233(b)-1 Residents receive information at time of intake about the zero-tolerance policy, how to report incidents or suspicions of sexual abuse or harassment, their rights to be free from

sexual abuse and sexual harassment and to be free from retaliation for reporting such incidents, and regarding agency policies and procedures for responding to such incidents.

- (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. This handout also provides telephone numbers regarding how to report incidents of prohibited sexual behavior as well as other prevention and intervention tips. 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. Furthermore, clients receive information that they could be discharged or sanctioned for violations of the programs' PREA policies. Intake and admission staff discuss the PREA guidelines and their rights with clients. Clients sign an acknowledgment form that states they have received and understand the materials. This acknowledgment form is placed in the client's electronic health record.
- (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.

115.233(c)-1 Resident PREA education is available in formats accessible to all residents, including those who are:

- *Limited English proficient*
- *Deaf • Visually impaired*
- *Otherwise disabled*
- *Limited in their reading skills*

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

115.233(d)-1 The agency maintains documentation of resident participation in PREA education sessions.

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.

Interviews:

- Intake Staff
- Random Clients

When clients are admitted to the Haven, they are provided with PREA information that includes a brochure. The information is provided for all new intakes, even those transferring from institutional settings. The orientation will be provided by employee responsible for completing the clients' intake process. The facility PAQ states there were twenty-eight (28) clients admitted to the facility in the past

12 months. None of them were transferred from another community confinement facility; however, they were transferred from another institution (i.e., prison, or county jail).

During the intake process, the clients will watch a PREA video. Client interviews confirm they watch the video almost immediately upon their admission to the facility. Clients sign an acknowledgement form after watching the video, which verifies they understand the information provided to them. The auditor reviewed random client files with the PREA Coordinator and verified the clients sign an acknowledgement upon intake.

In the instances where a client is limited English speaking, a translator will be made available to communicate with client in a language that they understand. If a client is unable to read or write, the staff member conducting the intake will review the information with the client within 24 hours.

The Haven has demonstrated a commitment to ensuring the program clients understand their rights to be free from sexual abuse and sexual harassment. Clients receive PREA information immediately upon their admission to the facility. There are posters visible throughout the facility that indicates the clients have the ability to call the DOC hotline to make a report of sexual abuse and sexual harassment. The clients shared that there is a landline in the bathroom that will automatically dial the hotline if they need to make the call.

Conclusion:

Based upon the review and analysis of the available evidence, the auditor has determined the facility is in compliance with this standard regarding resident education. No corrective action is required.

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 receive 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

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

Documents Reviewed:

- Facility PAQ
- Policy Specialized training: Investigations
- Training Certificate

115.234(a-c) Agency policy requires that investigators are trained in conducting sexual abuse investigations in confinement settings.

- (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. PREA Coordinators receive additional training in order to assure the safe and appropriate conduct of investigations of incidents which do not

involve an allegation of sexual abuse. At minimum, PREA Coordinators will review the content provided in the "PREA: Investigating Sexual Abuse In a Confinement Setting" by NIC, or similar training which includes all items described in 115.234(b).

- (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.
- (c) Documentation that Agency Investigators have completed all appropriate trainings are maintained in his or her personnel file, located at either ARTS Administration (for Peer I) or Haven Administration (for Haven)

Interviews:

- PREA Coordinator
- Investigative Staff

The PREA Coordinator provided the auditor with proof that she has completed the investigators training, which qualifies her to conduct the facility administrative investigations. The facility PAQ and interviews with the PREA Coordinator indicate the PREA Coordinator is the only employee with the training to conduct sexual abuse and sexual harassment investigations. The training curriculum confirms the PREA Coordinator received the specialized training that covered; interviewing sexual abuse victims, 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.

The PREA Coordinator explained that she will investigate all staff-on-client and client-on-client investigations. All allegations that involve criminal behavior will be referred to the Denver Police Department Sex Crime Unit who will work with the district attorney's office for filing of charges.

Conclusion:

Based upon the review and analysis of the available evidence, the auditor has determined the facility is in compliance with this standard regarding specialized training for investigations. No corrective action is required.

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? (N/A if the agency does not have any full- or part-time medical or mental health care practitioners who work regularly in its facilities.)
☒ Yes ☐ No ☐ NA
- 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? (N/A if the agency does not have any full- or part-time medical or mental health care practitioners who work regularly in its facilities.) ☒ Yes ☐ No ☐ NA

- 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? (N/A if the agency does not have any full- or part-time medical or mental health care practitioners who work regularly in its facilities.) ☒ Yes ☐ No ☐ NA
- 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? (N/A if the agency does not have any full- or part-time medical or mental health care practitioners who work regularly in its facilities.) ☒ Yes ☐ No ☐ NA

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 does not employ medical staff or the medical staff employed by the agency 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? (N/A if the agency does not have any full- or part-time medical or mental health care practitioners who work regularly in its facilities.) ☒ Yes ☐ No ☐ NA

115.235 (d)

- Do medical and mental health care practitioners employed by the agency also receive training mandated for employees by §115.231? (N/A if the agency does not have any full- or part-time medical or mental health care practitioners employed by the agency.) ☒ Yes ☐ No ☐ NA
- 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 if the agency does not have any full- or part-time medical or mental health care practitioners contracted by or volunteering for the agency.) ☒ 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

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

Documents Reviewed:

- Facility PAQ
- Policy Specialized training: Medical and mental health care
- Training Records

115.235(a)-1 The agency has a policy related to the training of medical and mental health practitioners who work regularly in its facilities.

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 physician's assistant or doctor who is employed by ARTS who provides psychiatric medication management services to Haven or Peer I residents). Furthermore, Peer I and/or the Haven may hire persons for whom mental health care is all or part of their assigned job duties. All of these individuals providing medical or mental health care at Peer I and/or the Haven are provided with PREA training, which at minimum, encompasses items 115.235(a)1-4 as defined above. Furthermore, most of these professionals receive training on how to respond when a client has potentially been a victim or perpetrator of sexual abuse or harassment through their professional degree or certification program. Evidence of professional degree, certification and/or licensure is retained in the ARTS administration office. In the event that the immediate supervisor of one of these professionals is not within the Peer I and/or Haven organizational structure, the individual will report any allegations to The Haven or Peer I director.

Interviews:

- PREA Coordinator
- Facility Director
- Mental Health Staff

Conclusion: Based upon the review and analysis of the available evidence, the auditor has determined the facility is in compliance with this standard regarding specialized training for medical and mental health care. No corrective action is required.

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

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

Documents Reviewed:

- Facility PAQ
- Screening for Risk of Victimization and Abusiveness
- Risk Screening Tool

115.241(a)-1 The agency has a policy that requires screening (upon admission to a facility or transfer to another facility) for risk of sexual abuse victimization or sexual abusiveness toward other residents.

All clients are screened upon intake for their risk of victimization or abusiveness. This screening occurs within the first 12 hours of admission. As of August 1, 2015, all clients who are returned to custody or transferred to another facility are re-screened, as part of the discharge process.

Interviews:

- Case Manager
- Random Clients

According to the facility PAQ, twenty-eight (28) clients were admitted to the facility in the past 12 months whose risk for victimization or risk for offending was assessed. All of the clients were screened for risk of victimization or risk of sexually abusing other residents upon admission and within the first hour of the arrival. The staff member responsible for completing the intake process utilizes the electronic version of the PREA Victim/Predator Screening tool. Within 30-days of the each client's admission the PREA Coordinator will review the risk screening tool to update any information that was unknown during the intake process.

University of Colorado Anschutz requires the intake worker to perform a battery of screens and assessments to address the clients' safety and their treatment needs. The entire process takes place as soon as the client is admitted to the facility and the staff will continue to monitor the clients for several days after their admission.

Conclusion: Based upon the review and analysis of the available evidence, the auditor has determined the facility exceeds compliance with this standard regarding screening for risk of victimization and abusiveness. No corrective action is required.

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? (N/A if the agency has a dedicated facility, unit, or wing solely for the placement of LGBT or I residents pursuant to a consent decree, legal settlement, or legal judgement.) ☐ Yes ☐ No ☒ NA
- 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? (N/A if the agency has a dedicated facility, unit, or wing solely for the placement of LGBT or I residents pursuant to a consent decree, legal settlement, or legal judgement.) ☐ Yes ☐ No ☒ NA
- 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? (N/A if the agency has a dedicated facility, unit, or wing solely for the placement of LGBT or I residents pursuant to a consent decree, legal settlement, or legal judgement.) ☐ 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

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

Documents Reviewed:

- Facility PAQ
- Use of Screening Information

115.242(a)-1 The agency/facility uses information from the risk screening required by § 115.241 to inform housing, bed, work, 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.

The Haven and Peer I use information from the risk screening required by § 115.241 to inform housing, bed, work, 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 milieu, it is not possible to maintain complete separation between those assessed as "possible predators" and "known" or "possible victims". Staff supervision and awareness of these risk factors is used by staff when developing housing, bed, work, education, and program assignments. If there is a specific concern about interaction between two clients, therapeutic interventions, such as a "ban" on contact between those clients may be used to increase protective factors and staff awareness.

Interviews:

- Case Managers
- Client who identifies as LGBTI

The facility has established a policy that provides guidance to address the special needs for clients who identify as transgender. The policy states facility and housing assignments for transgender clients will be addressed on a case-by-case basis. The PREA Coordinator shared that a client was admitted to the facility since the last audit who identified as transgender. The client's risk for victimization or offending was screened utilizing the risk screening tool. The client was housed in a single room and consistent with the facility practice the client was allowed to shower alone.

During the onsite audit there were zero (0) clients residing in the facility who identified as transgender. The PREA Coordinator indicated a client's gender identity would not prevent them from being admitted. A client who identifies as transgender would be interviewed, assessed and screened for their appropriateness for the program in the same manner as all other clients.

Should a resident be identified as high risk of victimization they will be assigned to a sleeping room with clients with a similar risk classification. If the facility is unable to maintain a client safely in the facility the client would be discharged from the program.

Conclusion: Based upon the review and analysis of the available evidence, the auditor has determined the facility is fully compliant with this standard regarding use of screening information. No corrective action is required.

REPORTING

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

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

Documents Reviewed:

- Facility PAQ
- Policy Resident Reporting
- Zero Tolerance Posters
- Hotline Posters

115.251(a)-1 The agency has established procedures allowing for multiple internal ways for residents to report privately to agency officials about: • Sexual abuse or 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.

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. Specifically, clients are given the following options, in writing, at intake and the same reporting options are listed throughout the program facilities.

115.251(b)-1 The agency provides at least one way for residents to report abuse or harassment to a public or private entity or office that is not part of the agency.

Peer I and The Haven also inform residents of multiple methods they may use which are not part of Peer I, The Haven or ARTS. Each of the entities below has the ability to receive and immediately forward resident reports of sexual abuse and sexual harassment to The Haven and Peer I directors. These reporting methods allow the resident to remain anonymous if requested.

- (1) For Both Peer I and The Haven
 - i) Meet with, call, or write a letter to your case manager or community parole officer.
 - ii) Contact local law enforcement.
 - iii) Write the DOC PREA Manager at 2862 South Circle Drive Colorado Springs CO, 80906.
 - iv) Use the confidential PREA-designated telephone line. These phones are located in a bathroom, in the common living area at each residential house. These phone lines automatically dial the DOC TIPS Line (1-877-DOC-TIPS).
 - v) Call 24 Hour Rape Crisis Hotline 1-800-809-2344 or 303-322-7273.

115.251(c)-1 & 115.251(d)-1 The agency has a policy mandating that staff accept reports of sexual abuse and sexual harassment made verbally, in writing, anonymously, and from third parties. The agency has established procedures for staff to privately report sexual abuse and sexual harassment of residents.

The program will accept and investigate reports made by any means. All staff members have been trained to report immediately to their supervisor. This includes all reports made in any way, whether verbally, in writing, anonymously, and from third parties. The program will promptly document all reports and investigations.

Grievance Procedure

Due to the Therapeutic Community modality of treatment, clients have a number of ways to express their dissatisfaction. Clients are able to use program tools to work out their differences with other clients, notify staff regarding their frustrations or concerns, or write their concerns out to be addressed by their phase counselor or milieu supervisor. Clients are encouraged to use these tools to resolve problems and to notify their designated counselor. Likewise they will be encouraged to work directly with the party involved with the complaint/concern as an attempt to resolve the problem prior to initiating a grievance form. If they feel they are unable to resolve an issue via the program tools or if they feel they need to elevate the complaint, they can file a grievance at any time. (See attached forms and below procedure) **It should be noted that a client is not required to go through an internal grievance process if they do not choose to do so** and may directly contact the below resources who are also the resources to submit an appeal to. Furthermore, family members of ARTS clients or other individuals involved in the client's treatment may also utilize the below procedures to file a grievance. All clients may access all resources for grievance and appeal reasons. A copy of all grievances goes to ARTS Quarterly Improvement Coordinator for review.

If the grievance is not satisfactorily resolved by the client representative, an appeal may then be made to: ARTS EXECUTIVE DIRECTOR

Kristen Dixon

3732 W. Princeton Circle
Denver, CO 80236
Ph: (303) 761-6703

When a grievance is not satisfactorily resolved through the above process, the client may then proceed to contact any one of the following:

SIGNAL BEHAVIORAL HEALTH NETWORK

Mindy Paddock
6130 Greenwood Plaza Blvd., Suite #150
Greenwood Village, CO 80111
Ph: (720) 263-4859

OFFICE OF BEHAVIORAL HEALTH

Colorado department of social services

3824 West Princeton Circle
Denver, CO 80236-3111
Ph: (303) 866-7400

DEPARTMENT OF REGULATORY AGENCIES (DORA)

Division of Registrations
303-894-7800 (select the option for "complaint") or
303-894-7766

Interviews:

- PREA Coordinator
- Random Clients
- Random Staff

The Haven provides the clients with multiple internal methods to make a confidential private report of sexual abuse and sexual harassment. The internal reporting methods include making a verbal or written report to any staff member and file a grievance using the client database system. During client interviews they verified the different methods of reporting. Also, during client interviews they consistently report they have the ability to contact the DOC PREA hotline, talk to their case manager, the facility Director, a trusted staff member, and have the ability to report directly to law enforcement.

Clients may use any means at their disposal to report incidents of sexual assault, sexual violence, sexual misconduct or sexual contact when they are a victim of such acts, or when they have direct knowledge that such acts have been perpetrated or are being planned to be perpetrated upon any other client. In an effort to provide clients with several reporting options, including outside agencies that accept reports, and options that would protect the reporting party's identity from being revealed to other clients, the following specific reporting options will be afforded:

1. Direct verbal report to any the Haven staff member, contractor/vendor, or volunteer.
2. Direct written report to any the Haven staff member, contractor/vendor, or volunteer.
3. Through the DOC tip line (1-877-DOC-TIPS/1-877-362-8477).

The facility has installed a landline in one of the bathrooms which dials directly to the hotline. The phone is in the bathroom because the client would not have to get permission from staff and the bathroom affords them privacy to make a report. The auditor tested the phone line while on-site and was successful connecting with the Colorado Department of Corrections reporting hotline.

Staff interviews indicated that they have a variety of private reporting mechanisms available for them to make a private report sexual abuse. There is an understanding they can contact the agency Human Resource staff, . make a report to their supervisor, the agency PREA Coordinator, the facility Program Director/PREA Compliance Manager. Additionally, the staff report they also have the ability to contact the DOC PREA hotline.

Conclusion:

Based upon the review and analysis of the available evidence, the auditor has determined the facility exceeds this standard regarding resident reporting. Residents are provided with numerous ways to report both internally and externally. No corrective action is required

Standard 115.252: Exhaustion of administrative remedies

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

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

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

Documents Reviewed:

- Facility PAQ
- Policy Upgrades to facilities and technology

- (a) An agency shall be exempt from this standard if it does not have administrative procedures to address resident grievances regarding sexual abuse.
- (b)
- (1) The Agency shall not impose a time limit on when a resident may submit a grievance regarding an allegation of sexual abuse.
 - (2) The agency may apply otherwise applicable time limits on any portion of a grievance that does not allege an incident of sexual abuse.
 - (3) The agency shall not require a resident to use any informal grievance process, or to otherwise attempt to resolve with staff, an alleged incident of sexual abuse.
 - (4) Nothing in this section shall restrict the agency's ability to defend against a lawsuit filed by a resident on the ground that the applicable statute of limitations has expired.
- (c) The agency shall ensure that-
- (1) A resident who alleges sexual abuse may submit a grievance without submitting it to a staff member who is the subject of the complaint, and
 - (2) Such grievance is not referred to a staff member who is the subject of the complaint.
- (d)
- (1) The agency shall issue a final agency decision on the merits of any portion of a grievance alleging sexual abuse within 90 days of the filing of the grievance.
 - (2) Computation of the 90 day time period shall not include time consumed by residents in preparing any administrative appeal.
 - (3) The agency may claim an extension of time to respond, up to 70 days, if the normal time period for response is insufficient to make an appropriate decision. The agency shall notify the resident in writing of any such extension and provide a date by which the decision will be made.
 - (4) 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, the resident may consider the absence of a response to be a denial at that level.
- (e)

- (1) Third parties, including fellow residents, staff members, family members, attorneys, and outside advocates, shall be permitted to assist residents in filing requests for administrative remedies relating to allegations of sexual abuse and shall also be permitted to file such requests on behalf of residents.
 - (2) 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.
 - (3) If the resident declines to have the request processed on his or her behalf, the agency shall document that resident's decision.
- (f)
- (1) The agency shall establish procedures for the filing of an emergency grievance alleging that the resident is subject to a substantial risk of imminent sexual abuse.
 - (2) After receiving an emergency grievance alleging a resident is subject to a substantial risk of imminent sexual abuse, the agency shall immediately forward the grievance (or any portion thereof that alleges the substantial risk of imminent sexual abuse) to a level of review which immediate corrective action may be taken, shall provide an initial response within 48 hours, and shall issue a final agency decision within 5 calendar days. The initial response and final agency decision shall document the agency's determination whether the resident is in substantial risk of imminent sexual abuse and the action taken in response to the emergency grievance.
 - (3) The agency may discipline a resident for filing a grievance related to alleged sexual abuse only where the agency demonstrates that the resident filed the grievance in bad faith.

Interviews:

- PREA Coordinator

The agency policy allows a client to submit a grievance alleging an allegation of sexual abuse at any time regardless of when the incident is alleged to have occurred. Clients are encouraged to resolve grievances directly with staff but are not required to do so. Also, they are not required to try to resolve a sexual abuse grievance with the staff member named in the grievance or with any other staff member. The facility received zero emergency grievances alleging substantial risk of imminent sexual abuse that were filed in the past 12 months.

The facility PAQ states there were zero (0) grievances alleging sexual abuse. The interviews with the clients at the Haven shared that they have access to the Program Director. The auditors impression is that since the Program Director is so accessible the clients have the ability to address their grievances through informal means. Every client denied submitting a grievance for any reason since their admission to the program.

Conclusion: Based upon the review and analysis of the available evidence, the auditor has determined the facility is fully compliant with this standard regarding exhaustion of administrative remedies. No corrective action is required.

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

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

Documents Reviewed:

- Facility PAQ
- Policy Exhaustion of Administrative Remedies
- Policy Grievance
- Policy Grievance/Appeals Procedure

115.253(a)-1 The facility provides 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) for local, state, or national victim advocacy or rape crisis organizations;*
- Enabling reasonable communication between residents and these organizations in as confidential a manner as possible.*

During admission, clients are asked to read and sign a PREA Acknowledgement form that contains information on how to access outside victim advocates and emotional support services. The form includes mailing addresses, telephone numbers, and toll free hotline numbers. Copies of the PREA “Facts You Should Know” document containing the contact information are given to all clients upon intake. Additionally, other copies of this brochure are prominently displayed and available at each residential house. Residents have the right to access these services as confidentially as possible. For example, a resident who needs to speak with a victim advocate may be allowed to use a phone in a room where no other residents can see or hear the conversation. Phone calls are not recorded, and any records of client contact with these advocates and support services would be retained in either the client’s electronic or paper chart.

Interviewed:

- Facility Director
- PREA Coordinator
- Random Residents

Clients are made aware of their right to access outside victim advocates for emotional support services related to sexual abuse during the orientation.

According to the PAQ, and interviews with the PREA Coordinator residents would be informed prior to contacting a victim advocate the extent to which such communication would be monitored, the mandatory reporting rules, confidentiality, and/or privilege that apply for disclosures of sexual abuse made to outside victim advocate; including any limits to confidentiality.

The agency has an established relationship with the Blue Bench to provide counseling and advocacy services for sexual assault victims residing at the Haven.

Conclusion:

Based upon the review and analysis of the available evidence, the auditor has determined the facility is fully compliant with this standard regarding resident access to outside confidential support services and legal representation. No corrective action is required.

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

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

Documents Reviewed:

- Facility PAQ
- Policy Third-party reporting

The agency shall establish a method to receive third-party reports of sexual abuse and sexual harassment and shall distribute publicly information on how to report sexual abuse and sexual harassment on behalf of a resident.

Interviewed:

- PREA Coordinator

Both the agency and the facility provide methods for third-party reporting. On the agency website at: <https://www.artstreatment.com/prea/>. The website lists the DOC reporting hotline as a reporting option. Another option is to write a note to staff, talk to a staff member, the PREA Coordinator or submit report from the link on the agency website. Reporting information is also made available through posters and facility PREA brochures.

Conclusion:

Based upon the review and analysis of the available evidence, the auditor has determined the facility is in compliance with this standard regarding third-party reporting. No corrective action is required.

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, do 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 persons 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

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

Documents Reviewed:

- Facility PAQ
- Policy Staff and Agency Reporting Duties

115.261(a)-1 The agency requires all staff to report immediately and according to agency policy any knowledge, suspicion, or information they receive regarding an incident of sexual abuse or sexual harassment that occurred in a facility, whether or not it is part of the agency.

The agency shall 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 the facility, whether or not it is part of the agency; retaliation against resident or staff who reported such an incident; and any staff neglect or violation of responsibilities that may have contributed to an incident or retaliation.

115.261(b)-1 Apart from reporting to designated supervisors or officials and designated state or local services agencies, agency policy prohibits staff from revealing any information related to a sexual abuse report to anyone other than to the extent necessary to make treatment, investigation, and other security and management decisions.

Apart from reporting to designated supervisors or officials (as indicated by coordinated response flow chart), staff will not share any information related to a sexual abuse report to anyone other than to the extent necessary to coordinate treatment. It is the supervisor's responsibility to provide guidance to staff regarding how to best support these issues of confidentiality as it pertains to milieu treatment and milieu security concerns. The Haven/Peer I management team will provide further instruction about "need to know" reporting dependent upon the individual situation. Generally, information related to a sexual abuse report shall be shared strictly on a "need to know" basis.

115.261(d)-1

If the alleged victim is under the age of 18 or is considered a vulnerable adult under State or Local vulnerable person's' statute, the agency shall report the allegation to the designated state or local social services agency under applicable mandatory reporting laws. In the event of sexual assault, The Haven and Peer I report to (as applicable to the individual): OBH, Signal, Community Corrections, DCJ, ARTS Directors/QPI, University Risk Management.

115.261(e)-1

Peer I and Haven staff report all allegations of sexual abuse and sexual harassment, including third-party and anonymous reports to their supervisor, regardless of whether this incident occurred in and ARTS facility or another facility. If the concern involves the supervisor, the staff may also report to the Program Director or PREA Coordinator/Investigator. Program director or designee will provide notification to outside facilities/agencies involved in the alleged incident if the incident occurred outside of ARTS/Peer I/The Haven.

Interviewed:

- Facility Director
- Mental Health Staff
- Random Staff

Staff interviews confirm they are required to immediately report to their supervisors or the staff member in charge when there is an allegation of sexual abuse. This expectation was evident throughout the agency hierarchy. All staff reported understanding that they are required to comply with the PREA reporting standard. In any case where an allegation of sexual abuse is reported, the first staff member to receive the report shall inform their supervisor, who will initiate the agencies required notifications.

Conclusion:

Based upon the review and analysis of the available evidence, the auditor has determined the facility is compliant with this standard regarding staff and agency reporting duties. No corrective action is required.

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

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

Documents Reviewed:

- Facility PAQ
- Policy Agency Protection Duties

When an agency learns that a resident is subject to a substantial risk of imminent sexual abuse it shall take immediate action to protect the resident.

Interviewed:

- Executive Director
- Facility Director
- Random Staff

There were zero (0) allegations where the facility determined that a resident was subject to substantial risk of imminent sexual abuse.

The Executive Director, Program Manager, and the PREA Coordinator confirmed staff should respond "Immediately" to protect clients who are subject to a substantial risk of imminent sexual abuse. Protective measures would include separating the potential victim from the potential aggressor. If the risk involves a staff member as the potential aggressor, the staff member will be limited or prohibited by either changing their assignment or the individual staff member on administrative leave.

Staff interviews indicate that if they were to receive a sexual abuse allegation report, they would immediately separate the alleged victim from the alleged perpetrator; inform their supervisor, make the appropriate notifications, and finally document the information received. The Haven has the ability to make room assignment changes. If a client cannot be safe with a room change the alternative is to discharge the client who presents a safety issue. In the rare instances that a client cannot be managed safely within the program, the last alternative would be to return the client to their previous institutional setting (i.e., DOC or local jail).

According to the PAQ there were zero (0) instances where the facility determined that a client was subjected to substantial risk of imminent sexual abuse. Of the clients interviewed by the auditor none of them reported being at risk of imminent sexual abuse.

Conclusion:

Based upon the review and analysis of the available evidence, the auditor has determined the facility is fully compliant with this standard regarding agency protection duties. No corrective action is required.

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

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

Documents Reviewed:

- Facility PAQ
- Policy Agency Protection Duties

Policy

- (a) Upon receiving an allegation that a resident was sexually abused while confined at another facility, the head of the facility that received the allegation shall notify the head of the facility or appropriate office of the agency where the alleged abuse occurred.
- (b) Such notification shall be provided as soon as possible, but no later than 72 hours after receiving the allegation.
- (c) The agency shall document that it has provided such notification.

(d) The facility head or agency office that receives such notification shall ensure that the allegation is investigated in accordance with these standards.

Interviewed:

- Executive Director
- Facility Program Manager

The facility PAQ indicates there were zero (0) allegations received by the facility that a client was abused while confined at another facility; additionally, there have been zero (0) allegations of sexual abuse that the facility received from other facilities. Interviews with the Executive Director, Program Manager and the PREA Coordinator indicated they have knowledge of this requirement and confirm that this policy will be strictly followed.

Conclusion:

Based upon the review and analysis of the available evidence, the auditor has determined the facility is in compliance with this standard regarding reporting to other confinement facilities. No corrective action is required.

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

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

Documents Reviewed:

- Facility PAQ
- Policy Staff First Respondent duties

115.264(a)-1 The agency has a first responder policy for allegations of sexual abuse. If YES, the policy requires that, upon learning of an allegation that a resident was sexually abused, the first security staff member to respond to the report shall be required to:

- (1) Separate the alleged victim and abuser;*
- (2) Preserve and protect any crime scene until appropriate steps can be taken to collect any evidence;*
- (3) If the abuse occurred within a time period that still allows for the collection of physical evidence, 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; and/or*
- (4) If the abuse occurred within a time period that still allows for the collection of physical evidence, 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.*

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 AND complete and document each of the following on the First Responder Duties Form:

- (1) Separate the alleged victim and abuser. First responder and supervisor will use best judgment to ascertain the safest locations for each the alleged victim and the alleged abuser. Generally

the safest place will be in a staff office accompanied by a staff member. Additional staff from other program houses may be asked to provide additional support if necessary.

- (2) Preserve and protect any crime scene until appropriate steps can be taken to collect any evidence. This includes, at minimum, eliminating further foot traffic in the room or rooms in which the alleged abuse occurred. First responder and supervisor (or designee) will determine the spaces that need to be protected and identify a plan of action for protecting the scene. This may include a broad range of activities, from taping off a single room to having all residents go to another location on campus until such a time the scene can be investigated. All evidence collection will be conducted by Denver Police Department. First responder will document any known disruption of the crime scene between the time the alleged event occurred and the time that evidence is collected.
- (3) If the abuse occurred within a time period that still allows for the collection of physical evidence, the first responder requests that the alleged victim does not take any actions that could destroy physical evidence, including as appropriate washing, brushing teeth, changing clothes, urinating, defecating, smoking, drinking, or eating.
- (4)
 - a) If the abuse occurred within a time period that still allows for the collection of physical evidence, request that the alleged abuser not take any actions that could destroy physical evidence, including, as appropriate, washing, brushing teeth, changing clothes, urinating, defecating, smoking, drinking or eating. First responder will provide supportive instruction around these issues.
 - b) If the first responder is not trained to perform security staff member duties, the responder must request that the alleged victim not take any actions that could destroy physical evidence and then notify the nearest staff member who has been trained in security staff duties. All Haven milieu staff and supervisors are trained in security staff duties within 30 days of hire, and all Operations staff at Peer I are trained in security staff duties within 30 days of hire

Interviewed:

- Random Staff

The facility PAQ indicates there were zero (0) allegations that a client was sexually abused while being housed at the Haven in the past 12 months or since the last audit. Random staff interviews indicate they would accept an allegation and separate the alleged victim from the alleged perpetrator. The staff report if the alleged perpetrator is another client they would speak with their supervisor to determine the next appropriate steps to take to ensure the alleged victims safety. If the alleged perpetrator is a staff member the staff interviews indicate they would keep the alleged victim in their vicinity until the on-call administrator determines the next appropriate steps to take and refer the client to one of the mental health professionals for crisis intervention care.

Interviews with contract staff members who are not designated as a security staff member are required to report the allegation to a facility supervisor as well as their department supervisor. The contract staff indicated they would wait for guidance from the security staff to determine their next steps to make sure they are not interfering with the investigation.

Conclusion:

Based upon the review and analysis of the available evidence, the auditor has determined the facility is fully compliant with this standard regarding staff first responder duties. No corrective action is required.

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

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

Documents Reviewed:

- Facility PAQ
- Coordinated Response

The Haven and Peer I have developed a written institutional plan to coordinate actions taken in response to an incident of sexual abuse, among staff first responders, medical and mental health practitioners, investigators, and facility leadership.

Interviewed:

- Facility Program Director

The Haven staff will refer to the facility coordinated response plan and work closely with community agencies like law enforcement, hospitals, mental health treatment providers, and rape crisis centers to provide victims with services that equal that of the community level of care. The PREA Coordinator stated the facility/agency would be transparent and share all necessary information with those with a need to know while protecting client confidentiality to the extent possible.

Conclusion:

Based upon the review and analysis of the available evidence, the auditor has determined the facility is in compliance with this standard regarding a coordinated response to an incident of sexual abuse. No corrective action is required.

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

Documents Reviewed:

- Facility PAQ
- Policy Agency Protection Duties

- (a) Neither the agency nor any other governmental entity responsible for collective bargaining on the agency's behalf shall 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 of a determination of whether and to what extent discipline is warranted.
- (b) Nothing in this standard shall restrict the entering into or renewal of agreements that govern:
 - (1) The conduct of the disciplinary process, as long as such agreements are not inconsistent with the provisions of 115.272 and 115.276; or

- (2) Whether a no-contact assignment that is imposed pending the outcome of an investigation shall be expunged from or retained in the staff member's personnel file following a determination that the allegation of sexual abuse is not substantiated.

Interviewed:

- Executive Director

The Haven is a state facility under the jurisdiction of the University of Colorado Anschutz. The employees are not a part of a collective bargaining agreement. The majority of the employees are at-will, which does not require the agency or an employee to give advance notice of termination or resignation. There are some staff that fall under the state classified system. Those employees are afforded the right to due process, which would require placing an employee on administrative leave until an investigation into an allegation of sexual misconduct is concluded.

Conclusion:

Based upon the review and analysis of the available evidence, the auditor has determined the facility is fully compliant with this standard regarding the preservation of ability to protect residents from contact with abusers with the absence of a collective bargaining agreement. No corrective action is required.

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

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

Documents Reviewed:

- Facility PAQ
- Policy Agency Protection Against Retaliation

115.267(a)-1, 115.267(c-e) The agency has 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. The agency and/or facility monitors the conduct or treatment of residents or staff who reported sexual abuse and of residents who were reported to have suffered sexual abuse to see if there are any changes that may suggest possible retaliation by residents or staff.

- (a) The Haven and Peer I programs protect all residents and staff who report sexual abuse or harassment or cooperate with sexual abuse or sexual harassment investigations.
- (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 conduct and treatment of that person.
- (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.

115.267(b)-1

The Haven and Peer I programs will employ multiple measures to assure protection from retaliation. These measures may include but is not limited to one or more of the following:

- (4) 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.
- (5) 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**.

Interviewed:

- Executive Director
- Facility Director
- PREA Coordinator

Interviews indicate the facility staff have the option of transferring clients from room to another, or discharge a client who is alleged to have sexually harass or sexually another client or staff member. The PREA Coordinator, Program Director or designee, and other staff when on duty are responsible for monitoring for retaliation against staff or clients who reported or participated in a PREA investigation. Monitoring involves reviewing behavior documentation, incident reports, progression in the program, and the clients' ability to access services. When a client makes a PREA report the facility will offer emotional support services for clients or staff that fear retaliation for reporting sexual abuse or sexual harassment or for cooperating with investigations.

The Program Director has an expectation that all of the Haven staff will report possible retaliation of threats against victims and witnesses. The policy explicitly states retaliation monitoring will occur on a regular basis for periodic status checks, to monitor for signs of retaliation from other clients or staff. Retaliation will continue for a minimum of 90 days, and can occur for longer if deemed necessary. All

retaliation monitoring check-in are documented in the client's file or a staff member personnel file. The facility reports zero (0) incidents of retaliation in the past 12 months and since the last PREA audit.

Conclusion:

Based upon the review and analysis of the available evidence, the auditor has determined the facility is compliant with this standard regarding agency protection against retaliation. No corrective action is required.

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 (I)

- 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

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Documents Reviewed:

- Facility PAQ
- Policy Criminal and Administrative Agency Investigations

115.271(a)-1 The agency/facility has a policy related to criminal and administrative agency investigations.

The Peer I/Haven Programs ensure that all internal criminal and administrative investigations regarding allegations of sexual abuse and harassment will be prompt, thorough, and objective for all reports, including third-party and anonymous reports.

115.271(b)-1 & 115.271(c)-1

- (b) The Haven and Peer I programs do not investigate any PREA allegations which appear to be criminal in nature. Where sexual abuse is alleged, only investigators with special training in sexual abuse such as Denver Police Department Sex Crimes Unit or SANE Nurses (through Denver Health Medical Center) will conduct investigations in accordance with PREA Standard 115.234.
- (c) The Haven and Peer I programs do not gather any evidence as part of a criminal investigation, unless specifically instructed to do so by a member of law enforcement. Law Enforcement Investigators shall gather and preserve direct and circumstantial evidence, including any available physical, DNA evidence and any available electronic monitoring data; shall interview alleged

victims, suspected perpetrators and witnesses; and shall review prior complaints and reports of sexual abuse involving suspected perpetrator.

(1) Haven and Peer I PREA Coordinators will assist trained investigators in accessing prior complaints and reports of sexual abuse involving the suspected perpetrator for any complaints or reports generated by The Haven or Peer I.

(2) Haven and Peer I staff will support the evidence gathering process by completing first responding duties.

115.271(d)-1 & 115.271(h)-1

(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.

(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 The Haven or Peer I.

115.271(f)-1 & 115.271(g)-1

(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.
- (3) Please see attached for the Administrative Investigation Process

(h) Criminal investigations are documented in a written report, the **PREA Incident Report**, which contains a thorough description of all evidence gathered and attaches copies of all documentary evidence when feasible.

115.271(i)-1

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).

115.271(j)-1

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.

Interviews:

- Facility Program Director
- PREA Coordinator

- Investigative Staff

All suspected, threatened or reported acts of sexual assault, sexual violence, sexual misconduct or sexual contact that occurs within the facility or any other location where a client works or they participate in community services will be investigated according to the protocols established by the Denver Police Department Sex Crime Unit. When a client makes a report that they were sexually harassed or sexually abused the facility will immediately initiate an investigation. The staff are expected to ensure the client is safe by separating the victim from the offender and immediately make a report to their immediate supervisor of the supervisor on duty.

The PREA Coordinator has completed investigator training and she meets the requirements necessary to conduct administrative investigations. The facility investigation report shall include an effort to determine if staff actions or failure to act contributed to the abuse. The report shall also include a description of the physical and testimonial evidence, the reasoning behind credibility assessments, and the investigative facts and findings. All potential legal considerations will be brought to the attention of the responsible law enforcement officer who may in turn consult with the District Attorney's office for legal guidance.

All acts of sexual abuse by a staff member will result in their termination and reported to local law enforcement and the appropriate licensing/certification board. Any employee who resigns during an investigation, or before their employment can be terminated, will not be a basis for terminating an investigation. All administrative and criminal investigations will continue until completion. The departure of an alleged abuser or victim from the Haven, whether they were an employee or client, shall not provide basis for terminating an investigation. The PREA Coordinator stated she will conduct a thorough investigation even if a client is discharged from the program or a staff member was no longer employed.

Conclusion:

Based upon the review and analysis of the available evidence, the auditor has determined the facility is fully compliant with this standard regarding criminal and administrative agency investigations. No corrective action is required.

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

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

Documents Reviewed:

- Facility PAQ
- Policy Evidentiary Standard of Administrative Investigations

As it pertains to PREA Investigations, The Haven and Peer I conduct administrative investigations and use no standard higher than a preponderance of the evidence in determining whether the allegations are substantiated. Relevant to this standard, The Haven and Peer I consider 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 I and the Haven notify the Denver Police Department Sex Crimes Unit, which is also subject to this evidentiary standard.

Interviews:

- PREA Coordinator/Investigator

Once the PREA Coordinator receives a PREA report she would coordinate with the Program Director to ensure a thorough investigation is conducted. If during the investigation it was determined that a possible crime was committed a report would be made to the Denver Police Department Sex Crime Unit. The PREA Coordinator stated the agency/facility would cooperate fully with law enforcement during all criminal investigations. The agency does not have the authority to determine a prosecutable crime; therefore, the facility would support and cooperate with the decision made by law enforcement.

In cases where the incident resulted in an administrative and criminal investigation, a standard of "preponderance of the evidence" will be used by the PREA Coordinator in determining whether allegations are considered substantiated, unsubstantiated, or unfounded.

Conclusion:

Based upon the review and analysis of the available evidence, the auditor has determined the facility is fully compliant with this standard regarding evidentiary standard for administrative investigations. No corrective action is required.

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 the agency's 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

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

Documents Reviewed:

- Facility PAQ
- Policy Reporting to Residents
- PREA Resident Notification of Investigation Outcome form

- (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. The original document will be retained in the PREA Investigation Binder and a copy will be given to the resident. If resident is no longer at The Haven or 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/The Haven 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/The Haven;
 - (3) the agency learns that the staff member has been indicted on a charge related to sexual abuse within Peer I/The Haven or

- (4) Peer I/The Haven 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) The Peer I/Haven programs are not obligated to report under this standard if the resident is released from the Peer I or The Haven's custody.

Interviews:

- PREA Coordinator/Administrative Investigator
- Facility Director

The facility received one (1) PREA allegation that involved sexual misconduct (i.e., client-on-client misconduct that involved letter writing that indicated a romantic interest) in the past 12 months or since the last PREA audit. At the conclusion of the investigation the clients received written notification about the outcome of the investigation.

When a client makes a sexual abuse report while residing at the Haven, the PREA Coordinator will inform the client-victim of the outcome of the investigation at the conclusion. The notification will be made whether the investigation was conducted by the facility or the Denver Police Department. If the allegation involves a staff member and resulted in a substantiated finding, The Haven will keep the client-victim apprised of that staff member's employment status and also inform the client-victim when/if the offending staff member is indicted or convicted on related criminal charges. If the allegation was against another client, the Haven will inform the client-victim when/if their abuser is indicted or convicted of criminal charges related to sexual abuse in the facility. The practice within the facility is to inform clients about the outcome of all sexual harassment and sexual abuse allegation no matter the outcome.

The Haven will document in the client-victim's file all notifications, and attempts to notify, until such time as the client-victim is no longer a client of the Haven. At that time, the Haven's obligation to report to the client-victim about their abuser is fulfilled.

Conclusion:

Based upon the review and analysis of the available evidence, the auditor has determined the facility is fully compliant with this standard regarding reporting to residents. No corrective action is required.

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

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

Documents Reviewed:

- Facility PAQ
- Policy Disciplinary Sanctions for Staff

- (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 policies 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 Resources 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.

Interviews:

- Program Director
- PREA Coordinator

The facility PAQ indicates there has not been any staff member that has been reported to have violated the agency sexual abuse/sexual harassment policy in the past 12 months or since the last audit.

Any allegation against a Haven employee that is substantiated or unsubstantiated will subject the employee to disciplinary sanctions up to, and including, termination. Discipline will be commensurate with the nature of the offense and circumstances.

All acts of sexual abuse by a staff member will result in their termination and reported to local law enforcement. Any employee who resigns during an investigation, or before their employment can be terminated, will not be a basis for terminating the investigation. All administrative and criminal investigations will continue until completion.

Conclusion:

Based upon the review and analysis of the available evidence, the auditor has determined the facility is fully compliant with this standard regarding disciplinary sanctions for staff. No corrective action is required.

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

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

Documents Reviewed:

- Facility PAQ
- Policy Corrective Action for Contractors and Volunteers

- (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.

Interviews:

- PREA Coordinator
- Program Director

The University of Colorado Anschutz does not employ any contractors to provide services within the facility. Since the country has been impacted by the pandemic, the facility has not allowed volunteers to provide services to the clients. Prior to the pandemic, the facility did not have to deal with a volunteer for violating the zero tolerance policy.

Conclusion:

Based upon the review and analysis of the available evidence, the auditor has determined the facility is fully compliant with this standard regarding corrective action for contractors and volunteers. No corrective action is required.

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)

- If the agency prohibits all sexual activity between residents, 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

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

Documents Reviewed:

- Facility PAQ

- Policy Disciplinary Sanctions for Residents
- Incident Report
- Investigation Report

115.278(a)-1, 115.278(b)-1 & 115.278(c)-1 Residents are subject to disciplinary sanctions only pursuant to a formal disciplinary process following an administrative finding that a resident engaged in resident-on-resident sexual abuse.

- (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.

115.278(d)-1 The facility offers therapy, counseling, or other interventions designed to address and correct the underlying reasons or motivations for abuse.

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 deem 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. This may include individual therapy services and may require these services as a condition of continued participation in the program.

115.278(e)-1 The agency disciplines residents for sexual conduct with staff only upon finding that the staff member did not consent to such contact.

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.

Interviews:

- PREA Coordinator
- Program Director

The Haven provided the auditor with an incident and investigation report which shows two clients engaged in misconduct that resulted in a PREA investigation by the PREA Coordinator. The investigation report demonstrates a thorough investigation was conducted that involved interviewing the involved client, reviewing documented evidence and making a finding at the conclusion of the investigation. The investigation made a substantiated finding, which resulted in the involved clients being discharged from the program and returned to custody. The PREA Coordinator explained when it has been determined that a client has violated the zero tolerance policy they facility would move to discharge the client from the program for the safety of all of the other clients.

Conclusion:

Based upon the review and analysis of the available evidence, the auditor has determined the facility is fully compliant with this standard regarding interventions and disciplinary sanctions for residents. No corrective action is required.

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

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

Documents Reviewed:

- Facility PAQ
- Policy Access to Emergency Medical and Mental Health Services

115.282(a)-1, 115.282(b)-1 & 115.282(c)-1 PResident victims of sexual abuse receive timely, unimpeded access to emergency medical treatment and crisis intervention services.

Resident victims of sexual abuse while incarcerated are 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.

- (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) If mental health or senior counseling staff is not on duty, and immediately following referral and coordination of emergency medical care, the PREA Coordinator will notify the on-call Mental Health Therapist at the Haven or the Designated Senior Counseling Staff at Peer I. If sexual abuse has occurred and the victim is transported to Denver Health, the designated on-call staff member will stay with the victim at the hospital to coordinate care. In conjunction with Denver Health, the Blue Bench will be notified and per MOU, will meet the client at Denver Health

Medical Center to provide advocacy services. 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.

115.282(d)-1 Treatment services are provided to every victim without financial cost and regardless of whether the victim names the abuser or cooperates with any investigation arising out of the incident.

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.

Interviews:

- PREA Coordinator
- Mental Health
- Random Staff
- Clients

Interviews with clients and staff suggest clients would have easy and unimpeded access to emergency medical treatment and crisis intervention services if they are victims of sexual abuse. Clients can access medical services at Denver Health and advocacy support through the Blue Bench, which is the local community rape crisis center. An interview with the mental health practitioner indicated she would support the client and ensure all of their needs are addressed when they have been identified as a victim of any traumatic event, which includes sexual abuse and sexual harassment. She stated if a client's needs could not be addressed by the facility she would refer the client to a community provider.

Conclusion:

Based upon the review and analysis of the available evidence, the auditor has determined the facility is fully compliant with this standard regarding access to emergency medical and mental health services. No corrective action is required.

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. *Note: in “all-male” facilities, there may be residents who identify as transgender men who may have female genitalia. Auditors should be sure to know whether such individuals may be in the population and whether this provision may apply in specific circumstances.*) ☒ 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. *Note: in “all-male” facilities, there may be residents who identify as transgender men who may have female genitalia. Auditors should be sure to know whether such individuals may be in the population and whether this provision may apply in specific circumstances.*) ☒ 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

115.283 (h)

- 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

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

Documents Reviewed:

- Facility PAQ
- Policy Ongoing Medical and Mental Health Care for Sexual Abuse Victims and Abusers

- (d) The Haven and Peer I programs 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. The incident will be relayed to the PREA Coordinator and program director. With respect to federal confidentiality laws (42CFR), the DOC PREA specialist will be informed so that the facility where the incident occurred can be advised. Additionally, all clients receive an initial physical examination within 4 weeks of being admitted into the programs. All services delivered in accordance with this section will be done in accordance with professionally accepted standards of care.
- (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. All services delivered in accordance with this section will be done in accordance with professionally accepted standards of care
- (b) The Haven has a mental health therapist and Peer I 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. All services delivered in accordance with this section will be done in accordance with professionally accepted standards of care
- (c) All clients who have had sexually abusive vaginal penetration will be referred within 24 hours to Sheridan Health Services for pregnancy testing. All services delivered in accordance with this section will be done in accordance with professionally accepted standards of care
- (d) If the resident is positive for pregnancy then OBGYN and prenatal services will be provided by Sheridan Health Services. In addition, Sheridan Health Services and the program mental health team will provide pregnancy options counseling regarding lawful pregnancy-related services. Clients at the Haven will also be provided doula services and case management services to doctor appointments. All services delivered in accordance with this section will be done in accordance with professionally accepted standards of care

- (e) Victims of sexual abuse will be referred to Sheridan Health Services for detection and treatment of sexually transmitted infections. All services delivered in accordance with this section will be done in accordance with professionally accepted standards of care
- (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 I 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 care coordination meeting will occur to determine risk to clients and a plan for services will be initiated. The Haven and Peer I programs reserve the right to reject after accept if the abuser does not appear appropriate for these programs due to their history. However, directors and senior staff, along with the PREA coordinator and compliance manager will staff the situation to determine risk, prior behaviors, mental health, and severity of their former sexual offense and within 60 days of learning of such abuse history the programs will offer treatment when deemed appropriate by administrators and mental health practitioners. All services delivered in accordance with this section will be done in accordance with professionally accepted standards of care

Interviewed:

- Program Director
- PREA Coordinator

According to the Program Director and the PREA Coordinator, if it was found that a client was an offender of sexual abuse or sexual harassment while residing at the Haven, the client would be discharged from the program. Since the Haven is a therapeutic facility that is intended to address substance use and mental health, a client with a sex offense would not be appropriately served in the program and could potentially influence the safety in the facility.

Conclusion:

Based upon the review and analysis of the available evidence, the auditor has determined the facility is fully compliant with this standard regarding ongoing medical and mental health care for sexual abuse victims and abusers. No corrective action is required.

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

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

Documents Reviewed:

- Facility PAQ
- Policy Sexual Abuse and Incident Review
- PREA Incident Review Team Report

- (a) Peer I and the Haven conduct 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. PREA Coordinator will report, at minimum, to program director when an 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.
 - (1) The Peer I Incident Review team will include: the Program Director, the Assistant Director, one or more of the House Managers, the head of the Operations Department (as needed), and the PREA Coordinator. Other positions may be added as needed.
 - (2) Haven Incident Review team will include at minimum: the Program Director, one or more Milieu Coordinators, the Haven PREA Coordinator. Other positions may be added as needed.
- (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. The team will then assess if staffing levels are appropriate, if the

floor plans in the facilities influence the potential for such incidents, and if monitoring technology should be deployed or augmented to supplement supervision by staff.

- (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.

Interviews:

- PREA Coordinator/Investigator
- Facility Program Director
- Mental Health Practitioner
- Supervisor

At the conclusion of every PREA incident that resulted in an administrative and/or criminal investigation, the PREA Coordinator would convene the incident review team. The PREA Coordinator will see to it that the PREA incident review team report is complete. The review form will assess possible risk factors that contributed to the incident, and a narrative of the review. Once complete the PREA Coordinator will forward the report to the Program Director to review and sign. The PREA Coordinator and the Program Director will work collaboratively to ensure that all recommended improvements and changes are implemented.

Conclusion:

Based upon the review and analysis of the available evidence, the auditor has determined the facility is in compliance with this standard regarding sexual abuse incident reviews. No corrective action is required.

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

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

Documents Reviewed:

- Facility PAQ
- Policy Data Collection

115.287(a)-1 The agency collects accurate, uniform data for every allegation of sexual abuse at facilities under its direct control using a standardized instrument and set of definitions.

The Peer I/Haven Programs 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.

115.287(a)-1, 115.287(b)-1, 115.287(c)-1, 115.287(d)-1, & 115.287(f)

The agency maintains, reviews, and collects data as needed from all available incident-based documents, including reports, investigation files, and sexual abuse incident reviews.

The agency provided Department of Justice data from the previous calendar year upon request.

- (a) The Peer I/Haven Programs 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 and the Haven do not contract with private facilities for the confinement of residents.
- (f) Upon request to the Program Director or PREA Coordinator, the Peer I and The Haven provide all such data from the previous calendar year to the Department of Justice no later than June 30th.

Interviewed:

- Executive Director
- PREA Coordinator/Investigator

The PREA Coordinator who also has the responsibility to conduct administrative investigations will document their findings, even if law enforcement conducts a criminal investigation. The PREA Coordinator receives a notification and the incident reports for all PREA allegations. She will use the incident reports to track the incidents for data collection.

The findings for all investigations will be documented in an annual report prepared by the PREA Coordinator. The report will document a comparison of PREA incidents from previous years. The report does not include personally identifying information and any information that would present a clear and specific threat to the safety and security of the facility will also be redacted.

On an annual basis, the PREA Coordinator will meet with the Program Directors to review the previous year's findings, any incidents from the previous year, and identify problem areas. Corrective action will be taken to improve the effectiveness of the Haven's prevention, detection, training, and response policy and procedure. Prior to the report being published on the agency website, the Executive Director will review and sign off on the report.

The University of Colorado Anschutz-Haven did not receive a request from DOJ to provide data from the previous year.

Conclusion:

Based upon the review and analysis of the available evidence, the auditor has determined the facility is in compliance with this standard regarding data collection. No corrective action is required

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

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

Documents Reviewed:

- Facility PAQ
- Policy Data Review for Corrective Action

- (a) The Peer I and Haven programs will collect and aggregate data in conjunction with 115.287 in order to improve the programs ability to prevent, detect, and respond to sexual abuse. In addition, this data will be used to improve daily practices and training.
- (1) Problem areas will be identified on an ongoing basis and will be discussed, at minimum, between the Program Director and the PREA Coordinator. These problem areas will be identified using the aggregate data reported in 115.287.
- (2) Corrective action will be taken on an ongoing basis. Corrective action may be evidenced in policy changes, staff trainings or by using other methods which are documented by the PREA coordinator.
- (3) Reports
- (a) An annual report of all findings and corrective actions will be prepared for each the Peer I and Haven Programs.
- (b) The report will include a comparison of the current year's data and corrective actions with those from years prior and will also provide an assessment of the agency's progress in addressing sexual abuse. Corrective action items which have not been fully addressed will be reviewed by the respective program's management team to assess whether different, alternative, or modification to the corrective action item needs to occur in order to achieve compliance with the original corrective action plan or item.
- (c) The report will be approved by the program director and will be made public through the ARTS website and will clearly differentiate between the Peer I and Haven programs through naming conventions or other readily understandable and accessible means.
- (d) Specific material maybe redacted from such reports in public publication only when such information present a specific threat to the safety and security of the facility. Information which presents a specific threat to the facility will be identified by the PREA Coordinator and/or program director. Identified threats will be discussed, at minimum, by the ARTS Management meeting and information may be communicated to the appropriate entity within the University, if appropriate. In the event that redaction is necessary, the report will indicate the nature of the material redacted. Any such clauses in the report will be reviewed by the program director prior to public release of the report.

Interviewed:

- Executive Director

During the interview with the Executive Director she stated the PREA Coordinator will meet with the Program Directors to review the previous year's findings, any incidents from the previous year, and any other problem areas. The purpose is to identify and address themes that present a risk to the safety of the clients. Areas of concern will be addressed through training, policy and procedure modification, and possibly installing security monitoring equipment to address blind spots.

Conclusion:

Based upon the review and analysis of the available evidence, the auditor has determined the facility is in compliance with this standard regarding data review for corrective action. No corrective action is required.

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

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

Documents Reviewed:

- Facility PAQ
- Policy Storage

115.289(a)-1 The agency ensures that incident-based and aggregate data are securely retained.

The Peer I/Haven programs 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.

Interviews:

- PREA Coordinator

Conclusion:

Based upon the review and analysis of the available evidence, the auditor has determined the facility is in compliance with this standard regarding data storage, publication, and destruction. No corrective action is required.

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 residents? ☒ 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

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

Documents Reviewed:

- Facility PAQ
- Policy Frequency and Scope of Audits

The Peer I/Haven programs will comply with and be subject to all standards and requirements listed within the Frequency and Scope of Audits CCS 115.401. Program staff, including the PREA Coordinator, will ensure and maintain documentation that PREA audits are conducted within prescribed designated time frames. Documentation will be stored in the PREA Policy Material housed in the Program Director's office or the PREA Coordinator's office. In addition the PREA Coordinator will respond to the need of an expedited audit if such a need arises. During any PREA audit program staff will make available all information listed in the various formats prescribed within the standard. Program staff will allow an auditor access to all areas of the facility. Program staff and clientele will participate in requested interviews in whatever format determined by the auditor. Furthermore, program participants will be allowed to send confidential information/correspondence to the auditor in the same manner as if communicating with legal counsel. The program understands auditors may contact community-based or victim advocates who may have insight into relevant conditions in the facility.

University of Colorado Anschutz operates a number of programs, but the two residential therapeutic programs on the Fort Logan campus is Peer I and the Haven. The Haven has a capacity of twenty (20); however the average daily population for the past 12 months has been sixteen (16) clients. The Haven is participating in a PREA audit for the third time, and each audit resulted in a finding of compliance. DOJ has not made a request or required the Haven to complete an expedited audit.

The auditor utilized the Auditor Compliance Tool for guidance on the conduct and contents of the audit. The University of Colorado Anschutz-Haven has demonstrated their continued efforts to comply with the standards and continues to take steps to improve their practices. The audit process involved reviewing all relevant policies, reports, handbooks, training curriculum and supporting documents; as well as conducting staff, contactor/volunteer, and resident interviews. The auditor reviewed documents and records involving information for 12 months prior to the onsite audit.

The auditor is sufficiently satisfied that she was able to view every aspect of the facility during the site review. During the on-site audit as well as during the report writing phase of the audit, the auditor

requested additional documentation to support the auditor's findings and received the documents within days of making the request. All audit material relied upon has been retained by the auditor and will be provided to the DOJ upon request.

The Haven clients were able to send confidential information or correspondence to the auditor in the same manner as if they were communicating with legal counsel. The auditor did not receive correspondence from any staff member, resident or community member.

The draft final report was issued on January 10, 2022, to allow the PREA Coordinator to review and provide feedback. The final report was issued on January 18, 2022, after an editing and review period.

Conclusion:

Based upon the review and analysis of the available evidence, the auditor has determined the facility is fully compliant with this standard regarding frequency and scope of audits. No corrective action is required.

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. The review period is for prior audits completed during the past three years PRECEDING THIS AGENCY AUDIT. 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

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

Documents Reviewed:

- Facility PAQ
- Policy Audit Contents and Finding

The Peer I/Haven programs understand that audits will be conducted by a PREA qualified auditor and that all audits must comply with PREA standard CCS 115.403, specifically:

- (a) Each audit shall include a certification by the auditor that no conflict of interest exists with respect to his or her ability to conduct an audit of the agency under review.
- (b) Audit reports shall state whether agency-wide policies and procedures comply with relevant PREA standards.
- (c) For each PREA standard, the auditor shall determine whether the audited facility reaches one of the following findings: Exceeds Standard (substantially exceeds requirement of standard); Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period); Does Not Meet Standard (requires corrective action). The audit (d) Audit reports shall describe the methodology, sampling sizes, and basis for the auditor's conclusions with regard to each standard provision for each audited facility, and shall include recommendations for any required corrective action.
- (e) Auditors shall redact any personally identifiable inmate or staff information from their reports, but shall provide such information to the agency upon request, and may provide such information to the Department of Justice.
- (f) The agency shall ensure that the auditor's final report is published on the agency's website summary shall indicate, among other things, the number of provisions the facility has achieved at each grade level.

The University of Colorado Anschutz-Haven has published all of the final PREA audit reports for all of their facilities. The audit reports can be found at: <https://www.artstreatment.com/prea/>

The auditor certifies that no conflict of interest exists with respect to her ability to conduct an audit of any University of Colorado Anschutz facility or the Haven specifically.

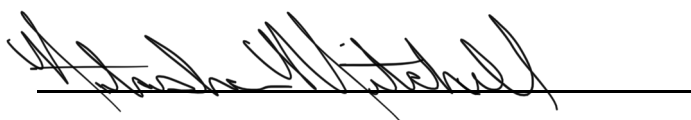
AUDITOR CERTIFICATION

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.¹ Auditors are not permitted to submit audit reports that have been scanned.² See the PREA Auditor Handbook for a full discussion of audit report formatting requirements.



Auditor Signature

1-18-2022

Date

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

² See *PREA Auditor Handbook*, Version 1.0, August 2017; Pages 68-69.