3.000
STANDARDS OF PRACTICE FOR TREATMENT PROVIDERS

3.000 Sex offense-specific treatment uses evidenced-based modalities to prevent reoccurring sexually abusive/aggressive behavior by helping clients at risk of sexually offending to: (a) effectively manage the individual factors that contribute to sexually abusive behaviors, (b) develop strengths and competencies to address criminogenic needs, (c) identify and change thoughts, feelings and actions that may contribute to sexual offending, and (d) establish and maintain stable, meaningful and pro-social lives. Objectives include enhancing client success and contributing to safer communities.

The following standards for the practice of treatment providers are designed to include current evidence-based principles and best practices for therapeutic interventions in the promotion of client progression and community safety. The purpose of treatment is to facilitate positive change in clients by replacing sexually abusive or sexually problematic behaviors with behaviors that support healthy, consensual relationships. Meaningful change is possible and essential with clients who have been found guilty of a sexual offense. Such practice promotes safer communities by working to prevent re-offense.

Treatment needs are determined through evidence-based risk assessment. Not all clients are at high risk for a sexual re-offense. Research advises that clients who present with higher risk for recidivism require more intense treatment than clients who present with a lower risk for recidivism.[1] As clients present with varying factors associated with risk, therapy is individualized to address the treatment needs of each client. Therapeutic interventions are adjusted as a client's treatment needs change.

Favorable treatment outcomes are enhanced by a positive therapeutic alliance characterized as supportive and encouraging.[2] Treatment plans are designed to include specific, attainable, and measurable goals that target individual treatment needs and that support the client's change process. Because of the potential for clients to engage in harmful behaviors, treatment plans include goals that promote community safety. Treatment providers affirm the potential change in clients, do not compromise victim or community safety, and encourage hope for all those impacted by sexual offense.

3.100 Sex offense-specific treatment for clients convicted of a sexual offense shall be provided by persons (hereafter referred to as providers or listed providers) meeting qualifications described in Section 4.000 of these Standards and Guidelines.

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[1] Lovins, B., Lowenkamp, C. T., & Latessa, E. (2009). Applying the risk principle to sex offenders: Can treatment make some sex offenders worse? *The Prison Journal, 89(3),* 344-357.; Smid, W. J., Kamphuis, J. H., Wever, E. C., & Verbruggen, M. C. F. M. (2015). Risk levels, treatment duration, and drop out in a clinically composed outpatient sex offender treatment group. *Journal of Interpersonal Violence, 30(5),* 727-743.; Wakeling, H. C., Mann, R. E., & Carter, A. J. (2012). Do low-risk sexual offenders need treatment? *The Howard Journal of Criminal Justice, 51(3),* 286-299.

[2] Blasko, B. L. & Jeglic, E. L. (2016). Sexual offenders' perceptions of the client-therapist relationship: The role of risk. *Sexual Abuse: A Journal of Research and Treatment, 28(4),* 271-290.; Watson, R., Daffern, M., & Thomas, S. (2017). The impact of interpersonal style and interpersonal complementarity on the therapeutic alliance between therapist and offenders in sex offender treatment. *Sexual Abuse: A Journal of Research and Treatment, 29(2),* 107-127.; Watson, R., Thomas, S., & Daffern, M. (2015). The impact of interpersonal style on ruptures and repairs in the therapeutic alliance between offenders and therapists in sex offender treatment. *Sexual Abuse: A Journal of Research and Treatment,* 1-20.

Discussion: A provider who chooses to begin treating an alleged client during the pre-conviction stage should provide treatment in compliance with these Standards and Guidelines.

DD/ID Discussion: When providing treatment to individuals with developmental disabilities who may exhibit sexually inappropriate behaviors but who have not been convicted of a sex offense, it is recommended that the Standards be used as guidelines. The treatment of non-convicted individuals does not fall under the purview of the Sex Offender Management Board (SOMB).

3.120 A provider who treats convicted sex offenders under the jurisdiction of the criminal justice system must use sex offense-specific treatment (see Definition Section). This does not preclude participation in adjunctive treatment as clinically indicated based on the risk level and needs of the client. Therapists shall use their clinical judgment to prioritize treatment needs and develop a treatment plan that responds to any additional treatment needs. The provider of the adjunct services shall be knowledgeable of sex offense related issues and must be approved by the Community Supervision Team. Upon initiating services, the adjunct therapist should be considered part of the Community Supervision Team (CST).

Discussion: There may be periods of time when offense specific treatment is suspended or supplemented in order to respond to other acute needs of the client. Supplemental treatment that is necessary for the client to benefit from offense-specific treatment should be incorporated into the client's treatment plan.

3.130 Treatment providers shall utilize strength-based interventions with the goal of aiding the client in desisting from sexually abusive behavior. Such interventions will include approach-oriented goals that will enhance inherent and/or developed pro-social strengths.

Discussion: Clients who have committed sexual offenses approach therapy with different levels of ambivalence regarding engagement in treatment. Research has shown that therapists who demonstrated an empathic, warm, rewarding, and directive approach resulted in the greatest positive changes in clients who have sexually offended.[3] *Research has shown that a challenging and supportive approach, rather than a harsh confrontational style, produced increased treatment benefits.*[4]

3.160 Sex Offense-Specific Treatment

Treatment Providers shall use the following primary interventions:

A. Assign a risk level for each client.

1. Assignment of risk shall be conducted by the provider within the first 30 days of treatment.

2. Assignment of risk shall be based upon the information available to the provider. This

[3] Glaser, B. (2009). Treaters or punishers? The ethical role of mental health clinicians in sex offender programs. *Aggression and Violent Behavior, 14,* 248-255.; Marshall, W. L. (2005). Therapist style in sexual offender treatment: Influence on indices of change. *Sexual Abuse: A Journal of Research and Treatment, 17(2),* 109-116.; Marshall, W. L., Serran, G. A., Moulden, H. Mulloy. R., Fernandez. Y.M., Mann, R.E., & Thorton, D. (2002). Therapist features in sexual offender treatment: Their reliable identification and influence on behaviour change. *Clinical Psychological and Psychotherapy, 9,* 395-405.

[4] Glaser, B. (2009). Treaters or punishers? The ethical role of mental health clinicians in sex offender programs. *Aggression and Violent Behavior, 14,* 248-255.; Marshall, W. L. (2005). Therapist style in sexual offender treatment: Influence on indices of change. *Sexual Abuse: A Journal of Research and Treatment, 17(2),* 109-116.; Marshall, W. L., Serran, G. A., Fernandez, Y.M., Mulloy, R., Mann, R. E., & Thornton, D. (2003). Therapist characteristics in the treatment of sexual offenders: Tentative data on their relationship with indices of behaviour change. *Journal of Sexual Aggression, 9,* 25-30.

includes but is not limited to: the pre-sentence evaluation, the pre-sentence investigation, police reports, clinical interview, observations, psychological test results, the intake, and possible updated risk assessments and psychological results.

3. Treatment providers shall tailor a client's treatment dosage and intensity to match the assessed risk of the client. Treatment dosage congruent with the client's risk and need increases the likelihood of a positive treatment outcome.[5] Responsivity factors (such as learning style, level of functioning, developmental maturity and language skills) shall be identified and incorporated when determining the course of treatment. As a client's risk or needs change, the provider shall modify treatment dosage accordingly. The provider shall consult with the CST regarding the need for referral to a program of different intensity if not offered in his/her program.

4. Risk assessment is an ongoing process throughout the client's treatment. (See Section 2.000 for a list of risk assessment tools.)

B. Core Treatment Concepts

1. Risk factors identified for treatment intervention shall be supported by evidenced-based research.

   Discussion: The provider should select one dynamic risk assessment instrument to identify specific risk factors to target. (See Section 2.200 for recommended instruments.) Other risk factors may be identified, provided the risk factors are supported in sex-offense peer-reviewed literature.

2. Providers shall address the client's individualized risk factors as priority treatment targets in addition to other clinical needs and concerns.

3. The following core treatment concepts shall also be a mandatory part of each client's sex offense-specific treatment:

   a. Acceptance of responsibility for offending and abusive behavior;

   b. Identify thoughts, feelings, and behaviors that lead up to the offending behavior;

   c. Restructure cognitive distortions;

   d. Establish adaptive pro-social functioning;

   e. Promote healthy sexuality and relationship skills;

   f. Gain knowledge of victim impact and empathy.[6]

[5] Smid, W. J., Kamphuis, J. H., Wever, E. C., & Verbruggen, M. C. F. M. (2015). Risk levels, treatment duration, and drop out in a clinically composed outpatient sex offender treatment group. *Journal of Interpersonal Violence, 30(5),* 727-743.; Wakeling, H. C., Mann, R. E., & Carter, A. J. (2012). Do low-risk sexual offenders need treatment? *The Howard Journal of Criminal Justice, 51(3),* 286-299.

[6] The SOMB recognizes empathy is not an evidenced-based risk factor. However, empathy is a necessary component for healthy social connections and an important skill in developing pro-social support systems. component for a client

i. Offense specific treatment shall incorporate a victim entered approach. This means a commitment to protecting victims, being sensitive to victim issues and responsive to victims' needs (see Section 8.000).

Discussion: Community safety and the rights and interests of victims and their families are important considerations when developing and implementing assessment, treatment and other strategies to reduce the risk posed by sexual abusers.[7]

Discussion: Therapists have an ethical obligation to the client. This focus includes a balanced response to the assessed needs of the client, the protection of identified victims and the prevention of further victimization. The needs of the client and victim exist on a continuum.

ii. Clarification work shall be a required component of treatment.

Discussion: Please refer to Section 5.753 regarding the victim clarification processes. Clarification is designed to primarily benefit the victim. A victim may or may not choose to participate in the clarification process, and the CST should also make a determination that clarification is in the victim's best interests. The clarification process may also be conducted for secondary victims.

Clarification work by the offender shall still occur regardless of whether the victim participates, and may include written letters, practice sessions with the provider, group work, and victim panels. In addition, verbal or face-to-face sessions with the victim may occur if the victim chooses to participate in clarification.

g. Develop Pro-social living plan.

i. The provider shall require clients to complete a Pro-Social Living Plan prior to completion of treatment.

ii. The Pro-Social Living Plan should aid the client in creating a life that is incompatible with offending behavior.

iii. This plan should be completed in collaboration with the client and incorporate individualized strategies.

4. Providers may expand interventions to additional treatment topics as necessary based on the client's risk and need, and community safety.

5. Therapy may include a combination of differential modalities and research-based interventions that includes but is not limited to: group, individual, family, psycho-educational, and other adjunct options.

[7] Dritt, J. L. (2011). *It's a big tent: Victim advocates and sex offender management professionals working together* [PowerPoint slides]. 30th Annual Association for the Treatment of Sexual Abusers Research and Treatment Conference.

6. Identified risk factors shall be documented in the individualized treatment plan.

   Upon a client entering treatment, a provider shall develop a written treatment plan based on the relevant needs and risks identified in current and past assessments/evaluations of the client. Treatment plans shall be reviewed with the client a minimum of every 6 months over the course of treatment. Reviews shall occur at more frequent intervals if pertinent information arises that warrants an earlier review. Clients who are in the maintenance or after-care phase of treatment shall have a treatment plan that is reviewed a minimum of every 12 months or sooner if pertinent information arises that warrants a review.

   A treatment plan, with measurable goals, outcomes, and timeframes, shall be implemented after the completion of the intake evaluation process. The process shall be guided by the therapist and developed through collaboration with the client. The individualized plan shall promote victim and community safety. In addition, the plan shall identify the behaviors mandating offense-specific treatment and specifically address all clinical issues outlined in the intake evaluation and via validated risk assessment. The treatment goals shall be consistent with the client's treatment needs, competency and ability. It shall include identified protective and risk factors. Treatment plans shall be written in a way that is understandable to the client, based on the client's responsivity factors. When necessary, the treatment plan shall include planning for and referral to adjunct treatment.

7. Deliver services in a manner that accommodates client characteristics.

   A. The provider shall employ treatment methods that are responsive to the assessed needs of the client and emphasize the physical and psychological safety of victims and potential victims. Treatment interventions shall be responsive to the client's level of intellectual functioning, learning style, personality characteristics, culture, mental and physical disabilities, motivation level, and level of denial.

      Discussion DD/ID: Achieving success in the above listed content areas for the client with developmental disabilities may require modifications based on the needs of the individual such as using pictures instead of written assignments, or using a data collection system by the treatment provider to document skills learned by the client. The presence of concrete thinking, difficulty with concepts and abstraction and the need for frequent repetition and simple, direct instruction is common.

   B. Providers shall build upon client strengths and protective factors such as motivation to change, literacy skills, lifestyle stability, and pro-social support systems.

   C. Providers shall utilize strength-based interventions and approach oriented goals.

8. A provider shall model behavior and conduct himself/herself in a manner that is humane, non-discriminatory and consistent with their professional ethics and rules. Additionally, providers shall not allow personal feelings regarding a client's crimes or behavior to interfere with professional judgment and objectivity. When a therapist cannot provide the highest quality of service for any reason, the provider shall refer the client elsewhere.

3.165 Use of Assessment Tools within Offense-Specific Treatment

Polygraph and sexual interest/sexual arousal assessments shall be used in treatment (See Section 6.000 and Section 7.000). These assessments can assist in learning more about a client's sexual history, sexual interest or arousal, and daily behaviors and compliance. These assessments can encourage honesty, verify progress, promote discussions, and further build therapeutic rapport. The provider shall discuss assessment results with the client to determine how these results may change the clients' individual treatment plan. Discussion pertaining to unresolved assessment outcomes shall not be the sole indicator for discharge from offense-specific treatment. If the client refuses to participate in the sexual history assessment process, the CST shall convene to identify and implement alternative methods of assessing and managing risk and need. For further direction on the use of polygraph results see Sections, 5.000 and 6.000.

Discussion: Providers who utilize this data shall be aware of the limitations of these technologies and shall recognize that this data is only meaningful within the context of a comprehensive evaluation and treatment process.

Discussion DD/ID: Use of some of these assessments and testing instruments with clients with developmental disabilities is relatively new. Employing these results for the purposes of assessing risk and planning for treatment should be done cautiously. Please see Section 2.000 (DD) for additional standards pertaining to evaluations. Wherever possible, materials appropriate for use with clients with developmental disabilities shall be utilized instead of materials developed for a non-developmentally disabled population.

3.170 Group Composition

A. The ratio of therapists to clients in a treatment group shall not exceed 1:8. Treatment group size shall not exceed 14 clients. Larger groups may be convened solely for educational purposes.

Discussion: When determining group size, a treatment provider should continually assess group dynamics to ensure the best size for healthy group functioning. When groups consistently exceed the 1:8 ratio, therapeutic benefit decreases substantially. While it is realistic to expect group size to occasionally fluctuate due to extenuating circumstances (e.g. holidays, clients making up a missed group, co-therapist illness), such increases in group size shall be temporary. People with additional needs, may need a smaller group to effectively progress through treatment.

B. Genders shall not be mixed in a sex offense-specific treatment group.

Discussion: For many individuals, gender identity and gender expression can lie on a spectrum. Allowing transgender individuals to participate in a group with peers that identify as the same sex as they do may have a greater potential for the successful completion of treatment. Placement of individuals that do not fall within the binary model of gender should be based on the best environment for the client and that which has all clients' best interests in mind.

Discussion: It is understood that informed supervision sessions, victim clarifications sessions and other modalities that do not require the same level of therapeutic work as a treatment group, may successfully contain, and sometimes require, a mix of genders to participate together.

1.175 Safety Planning

The provider should encourage and support clients in the development of safety plans for activities to prepare clients to address potentially risky situations and develop adaptive coping responses to

situations. Safety plans should address potentially risky situations while taking into account client needs and victim and community safety. Safety plans will be submitted to the Community Supervision Team (CST) for review.

3.180 Maintenance Phase of Treatment

The maintenance phase of treatment gives the client the ability to demonstrate the treatment gains and tools learned within offense-specific treatment. A client may move into the maintenance phase of treatment upon:

- Completing all the treatment objectives outlined in the individualized treatment plan;
- Sustaining compliance with the program expectations of treatment and supervision; and
- Appearing ready for a more autonomous phase of treatment.

Movement into the maintenance phase of treatment should be the therapist's decision based on the client's risk and needs.

3.200 Discharge from Treatment

A. Successful completion of treatment shall be determined by the provider. Such a determination will be based on the client's overall change through the treatment process, including risk level, any existing criminogenic needs and the client's sustained ability to integrate treatment concepts and tools (e.g., the Pro-Social Living Plan) into daily life. The provider shall discharge the client regardless of the length of time the client remains under supervision.

B. There may be instances when a client is discharged from treatment prior to successfully completing offense-specific treatment. Circumstances of such discharges could include:

1. Administrative Transfer – Due to a change in the client's circumstances, a client may need to change treatment providers. For example, a client has a job or residence creating an insurmountable transportation barrier.

2. Therapeutic Transfer – Through no fault of the client, the treatment provider is unable to meet the client's needs and will need to refer the client to another agency.

3. Medical Discharge – The client has a chronic medical condition that prohibits him from attending and benefiting from treatment.

4. Incompetency Discharge – The client cannot benefit from treatment due to a current state of incompetency.

5. Non-Compliance Discharge – The client's behavior is contradictory to the treatment and/or supervision conditions and the treatment provider, in consultation with the other CST members, determines that the client is no longer an appropriate candidate for the treatment program.

3.210 A discharge summary shall be completed at the time of discharge and in instances of a successful discharge, the discharge summary will be provided to the client prior to or at the time of discharge. In addition, the summary will be provided to the referral source, with a valid release of information, in a timely manner. Discharge summaries may be provided to other persons, with

a valid release, as requested and appropriate. The information recorded by the treatment provider shall, include but is not be limited to, the following:

A. Identification of the precipitating offense;

B. Length of time in treatment;

C. Reason(s) for discharge. If unsuccessful, include specific violations of the treatment contract;

D. The treatment goals and objectives completed as well as in process;

E. Current level of risk, including identification of specific risk and protective factors; and

F. Further recommendations.

3.300 Confidentiality

When enrolling a client in treatment, a provider shall obtain signed waivers of confidentiality based on the informed assent of the client. This waiver shall explain that written and verbal information will be shared between all team members. The waiver of confidentiality shall, if applicable, extend to the Department of Human Services, other individuals or agencies responsible for the supervision of the client, and the Board for the purpose of research related to evaluation or implementation of the *Standards and Guidelines* for sex offender management in Colorado. The information shall be provided in a manner that is easily understood, verbally and in writing, in the native language of the person, or through other modes of communication as may be necessary to enhance understanding.

Discussion: Waivers of confidentiality should be required of the client by the conditions of probation, parole, and community corrections and shall be part of the treatment provider-client contract.

3.310 DD/ID

A. The provider shall obtain the informed assent of the legal guardian, if applicable, and the informed assent of the client with developmental disabilities and/or intellectual disabilities for treatment. The guardian will be informed of the treatment methods, how the information may be used and to whom it will be released. The provider shall also inform the client with developmental disabilities and/or intellectual disabilities and the guardian about the nature of the provider's relationship with the client and with the court. The provider shall respect the client's right to be fully informed about treatment procedures.

B. If informed assent cannot be obtained after consulting with the third party, then the provider shall refer the case back to the Community Supervision Team or the court.

3.320 Waivers of confidentiality shall extend to the victim, the victim representative/therapist, the guardian ad litem of a child victim, the caseworker, the approved supervisor(s), the client's current partner, the guardian, or other individuals involved in the case. This is especially important with regard to, but not limited to:

- Client non-compliance with treatment;
- Information about risk, threats, and possible escalation of violence;
- Decisions regarding clarification or reunification of the family, and
- A client's contact with past or potential child victims.

3.330 The provider shall notify all clients in writing of the limits of confidentiality imposed on therapists by the mandatory reporting law, Section 19-3-304, C.R.S. and to Section 12-43-219, C.R.S.

3.340 The provider shall ensure that a client understands the scope and limits of confidentiality in the context of his/her particular situation, including the collection of collateral information, which may or may not be confidential.

3.400 Treatment Provider-Client Contract

3.410 The provider shall develop and utilize a written contract with each client prior to the commencement of treatment. The contract shall define the specific responsibilities of both the provider and the client. A client's failure to comply with the terms of the contract may result in discharge from treatment.

A. The provider's responsibility is to practice within their professional standards as defined in the Colorado Mental Health Practice Act[8]and in the *Standards and Guidelines* established by the Colorado Sex Offender Management Board.

B. The contract shall explain the responsibility of the provider to:

1. List the costs of assessment, evaluation, and treatment, including all medical and psychological tests, physiological tests and consultations;

2. Describe the waivers of confidentiality and limits of confidentiality pursuant to Section 3.300 of these *Standards and Guidelines*. A signed waiver is required for treatment to be provided;

3. Describe the right of the client to refuse treatment and to refuse to waive confidentiality, as a result of which the provider will be unable to provide services. The contract shall also describe the potential outcomes of that decision;

4. Describe the necessary procedures the client must follow in order to revoke a waiver of confidentiality;

5. The provider shall notify all clients in writing of the limits of confidentiality imposed on therapists by the mandatory reporting law, Section 19-3-304, C.R.S. and to Section 12-43-219, C.R.S.

6. Provide instructions and describe limitations regarding the client's contact with victims, secondary victims, and minor children as listed in these *Standards and Guidelines*; and

7. Establish expectations for the client to provide for the protection of past and potential victims from unsafe and unwanted contact with the client.

C. The contract shall explain any responsibilities of the client, as applicable, to:

1. Pay for the costs of assessment and treatment, and include how a client may address any inability to pay with the provider. The client may also be required to pay for the costs of

[8]Section 12-43-101, C.R.S.

treatment for the victim(s) of the client's sexually abusive behavior, as well as secondary victims such as family members;

2. Attend and participate in sex offense-specific treatment, including cooperating with polygraph testing and sexual arousal/interest testing as directed in the *Standards and Guidelines* (see Section 3.165);

3. Comply with the limitations and restrictions as described in the terms and conditions of probation, parole, and/or community corrections;

4. Describe the responsibility of the client to protect community safety by avoiding risky, aggressive, or re-offending behavior, avoiding high risk situations, and by reporting any such behavior to the provider and the supervising officer as soon as possible;

5. Agree to abide by the limitations regarding the client's contact with victims, secondary victims, vulnerable populations and minor children as outlined in the SOMB's *Standards and Guidelines*; and

6. Agree to support the protection of past and potential victims from unsafe and unwanted contact with the client.

Discussion: In addition, the provider may incorporate additional limits and expectations based upon the client's identified risks, needs and patterns of behavior. For example, limits may be placed regarding the use of pornography/sexually stimulating material, substance use, or internet use, as appropriate.

3.420 Client Files

Providers shall maintain client files in accordance with the professional standards of their individual disciplines and with Colorado state law and federal statutes on health care records. Client files shall:

A. Document the goals of treatment, the methods used, and the client's observed progress, or lack thereof, toward reaching the goals in the treatment plans;

B. Record specific achievements, failed assignments, rule violations and consequences; and

C. Accurately reflect the client's treatment progress, sessions attended, and changes in treatment

3.500 Managing Clients in Denial

Denial is a psychological defense mechanism used to protect the ego from anxiety producing information. In addition to being a psychological defense mechanism, denial may also be a normal,[9]conscious action to avoid internal or external consequences associated with the offense behavior. For the purpose of this section, denial is defined as the failure of a client to accept

[9] Mann, R. E., Hanson, R. K, & Thornton, D. (2010). Assessing risk for sexual recidivism: Some proposals on the nature of psychologically meaningful risk factors. *Sexual Abuse: A Journal of Research and Treatment, 22(2),* 191-217.; Yates, P. M. (2009). Is sexual offender denial related to sex offense risk and recidivism? A review and treatment implications. *Psychology, Crime, and Law, 15(2-3),* 183-199.

responsibility for the offense[10] on a continuum from low to moderate to high. There is conflicting research regarding denial as a risk factor for sexual re-offense.[11] However, the literature also frames denial as an issue of responsivity to treatment.[12] Therefore, the intent of this section is to consider clients in denial and treatment efficacy, not the risk factors associated with client denial.

Secrecy, denial, and defensiveness are behaviors frequently exhibited by clients.[13] Research has shown cognitive distortions are significantly associated with greater denial/minimization.[14] Furthermore, attitudes supportive of sexual offending behavior have been documented to reliably predict sexual recidivism.[15] Almost all clients fluctuate in their level of accountability or minimization of the offenses. Although most are able to admit responsibility for the sexual offense relatively soon after conviction, some clients do not. Denial impedes treatment engagement, progress and efficacy.[16] Client denial is also highly distressing and emotionally damaging to victims.[17]

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[10] Association for the Treatment of Sexual Abusers Practice Standards and Guidelines, 2001 (p. 63)

[11] Harkins, L., Beech, A. R., & Goodwill, A. M. (2010). Examining the Influence of denial, motivation, and risk on sexual recidivism. *Sexual Abuse: A Journal of Research and Treatment, 22(1),*79-94.; Langton, C. M., Barbaree, H. E., Harkins, L., Arenovich, T., McNamee, J., Peacock, E. J, … Marcon, H. (2008). Denial and minimization among sexual offenders: Posttreatment presentation and association with sexual recidivism. *Criminal Justice and Behavior, 35(1),* 69-98.; Mann, R. E., Hanson, R., K., & Thornton, D. (2010). Assessing risk for sexual recidivism: some proposals on the nature of psychologically meaningful risk factors. *Sexual Abuse: A Journal of Research and Treatment, 22(2),* 191-217.; Nunes, K., Hanson, K., Firestone, P., Moulden, H., Greenberg, D. & Bradford, J. (2007). Denial predicts recidivism for some sexual offenders. *Sex Abuse*, 91-105.

[12] Responsivity to treatment is the third principle of the Risk, Needs, and Responsivity Model, which influences the extent to which an offender will benefit from treatment. It states that the styles and modes of treatment delivery should be individually matched to the learning style of the offender to the extent possible (see, for example, Levenson, Prescott & D'Amora, 2010; Looman et al., 2005; Yates, 2009).

[13] Drapeau, M., Beretta, V., de Roten, Y., Koerner, A., & Despland, J. (2008). Defense styles of pedophilic offenders. *International Journal of Offender Therapy and Comparative Criminology, 52(2),* 185-195.; Harkins, L., Howard, P., Barnett, G., Wakeling, H., & Miles, C. (2015). Relationships between denial, risk, and recidivism in sexual offenders. *Archives of Sexual Behavior, 44,* 157-166.; Nunes, K., Hanson, K., Firestone, P., Moulden, H., Greenberg, D. & Bradford, J. (2007). Denial predicts recidivism for some sexual offenders. *Sex Abuse*, 91-105.

[14] Helmus, L, Hanson, R. K., Babchishin. K. M., & Mann, R. E. (2013). Attitudes supportive of sexual offending predict recidivism: A meta-analysis. *Trauma, Violence, & Abuse, 14(1),* 34-53.; Houtepen, J.A.B.M, Sijtsema, J. J., & Bogaets, S. (2014). From child pornography offending to child sexual abuse: A review of child pornography offender characteristics and risks for cross-over. *Aggression and Violent Behavior, 19,* 466-473.; Nunes, K. L., & Jung, S. (2013). Are cognitive distortions associated with denial and minimization among sex offenders? *Sexual Abuse: A Journal of Research and Treatment, 25(2),* 166-188.

[15] Helmus, L, Hanson, R. K., Babchishin. K. M., & Mann, R. E. (2013). Attitudes supportive of sexual offending predict recidivism: A meta-analysis. *Trauma, Violence, & Abuse, 14(1),* 34-53.; Mann, R. E., Hanson, R., K., & Thornton, D. (2010). Assessing risk for sexual recidivism: some proposals on the nature of psychologically meaningful risk factors. *Sexual Abuse: A Journal of Research and Treatment, 22(2),* 191-217.

[16] Blagden, N., Winder, B., Gregson, M., & Thorne, K. (2013) Working with denial in convicted sexual offenders: A qualitative analysis of treatment professionals' views and experiences and their implications for practice. *International Journal of Offender Therapy and Comparative Criminology, 57(3),* 332-356.; Levenson, J. S. (2011). "But I didn't do it!" Ethical treatment of sex offenders in denial. *Sexual Abuse: A Journal of Research and Treatment, 23(3),* 346-364.; Ware, J., Marshall, W. L., & Marshall L. E. (2015) Categorical denial in convicted sex offenders: The concept, its meaning, and its implication for risk and treatment. *Aggression and Violent Behavior, 25(B),* 215-226.

[17] Levenson, J. S., & Prescott, D. S. (2009). Treatment experiences of civilly committed sex offenders: A consumer satisfaction survey. *Sexual Abuse: A Journal of Research and Treatment, 21(1),* 6-20.; Levenson, J. S., Prescott, D. S., & D'Amora, D. A. (2010). Sex offender treatment: Consumer satisfaction and engagement in therapy. *International Journal of Offender Therapy and Comparative Criminology, 54(3),* 307-326.; Levenson, J. S., Macgowan, M. J, Morin, J. W., & Cotter, L. P.. (2009). Perceptions of sex offenders about treatment: Satisfaction and engagement in group therapy. *Sexual Abuse: A Journal of Research and Treatment, 21(1),* 35-56.

When clients take responsibility for their offense(s), they admit to the commission of the unlawful sexual behavior and the intent behind the behavior. Failure to take responsibility for the sexual offense by attributing it to external causes rather than the result of personal decisions and behavior has been identified as a risk factor for sexual re-offense. Acceptance of responsibility is unrelated to an admission of all sexual offending behaviors for which the client was convicted.[18] Taking responsibility for the sexual offense also includes the recognition of the harmful impact the behavior has had on the victim, and exhibiting motivation to engage in treatment to therapeutically address the sexually abusive behavior. It is important to recognize that motivation can be either external (system imposed) or internal (real willingness to change). One of the goals of treatment is to inculcate genuine internal motivation for change.

It is very important to remember that denial can take many forms and may change or vary in intensity over the course of treatment. Denial is considered to be a critical treatment target.[19] The more common types of denial presented by clients consist of the following: refutation of the offense, denial of intent, denial of extent, assertion of victim willingness, denial of planning and denial of relapse potential**.**[20]

3.510 Levels of Denial

The following is a description of different levels or intensity of denial.[21] These are intended to be used as a guide to help determine client denial and a potential treatment intervention. They should be used in conjunction with the remainder of 3.500. Consensus should be reached amongst the CST when determining a client's level of denial. It is imperative that the offense specific evaluator/therapist has the final discretion due to clinical judgment and expertise in this specific area.

Level 1: *Low Denial*

This level consists of clients who accept most of the responsibility for the unlawful sexual behavior involved in the offense, but may place some blame elsewhere. They may either justify their intent behind its occurrence and/or minimize its importance or harmful impact on the victim. These clients demonstrate some motivation to change.

Level 2: *Moderate Denial*

This level consists of clients who accept some of the responsibility for the unlawful sexual behavior in the offense. However, they place most of the blame elsewhere. They may deny the intent behind their unlawful sexual behavior and/or may not recognize the harmful impact their behavior has had on the victim. They may admit engaging in other harmful sexual behavior. They exhibit some motivation to change, although it may only be externally motivated.

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[18] McGrath, R. J., Lasher, M. P., & Cumming, G. F. (2012). The sex offender treatment intervention and progress scale (SOTIPS): Psychometric properties and incremental predictive validity with static-99 R. *Sexual Abuse: A Journal of Research and Treatment, 24(5),* 431-458.

[19] Blagden, N., Winder, B., Gregson, M., & Thorne, K. (2013) Working with denial in convicted sexual offenders: A qualitative analysis of treatment professionals' views and experiences and their implications for practice. *International Journal of Offender Therapy and Comparative Criminology, 57(3),* 332-356.; Levenson, J. S. (2011). "But I didn't do it!" Ethical treatment of sex offenders in denial. *Sexual Abuse: A Journal of Research and Treatment, 23(3),* 346-364.; McGrath et al., 2010

[20] See for example the Denial Minimization Checklist-III (Langton, Barbee, and McNamee, 2004) or the FoSOD, otherwise known as the Facets of Sex Offender Denial (Schneider & Wright, 2004).

[21] The utility of a multifaceted construct of denial and other forms of minimizations are emphasized as opposed to more simplified and dichotomous (yes or no) formats such as categorical denial. The importance of a continuous measure of denial has been supported by the literature in order to further distinguish an offender's criminogenic risks and amenability to engage in the therapeutic process (see for example, Langton, 2008; Levenson, 2011; Levenson and Macgowan, 2004).

Level 3: *High Denial*

This level consists of clients who do not accept **any** responsibility for **any** unlawful sexual behavior. They deny committing the current unlawful sexual behavior or even remotely similar behavior. They may not recognize the harmful impact sexual offending behavior has on victims (even if it is not their own behavior) and appear to have no motivation to change. Clients presenting with this level of denial may blame the victim or the system, and/or present as excessively hostile or defensive.

Discussion: Clients under appeal are not the same as clients in denial. The SOMB has a process to address treatment needs for such clients under appeal via a Standards Variance Request, which can be filed through the Application Review Committee of the SOMB.

3.520 Polygraph examinations may be a useful tool in reducing client denial. Clients in denial shall be referred for an instant offense polygraph examination. Arousal assessment or physiological assessment instruments may be used to assist this process. This applies to clients evaluated to be in any level of denial.

Discussion: In addition to requiring the client to undergo an instant offense polygraph regarding the offense of conviction, the CST may also require the client to undergo maintenance polygraph testing to monitor current behavior and enable the CST to respond to concerns quickly.

3.530 Clients who are evaluated and found to be in Level 1 or Level 2 Denial are not prohibited from participation in sex offense-specific treatment solely based on these levels of denial.

3.540 When making recommendations for clients evaluated and found to be in Level 3, High Denial, the evaluator/therapist shall consider the client's risk to re-offend sexually, his/her general criminogenic risk, victim impact and the client's protective and aggravating factors. There should be a balance between the client's need for treatment and mitigating and risk factors because untreated clients are often not in the best interest of community or victim safety.

3.550 Clients who are evaluated and found to be in Level 3, High Denial, are not appropriate to participate in sex offense-specific treatment. They shall participate in a Denier Intervention treatment to specifically address their denial and defensiveness. Denier Intervention should be performance based and establish clear expectations, target factors that may motivate the client to remain in denial and apply performance based discharge criteria. Denier intervention for those evaluated to be in Level 3 denial occurs separately from regular offense specific treatment. The goal of Denier Intervention is to foster a therapeutic alliance using a variety of treatment modalities[22] and assist the client in taking at least some responsibility for the offense in order to enter full offense-specific treatment.

3.560 Denier intervention shall not exceed 90 days unless the CST achieves consensus and provides documentation that the client has made some progress which would justify an extension of Denier Intervention for a prescribed period of time.[23] Clients who are still in Level 3 denial and are strongly resistant after any phase of Denier Intervention is completed shall be terminated from treatment and revocation proceedings should be initiated.

[22] A therapeutic alliance between the therapist and the client consists of three core elements: (1) an agreement on the treatment goals, (2) collaboration on the tasks that will be used to achieve the goals, and (3) an overall bond that facilitates an environment of progress and collaboration (see for example, Flinton & Scholz, 2006; Levenson, Prescott & D'Amora, 2010; Marshall et al., 2002; Polaschek & Ross, 2010; Schneider & Wright, 2004).

[23] Levenson, 2011; Yates, 2009

*Discussion: Under these **rare** circumstances, the CST should consider the following factors before granting any extension:1)Level of risk to sexually re-offend 2)Level of risk to commit a new criminal offense 3)Protective factors 4)Engagement and progress made in the Denier Intervention process 5)Compliance with supervision conditions 6) Victim input, as it is important to support victim recovery 7)Criminogenic needs, including but not limited to, the following: Deviant sexual interests/arousal, sexual preoccupation, pro-offending attitudes and beliefs, intimacy deficits, emotional congruence with children, callousness and pervasive anger or hostility, self-regulation deficits, social deviance, impulsive criminal lifestyle, dysfunctional coping, and 8) Any other factor making treatment ineffective for the client.*

3.560 DD/ID

An exception may be made for clients with developmental disabilities and/or intellectual disabilities who are in Level 3 denial and are strongly resistant after this three (3) month phase. If termination from treatment and revocation are not clearly indicated for a specific client, then a CST review shall occur at this 3-month mark to determine whether an extension of this pre-treatment phase followed by a second case review shall occur. Other options may be explored at this time and shall always consider the above noted discussion point (3.560).

3.570 Denier Intervention shall only be provided by treatment providers who also meet the requirements to provide sex offense-specific treatment, as defined in these Standards in section 4.000.

3.580 Treatment providers and community supervision teams must establish specific and measurable goals and tasks for clients in denial. These measurable goals shall be outlined in a treatment plan and will establish whether clients have reached the threshold of eligibility for referral to offense-specific treatment at the end of three months or earlier. It is especially important to document the client's accountability for their offenses**.**

3.600 Treatment of Clients Within the Department of Corrections

3.610 During incarceration and parole a continuum of treatment services shall be available to clients.[24]

3.620 Unless otherwise noted in this section, treatment for clients in prison shall conform to the *Standards and Guidelines* and for sex offense-specific treatment described in Section 3.000 and shall be provided by therapists who meet the qualifications for treatment providers described in Section 4.000.

Prior to beginning sex-offense specific treatment, clients who has been sentenced to the Department of Corrections (DOC), and is designated to participate in the Sex Offender Treatment and Management Program (SOTMP), and who did not receive a sex offense-specific evaluation at the time of the pre-sentence investigation shall receive a sex offense-specific evaluation.

3.630 SOTMP Treatment providers shall:

A. Prepare a summary of client's progress and participation in sex offender treatment and their institutional behavior. This summary shall be provided to the parole board prior to a release hearing;

[24] See C.R.S. 16-11.7-105.

B. Forward pertinent documents including any pre-sentence investigation reports to outpatient treatment providers upon request and with a valid release. (See Section 9.000 Continuity of Care.)