SEX OFFENDER MANAGEMENT BOARD

ANNUAL LEGISLATIVE REPORT

Evidence-Based Practices for the Treatment and Management of Adults and Juveniles Who Have Committed Sexual Offenses

A Report of Findings per 16-11.7-109(2) C.R.S.

January 2024

Prepared By:

Rachael Collie, Ph.D., Statistical Analyst

Alyssa Dalen, MPH, Statistical Analyst

Yuanting Zhang, Ph.D., Statistical Analyst

Chris Lobanov-Rostovsky, LCSW, Program Director

Office of Domestic Violence and Sex Offender Management

Chris Lobanov-Rostovsky, Sex Offender Management Unit Administrator

Division of Criminal Justice

Matthew M. Lunn, Ph.D., Director

Colorado Department of Public Safety

Stan Hilkey, Executive Director

COLORADO
Division of Criminal Justice
Department of Public Safety

COLORADO
Division of Criminal Justice
Department of Public Safety

The Division of Criminal Justice and the Office of Domestic Violence and Sex Offender Management (ODVSOM) is committed to the full inclusion of all individuals, and we are continually making changes to improve accessibility and usability of our services. As part of this commitment, the ODVSOM is prepared to offer reasonable accommodations for those who have difficulty engaging with our content. As an example, documents can be produced in an alternative file format upon request. To request this and other accommodations, or to discuss your needs further, please contact ODVSOM by phone at 303-239-4526 or emailing the SOMB staff.

Table of Contents

Contents

Executive Summary

Pursuant to § 16-11.7-109 (2), Colorado Revised Statutes (C.R.S), this annual report presents findings from an examination by the Sex Offender Management Board (SOMB) of best practices for the treatment and management of adults and juveniles who have committed sexual offenses.

The SOMB is statutorily mandated in § 16-11.7-101(2), C.R.S. to create evidence-based standards for the evaluation, treatment, management, and monitoring of adults and juveniles who have committed sexual offenses with the goal of preventing reoffending and enhancing the protection of victims and potential victims. To identify the most current research and evidence-based practices within the field of sex offender treatment and management, the SOMB conducted a series of literature reviews and research projects in support of ongoing committee work and the development of this report.

This report is a product of the SOMB as mandated by § 16-11.7-101(2), C.R.S. This report and the recommendations herein do not necessarily represent the views of Colorado's Governor's Office, Office of State Planning and Budgeting, the Colorado Department of Public Safety, or other state agencies.

Section 1: Research and Evidence-Based Practices

Victim-Centered Treatment: Victim Impact and the Victim Representative

- In § 16-11.7-103(4)(a), C.R.S., it requires that interventions shall prioritize the physical and psychological safety of victims and potential victims, alongside meeting the assessed needs of the individual who offended. Two important aspects of victim-centered offense-specific treatment are victim clarification interventions and the inclusion of a Victim Representative within adult Community Supervision Teams (CSTs) and juvenile Multidisciplinary Teams (MDTs).

- Victim clarification is a core component of offense-specific treatment and is necessary for successful treatment completion. Victim clarification involves the offender acknowledging to the victim, in a letter or in person, full responsibility for the sexually abusive behavior and the harm caused. It is *primarily* intended to benefit the victim, to ensure full responsibility is taken by the offender, and any victim-blame is reduced. Victims can choose to receive the letter or participate in a clarification session, but it is never required of them. Each CST and MDT is required to have a victim representative on the team, with part of the role being to manage any involvement of the victim or the victim's family in the victim clarification process.

- In 2022, the SOMB Victim Advocacy Committee requested a research review to examine the impact on victims of participating in the victim clarification process. In 2023, the SOMB Victim Advocary Committee requested a survey of SOMB Approved Treatment Providers about their implementation of victim clarification and use of the Victim Representative in the CST/MDTs.

Summary of Literature and Research

- For the research review, a systematic search of the research literature was undertaken with a preference for studies published in the last ten years. A total of 18 studies or other articles were analyzed. The main findings follow.

- Professionals who use victim clarification in their therapeutic work have a high degree of agreement about best practices for victim clarification and a strong belief that when conducted properly, it benefits the victim.

- A restorative justice program for adult sexual assault crime victims found a high level of victim satisfaction with the process. Important elements for the victim included offender acknowledgment of responsibility, having a safe opportunity to express how the offense harmed them, and ensuring the offender is accountable for getting treatment to prevent further offending from being committed.

- Research highlights specific factors that are likely to influence the degree to which victim clarification is positive or negative. These include that it is important for the victim to be empowered to choose whether contact occurs, for offender apologies to be sincere and consistent with the victim's experience of the offense, and for the victim to have a safe opportunity to assert themselves and seek answers about the offense. It also seems very relevant that the victim has a sense that justice is achieved and that the offender is accountable for addressing their offending.

- Unfortunately, there is little that can be drawn from the research about the intersection of victim clarification impacts and ethnicity-race or LGBTQ+ identity.

- Outside of sex offense-specific treatment, few other programs provide victims of sexual offenses the opportunity to participate in a victim clarification intervention. It is crucial that this specialized intervention is conducted with extreme care, sensitivity, and skill to ensure it is victim-centered and beneficial for the victim. For this reason, it is a multi-step process that requires flexibility, training, and competence. To be delivered ethically by clinicians, victim clarification interventions must also not cause harm to offenders and contribute to their treatment progress.

Highlight of SOMB Approved Provider Survey Findings

- An online survey of all SOMB Approved Adult and Juvenile Treatment Providers was conducted during March-April 2023. Participation was encouraged but optional. Participation was anonymous. A total of 74 treatment providers completed the survey, which was a 20% response rate. The survey sampled a good mix of adult and juvenile treatment providers from across Colorado with a range of years of experience. Highlights from the survey follow.

- Overall, the survey confirmed the value of victim clarification interventions for the offender and victim.

- The responses suggest treatment providers are conducting victim clarification interventions in accordance with the *Adult and Juvenile Standards and Guidelines*.

- The major issues affecting the ability to maximize the impact of victim clarification interventions are the challenge of programs connecting with victims, engaging victims in the process, and ensuring a consistent level of understanding between all professionals involved.

- Treatment providers reported that victim representatives added value to offense-specific treatment by being the coordinator and support for any victim contact, and by bringing other victim-centered knowledge and skills.

- Treatment providers who engaged with the survey provided very detailed comments suggesting high investment in victim clarification interventions and developing effective working relationships with the victim representative.

Managing Clients in Denial

- Denial is conceptualized in the *Adult Standards and Guidelines* as the failure to accept responsibility for sexual offending. It occurs along a spectrum and can relate to responsibility for different aspects of sexual offending, the harm caused to the victim, and the implications for treatment and risk management. Denial is defined in the *Adult Standards and Guidelines* as: **No Denial** (accepts *full* responsibility, does not place blame elsewhere), **Low Denial** (accepts *most* responsibility, places some of the blame elsewhere), **Moderate Denial** (accepts *some r*esponsibility, places most of the blame elsewhere), **High Denial** (accepts *no* responsibility, denies committing unlawful sexual behavior). High Denial is also called 'categorical denial' in the research literature.

- The SOMB Adult Standards Revision Committee requested a research update on client denial to inform its review of the *Adult Standards and Guidelines Section 3.500, Managing Clients in Denial*. An analysis of SOMB Provider Data Management records pertaining to client denial was also conducted to inform the Committee.

Summary of Literature and Research

- For the research review, a systematic search of the research literature was undertaken with a preference for studies published in the last ten years. Over 18 studies or other articles were analyzed. The main findings follow.

- Denial and minimization of offending are prevalent among individuals convicted of sexual offenses. It serves a number of different functions, including shame management, rejection of being a 'sex offender', and maintenance of identity and relationships. Particular thinking styles and cognitive distortions may give rise to and sustain denial and minimization.

- Denial has not emerged as a consistent risk factor for sexual recidivism, although research limitations and exceptions highlight a need for a better understanding of how it may be important in risk and desistance.

- Denial is a treatment responsivity factor that influences treatment engagement and rates of treatment completion, which in turn indirectly link it to an increased risk of recidivism.

- Offense-specific treatment is designed to work with individuals who minimize responsibility but nonetheless acknowledge the occurrence of a sex offense. Research shows that offense-specific treatment has an overall positive effect on sexual recidivism and leads to decreases in the minimization of offending.

- Different approaches to managing clients who are in categorical denial of their sex offending have been tried, although there is limited evaluation to determine if one approach is better than another. Research on pre-treatment interventions, like those used in Colorado, shows they appear to reduce categorical denial in about half the participants. Integrating 'deniers' into offense-specific treatments appears to work for some individuals, particularly if denial is not directly challenged, but can have a negative impact on group dynamics, be challenging to implement, and may not lead to any greater reduction in denial than pre-treatment programs.

- 'Deniers' programs designed to address criminogenic needs and not modify denial have been used for imprisoned offenders who refuse offense-specific treatment but are serving determinate sentences and will be released to the community at some point. Initial evaluations show they appear to lead to treatment gains, but they also differ in important respects from the type of offense-specific treatment typically provided in the United States.

- Approaches continue to evolve about how to work therapeutically with denial and minimization. Research indicates polygraph examination can increase disclosure of sex crimes.

SOMB Data Analysis of Client Denial

- The SOMB Provider Data Management System (PDMS) enables analysis of data regarding offenders who complete denier interventions and offense-specific treatment according to the *Adult Standards and Guidelines*. The data analysis used 1,481 client case records entered in the PDMS between October 2019 and November 2022. The data included 365 optional provider comments relating to the management of client denial. The aims of the data analysis were to: (i) describe client denial at the beginning and end of treatment contact, (ii) explore factors associated with client denial and progress addressing denial, and (iii) explore approaches treatment providers use to manage denial. A highlight of key findings follows.

- The majority of clients exhibited denial and minimization prior to treatment. However, the rates of categorical denial appeared lower than those reported in the research literature.

- About two-thirds of those who began treatment in categorical denial progressed to take some responsibility and enter offense-specific treatment. Although this rate is fairly consistent with other research, it also appears somewhat better than other pre-treatment programs reported in the research literature.

- Over one-third of all clients who undertake treatment accept full responsibility for their sex offending by the end of their treatment contact. Only 5% remain in categorical denial at the end of treatment contact.

- Female gender was associated with categorical denial, particularly at the beginning of treatment contact, perhaps because female sex offending is hard to acknowledge when it

deviates so markedly from gender norms. African American race-ethnicity was associated with categorical denial at the beginning and end of treatment, while Native American race-ethnicity was associated with categorical denial at the end of treatment. In contrast, Hispanic-Latino race-ethnicity was associated with greater improvement in denial across treatment. These findings highlight important intersections between race and culture and the effectiveness of treatment.

- Treatment providers appear to use a range of effective approaches to working with client denial and minimization that reflect the responsivity principle and contemporary CBT practice. Additional emphasis on exploring cultural responsiveness and culturally sensitive interventions is warranted to improve the effectiveness of Denier Interventions with African American and Native American clients.

SOMB Data Collection Analysis

- The SOMB data collection project completed its 4th year in 2023. The SOMB is mandated to collect data from SOMB Approved Evaluators, Treatment Providers, and Polygraph Examiners for each client seen under the Standards and Guidelines. The data is entered by providers at the time of service completion, regardless of the outcome of the service.

- The goal of the data collection is to assess if Approved Providers are adhering to the *Standards and Guidelines*, implementing the *Standards and Guidelines* as required, and providing services consistent with the RNR principles that individualize services to client risk and need levels.

- Approved Providers entered 486 client evaluation records, 650 treatment records, and 3,142 polygraph exam records. The amount of client data entered increased for all provider types (evaluation, treatment, and polygraph exam) compared to 2022. The proportion of clients who agreed to allow the use of their data when the SOMB studies the longer-term outcomes, including recidivism, also increased.

Evaluation Data

- Among the 486 evaluation records, 84% involved adult clients and 16% involved juvenile clients.[1] Of the adults, 56% had a contact offense and 20% had a non-sex crime conviction with a history of a sex crime. Of the juvenile clients, 83% had a contact offense and 5% had a non-sex crime conviction with a history of a sex crime. Over 80% of clients were referred for evaluation by probation.

- The demographics of clients showed most were male, with 2% female and less than 1% other gender identities. Race-ethnicity was 53% White, 26% Hispanic or Latino, and 13% African American. Native American/American Indian and Asian/Pacific Islander clients were less than 2% each.

- To match treatment to the level of risk, evaluations most frequently recommended adjunct treatment followed by adjustments to community access and the frequency of treatment. Most evaluations included individual self-reported needs and

[1] An "adult" means the clients was convicted in an adult court, while "juvenile" means the client was adjudicated in a juvenile court.

reviewed collateral information. Most evaluations also recommended an individualized treatment plan. Treatment needs were also frequently addressed with recommendations for increased resources and support. To address client responsivity issues, over half of the evaluations recommended the use of mental health-related adjunct therapy.

- Evaluations included the use of standardized and validated risk assessment instruments. Of the adult clients, 65% were classified as moderate risk or less, while 19% were high risk. Of the juvenile clients, 89% were classified as moderate risk or less, while 4% were high risk.

Treatment Completion Data

- Among the 650 treatment records, 90% involved adult clients and 10% involved juvenile clients. Of the adult clients, 71% had a contact offense and 2% had a non-sex crime conviction with a history of a sex crime. Of the juvenile clients, 88% had a contact offense and none had a non-sex crime conviction with a history of a sex crime. The treatment referral source was 41% probation, 31% parole/TASC, 10% the Department of Corrections, and 10% Court.

- The demographics of the clients showed most were male, with 4% female and less than 2% other gender identities. Race-ethnicity was 59% White, 25% Hispanic or Latino, and 11% African American. Native American/American Indian and Asian/Pacific Islander clients were less than 1% each.

- Most treatment providers identified the client's needs from client self-report and discussion with the adult Community Service Team (CST) or juvenile Multidisciplinary Team (MDT). Treatment needs were frequently addressed with individualized treatment plans, modified assignments, increased resources and support, flexible scheduling, and modifications to the treatment modality.

- Treatment responsivity factors were most often client factors (e.g., motivation), lack of support, substance use, lack of engagement with the community, and housing. To address client responsivity issues, treatment providers made efforts to get feedback from the client, adjust the frequency or modality of treatment services, use external supports, use mental health-related adjunct therapy, and use motivational interventions. A significant proportion (18%) of treatment providers also assessed for cultural, language, sexual orientation, gender identification, and/or family needs.

- At the beginning of treatment, 45% of adult clients were classified as either low-moderate or moderate risk, while 25% were either moderate-high or high risk. By the end of treatment, 50% of adult clients were either low-moderate or moderate risk, while 22% were moderate-high or high risk. At the beginning of treatment, 61% of juvenile clients were classified as low-moderate or moderate risk, while 9% were moderate-high or high risk. By the end of treatment, 64% of juvenile clients were low-moderate or moderate risk, while 8% were moderate-high or high risk.

- The small aggregate changes in risk levels from the beginning to the end of treatment obscure the fact that a substantial proportion of clients reduced risk levels over treatment. This discrepancy arises, in part, because some clients have also increased risk levels due to

engaging in risk-related behaviors or their 'true' pre-existing risk level becoming more apparent during treatment and supervision. Of the clients who began treatment at high risk, 29% lowered their risk over treatment. Of those who began at moderate-high risk, 49% lowered their risk over treatment. Of those who began treatment at either moderate or low-moderate risk, over 50% lowered their risk over treatment.

- At discharge, 41% of adult clients had successfully completed treatment and 32% were unsuccessful due to non-compliance. Another 16% had an administrative discharge and 9% were successful but needed continued treatment (e.g., they successfully completed treatment in prison but required further treatment in the community). At discharge, 72% of juvenile clients had successfully completed treatment and 14% were unsuccessful due to non-compliance. Another 9% had an administrative discharge and 5% were successful but needed continued treatment (e.g., they successfully completed treatment in residential care but required further treatment in the community).

- The percentage of clients with a successful discharge correlated with risk level. Greater successful discharges were present for clients with lower risk and fewer successful discharges were present for clients with higher risk. The median treatment length for clients with successful discharges was 19 months. The median treatment length for clients with unsuccessful discharges was 9 months.

Polygraph Examination Data

- Among the 3,142 polygraph records, 3,052 contained sufficient data to be included in the data analysis. Of these, 98% involved adult clients and 2% involved juvenile clients. Of the adult clients, 72% were maintenance/monitoring exams, 22% were sex history exams, and 5% were specific issue exams. Of the juvenile clients, 64% were maintenance/monitoring exams, 26% were sex history exams, and 9% were instant/index offense exams. The polygraph referral source was 67% probation, 27% parole/TASC, 4% Community Corrections, and 2% Department of Corrections.

- The demographics of the clients showed most were male, with 2% female and less than 1% other gender identities. Race-ethnicity was 64% White, 24% Hispanic or Latino, and 8% African American. Native American/American Indian and Asian/Pacific Islander clients were 1% each.

- Disclosures were made by 44% of adult clients and 59% of juvenile clients. Of the adult clients, 13% disclosed sexual behavior, 10% disclosed a change in circumstance/risky behavior, 10% disclosed historical information, and 6% disclosed sexually abusive thoughts, feelings, and attitudes. Of the juvenile clients, 20% disclosed sexual behavior, 14% disclosed historical information, 7% disclosed a change in circumstances/risky behavior, and 5% disclosed sexually abusive thoughts, feelings, and attitudes.

- No deception, or no deception/no opinion was indicated in 73% of adult polygraphs and 53.5% of juvenile polygraphs. Deception was indicated in 22% of adult polygraphs and 38% of juvenile polygraphs. The remaining polygraphs were inconclusive. The highest rate of deception was for instant/index offense exams.

Comparing Results Across the Four Years of Data Analyses

- Over the past four years, Approved Providers appear to be following the *Standards and Guidelines* and utilizing RNR to individualize evaluation and treatment. Overall, the pattern and trends identified during year four were consistent with those found in prior years. Encouragingly, the successful treatment discharge rates have been increasing over each successive year.

Section 2: Relevant Policy Issues and Recommendations

Each year in the annual legislative report, the SOMB makes policy recommendations based on research and highlights areas that may be of particular interest to the members of the General Assembly. The recommendations of the SOMB do not necessarily reflect the recommendations of the Department of Public Safety.

Recent Court Cases

People vs. Vigil *(2023COA12)*

- The Colorado Court of Appeals upheld the right of a defendant on probation to invoke his Fifth Amendment privilege against self-incrimination where his initial period for seeking postconviction relief had not ended. At issue was whether the State could revoke the defendant's sex offender intensive supervision probation (SOISP) because he refused to sign a treatment contract that included the acknowledgment that treatment was for victimizing others through sexually offensive behavior. Refusal to sign the contract excluded the defendant from attending offense-specific treatment, which was required by his probation conditions. The decision found that in the absence of any grant of immunity, the statement in the contract could constitute incriminating information and be used at a retrial on the original charges in the event postconviction relief was granted.

- The Court addressed the community safety concern that the ruling could allow some defendants seeking post-conviction relief to avoid certain aspects of treatment. The decision noted the SOMB allows providers to modify aspects of offense-specific treatment to avoid discussing the offense of conviction while an appeal is in motion. The Court also addressed the danger that there may be hesitancy to grant probation to individuals convicted of sexual offenses for concerns that their denial and refusal to sign pre-treatment acknowledgments will result in them being in the community but not in treatment. The decision noted that SOMB provides the option of a 'Use Immunity' agreement that protects defendants against their statements being used against them during a future prosecution.

- An implication of the Court of Appeal decision is a need to update the wording in the SOMB *Adult and Juvenile Standards and Guidelines* to indicate Fifth Amendment rights exist throughout the period that post-conviction relief runs and not only once a post-conviction motion is filed. The practical implementation of these changes will also require due consideration, as providers may have ethical concerns about providing offense-specific treatment to clients who deny their sexual offending.

People vs. Silvanic *(2023COA16)*

- The Colorado Court of Appeals ruled that before imposing a condition that subjects a probationer to ongoing, unfettered monitoring of their electronic devices and internet usage, the district court must (i) make sufficient factual findings concerning the extent of the electronic monitoring necessary to accomplish the legitimate purposes of the probationary sentence, and (ii) evaluate whether less restrictive means are available to achieve those ends.

- The case has implications for probation monitoring of risk-related behaviors as part of sex offender intensive supervision probation and the CST/MDT. It is an issue that may require clarification in the *Standards and Guidelines*.

Children with Problematic Sexual Behavior

- The SOMB Best Practices Committee convened a subcommittee to study and recommend best practices for children 12 years old and younger with problematic sexual behavior. The subcommittee met regularly throughout 2022 and prepared a SOMB White Paper in the form of a resource document. The document was published in 2023 and is available on the SOMB website, Children with Problematic Sexual Behavior Resource Document. The Sub-Committee offered the following recommendations:

1. When a child with problematic sexual behavior is identified by a child-serving systems agency as in need of services, it is essential that the system immediately intervene, refer to the appropriate treatment services, and ensure compliance with all treatment requirements. A systems agency may include the juvenile justice system, child welfare agencies, schools, and other child-serving organizations. Actors should be mindful of and attempt to mitigate the potential for their intervention to traumatize or retraumatize impacted families.

2. A multidisciplinary approach is important to provide the best outcomes for children with problematic sexual behavior. These children with problematic sexual behavior and their families may be involved with multiple different government and private agencies, and it is essential that there be cross-collaboration among professionals working with the child. In particular, it is also essential that all agencies, particularly those that require and fund services, stay engaged with the child and the child's family until treatment is completed.

3. A range of treatment services should be available for children with problematic sexual behavior from less intensive psychoeducation-based interventions to more intensive treatment for children with problematic sexual behavior. Practitioners working with this population should have proper training and experience, and although not required for non-adjudicated children, an SOMB Approved Juvenile Treatment Provider may be a suitable resource.

4. Treatment services for children with problematic sexual behavior can be expensive and unaffordable for a family. Support and financial assistance from agencies involved with the child and family may be helpful to ensure the child and other family members are able to complete treatment when it is warranted.

5. Treatment for children with problematic sexual behavior should be assessment-driven and should be individualized for each child. Not all children have the same treatment needs. A good assessment can determine what level of risk the child poses for future problematic sexual behavior and the level and intensity of the recommended intervention. All treatment interventions provided to children with problematic sexual behavior should be based on treatment needs, and treatment approaches should follow research-informed best practices.

6. School personnel are often the first point of contact for a child with problematic sexual behavior. The SOMB School Resource Guide provides helpful information for school personnel dealing with this population. School personnel may also be included in the multidisciplinary approach for working with children with problematic sexual behavior.

7. Parental and/or guardian involvement is critical in working with children with problematic sexual behavior. Agencies who are overseeing these cases should identify mechanisms to ensure supervisory adult participation where possible.

8. Given the potential negative outcomes associated with labeling children with problematic sexual behavior as "sex offenders" and "perpetrators," care should be utilized by agencies and systems to avoid administrative and legal actions that may label these children. One way to accomplish this may be to look at alternatives to adjudication for children ages 10-12 with problematic sexual behavior such as diversion and informal adjustment. Adjudication may be suitable for a small subset of children with problematic sexual behavior who exhibit the most severe behaviors and pose the highest risk to the community for future problematic sexual behavior, but care should be exercised in decisions to prosecute such cases.

Section 3: Milestones and Achievements

The following highlights some of the many achievements of the SOMB in 2023:

- Progress implementing the SOMB reauthorization bill, SB 23-264, including establishing and completing work of the SOMB/DOC Treatment Solutions Committee.
- Continued priority given to equity, diversity, and inclusivity (EDI) issues within the SOMB and provider community.
- The SOMB Victim Advocacy Committee published a resource guide on *Understanding Sex Offender Treatment and Supervision in Colorado: A Resource Guide for Victims of Sexual Assault.*
- Further progress on the ODVSOM recruitment and retention marketing and communication project to attract and retain providers in the sex offender management field, particularly professionals from underrepresented groups.
- Fully implemented the online provider application system.
- Managed 15 SOMB committees and workgroups.

- Conducted multiple research reviews and data analysis projects to support the work of the SOMB committees and inform the provider community.
- Managed 187 applications for placement or continued placement on the SOMB Approved Provider List.
- As of November 2023, there are **246** adult treatment providers and **185** juvenile treatment providers approved by the SOMB in Colorado. There are **25** adult polygraph examiners and **15** juvenile polygraph examiners.
- Every Colorado county has an adult evaluation, treatment, and polygraph examiner SOMB Approved Provider.
- Fully implemented the ODVSOM shared services model.
- Prioritized ongoing implementation of the Standards and Guidelines through the SOMB training hub, staff positions as Implementation Specialists, a range of communication strategies, training, and research.
- Office of Domestic Violence and Sex Offender Management hosted its annual conference in July 2023, which was attended by 586 providers and stakeholders.
- Conducted 26 training events with over 1,500 attendees from across Colorado.
- Published the 2024 SOMB Annual Legislative Report and the 2023 Lifetime Supervision of Sex Offenders Annual Report.

Section 4: Future Goals and Direction

- Continue to focus on executing the SOMB's statutory duties and supporting service providers to implement the *Standards and Guidelines* with fidelity.
- Continue efforts toward equity, diversity, and inclusion initiatives within the SOMB and provider community to maximize the effectiveness of treatment and the protection of victims and potential victims.
- Begin implementing the new mandated requirement to complete compliance reviews on 10% of SOMB Approved Providers every two years.
- Continue work toward Phase II of the data collection project to examine longer-term outcomes for individuals who received offense-specific treatment in Colorado, including examination of recidivism rates.
- Continue revisions and changes to the SOMB *Standards and Guidelines* to keep pace with emerging research and literature.
- Continue supporting projects led by the Victim Advocacy Committee to ensure that a community safety and victim-centered focus is optimized.

Introduction

Purpose

Pursuant to § 16-11.7-109 (2), C.R.S.,[2] this annual report presents findings from an examination by the Sex Offender Management Board (SOMB) of best practices for the treatment and management of adults and juveniles who have committed sexual offenses. This report fulfills the statutory mandate by providing:

1. A summary of emerging research and evidence-based practices for evaluation, assessment, treatment and supervision strategies in the field of sex offender management; and
2. A review of policy issues affecting the field of sex offender management that the Legislature may wish to review for potential statutory change.

Additionally, this report documents the 2023 achievements and current efforts being undertaken by the SOMB.

Background of the Sex Offender Management Board

In 1992, the Colorado General Assembly passed legislation (§ 16-11.7-101 through § 16-11.7-107, C.R.S.) that established a Sex Offender Treatment Board to develop *Standards and Guidelines for the Assessment, Evaluation, Treatment and Behavioral Monitoring of Adult Sex Offenders* (henceforth referred to as the *Adult Standards and Guidelines*). In 1998, the General Assembly changed the name to the Sex Offender Management Board (SOMB) as it better reflected the duties assigned to the Board.

The *Adult Standards and Guidelines* were originally created by the SOMB over a period of two years and first published in January 1996. They applied to adults who were convicted of a sexual offense and under the jurisdiction of the criminal justice system. From the beginning, the *Adult Standards and Guidelines* were designed to establish a basis for the systematic management and treatment of adults who had committed sexual offenses. The primary goals of the legislative mandates to the SOMB were to ensure the safety of the community and the protection of victims. The *Adult Standards and Guidelines* were revised in written form in 1998, 1999, 2008, 2011, 2017, 2019, 2021, 2022, and 2023. Since 2017, updates to sections have also been implemented in real-time on the SOMB website after being approved by the Board.

[2] § 16-11.7-109 (2), C.R.S.: On or before January 31, 2012, and on or before January 31 each year thereafter, the board shall prepare and present to the judiciary committees of the senate and the house of representatives, or any successor committees, a written report concerning best practices for the treatment and management of adult sex offenders and juveniles who have committed sexual offenses, including any evidence-based analysis of treatment standards and programs as well as information concerning any new federal legislation relating to the treatment and management of adult sex offenders and juveniles who have committed sexual offenses. The report may include the board's recommendations for legislation to carry out the purpose and duties of the board to protect the community.

In 2000, the General Assembly amended and passed legislation (§ 16-11.7-103, C.R.S.) to require the SOMB to develop and prescribe a standardized set of procedures for evaluating and identifying juveniles who had committed a sex offense. The *Standards and Guidelines for the Evaluation, Assessment, Treatment and Supervision of Juveniles Who Have Committed Sexual Offenses* (henceforth referred to as the *Juvenile Standards and Guidelines*) were first published in 2003 and revised in written form in 2008, 2011, 2014, 2017, 2019, 2020, 2021, 2022, and 2023. Since 2017, updates to sections have been implemented in real-time on the SOMB website after being approved by the Board. Like the *Adult Standards and Guidelines*, the *Juvenile Standards and Guidelines* prioritize public safety, specifically the physical and psychological safety of victims and potential victims.

The *Adult* and *Juvenile Standards and Guidelines* have been designed to provide an evidence-based framework for managing, assessing, and treating adults and juveniles who have committed sexual offenses. The *Standards and Guidelines* allow for a comprehensive range of therapeutic modalities and interventions tailored to the needs of the adult or juvenile, as well as behavioral monitoring strategies to improve supervision based on the level of risk. This systemic approach has the dual purpose of managing and reducing the risk of sexually abusive behavior while promoting protective factors that facilitate success. The standards and guidelines also detail the qualifications and training processes required to become approved for clinical services under the *Adult or Juvenile Standards and Guidelines*. This ensures that those offering these specialized services are qualified and competent to do so.

The *Adult* and *Juveniles Standards and Guidelines* support a coordinated approach where a Community Supervision Team (CST) oversees adults who have committed sexual offenses, and a Multi-Disciplinary Team (MDT) oversees juveniles who are adjudicated for sexual offenses. The CST/MDT designs an individualized treatment and supervision plan for the adult or juvenile to address their psycho-social deficits and potential risk factors. The treatment and supervision plan also builds upon and supports the adult or juvenile's resiliency and positive traits. To be effective, this approach must include interagency and interdisciplinary teamwork. The CST and MDT usually consist of a supervising officer, treatment provider, victim representative, polygraph examiner, and other adjunct professionals where applicable. Members of the CST and MDT possess vital expertise and knowledge that, when shared, can improve the team's decision-making process. This approach enhances both public safety and the supervision and accountability of the adult or juvenile.

The *Adult* and *Juvenile Standards and Guidelines* are based on research and best practices for managing and treating adults and juveniles who have committed sexual offenses. Other sources of knowledge have also been consulted where relevant, such as professional training, literature reviews, and documents from relevant professional organizations. The SOMB has processes in place to ensure the *Adult* and *Juveniles Standards and Guidelines* are periodically updated to reflect advancements in the field based on new empirical findings. Much of the work to stay up-to-date with the latest research and respond to issues coming from the field occurs through the SOMB active committees. These committees meet regularly and report back to the Board, providing valuable insights to inform potential revisions to the *Adult* and *Juvenile Standards and Guidelines*.

The following is a list of the SOMB committees:

1. Executive Committee
2. Best Practices Committee

3. Application Review Committee
4. Adult Standards Revisions Committee
5. Juvenile Standards Revision Committee
6. Victim Advocacy Committee
7. Training Committee
8. Sex Offender Surcharge Allocation Committee

Report Organization

The annual legislative report is divided into four sections. The first section gives an overview of key research and evidence-based practices that are informing updates to the *Adult and Juvenile Standards and Guidelines*. The second section focuses on relevant policy issues that may be of interest to the legislature. The third section highlights the accomplishments of the SOMB in the year 2023. The fourth and final section briefly highlights the future goals and directions of the SOMB.

Section 1: Research and Evidence-Based Practices

The SOMB is statutorily mandated in § 16-11.7-101(2), C.R.S., to create evidence-based standards for the evaluation, treatment, management, and monitoring of adults and juveniles who have committed sexual offenses with the goal of preventing reoffending and enhancing the protection of victims and potential victims. To ensure the *Standards and Guidelines* reflect evidence-based best practices, the SOMB conducts reviews of the relevant research literature and undertakes its own research projects.

Victim-Centered Treatment: Victim Impact and the Victim Representative

In § 16-11.7-103(4)(a), C.R.S., it specifies that interventions shall prioritize the physical and psychological safety of victims and potential victims, alongside meeting the assessed needs of the individual who offended. Two important aspects of victim-centered offense-specific treatment are victim clarification interventions and the inclusion of a Victim Representative within adult Community Supervision Teams (CSTs) and juvenile Multidisciplinary Teams (MDTs). In 2022, the SOMB Victim Advocacy Committee requested a research review to examine the impact on victims of participating in the victim clarification process. Subsequently, in 2023, the Committee requested a survey of SOMB Approved Treatment Providers to gather information on (i) the implementation and effectiveness of victim clarification work as part of offense-specific treatment, and (ii) the use of the Victim Representative within the CST/MDTs.

Victim clarification interventions initially emerged in treatment settings that addressed intra-familial sexual abuse (De Maio, Davis, & Smith, 2006), although they also overlap with features of restorative justice approaches (Koss, 2014). Victim clarification is a core component of SOMB offense-specific treatment and is necessary for successful treatment completion. It is *primarily* intended to benefit the victim, to ensure full responsibility for the offending is taken by the offender, and any victim-blame is reduced (De Maio et al., 2006). Victim clarification involves the offender acknowledging to the victim in a letter or in person full responsibility for the sexually abusive behavior and the harm caused. Victims can choose to receive the letter or participate in a clarification session, but it is never required of them. The offender writes the letter *as if* it will be received by the victim, whether or not that occurs at that point in time or in the future. Considerable care is taken to ensure the process is victim-centered and where a victim chooses to be involved, safe, and in their best interests. Other outcomes of the process for the offender may include challenging distortions held about the abuse and increasing empathy for the victim. In some cases, clarification with other secondary victims impacted by the offense may also be warranted.

The *Adult and Juvenile Standards and Guidelines*[3] outline the considerations involved in victim clarification work and *require* the treatment provider and client to collaborate with the victim

[3] See Section 5.745 of the Adult Standards and Guidelines and Sections 9.100-9.110 of the Juvenile Standards and Guidelines.

representative. Each CST and MDT is required to have a victim representative with part of that role being to manage any involvement of the victim or the victim's family in the victim clarification process. Other members of the CSTs and MDTs are also often involved, although not required. Clarification letters are prepared by clients, in their own words, and are reviewed by the treatment provider and victim representative. Clarification is a multi-step process involving revision based on input from the treatment provider, victim representative, and any other involved CST or MDT members. Any progression to in-person clarification sessions requires the wish of the victim and approval by the CST or MDT. In lieu of a clarification session involving the victim, an alternative 'mock' clarification sessions with a victim representative or others may be held.

The following sections highlight the findings from the research review on the impact to victims of clarification and the survey of treatment providers.

Summary of Literature and Research

For the review, a systematic search of the research literature was undertaken with a preference for studies published in the last 10 years. A total of 18 studies or other articles were analyzed. It was noteworthy that very little research directly examined victims' experiences of clarification. Rather, the review had to draw from studies that surveyed professionals who use victim clarification in their therapeutic work and restorative justice research. With respect to equity issues, a limitation of research in this area is that it has not, to-date, addressed the intersection of ethnicity-race or LGBTQ+ identity and victim experiences of clarification. Thus, it is unclear if the findings apply equally as well to members of minority ethnic-racial groups and the LGBTQ+ community, or what unique issues require consideration.

The most significant study on victim clarification processes as part of sex offense-specific treatment was conducted by De Maio et al. (2006). It involved surveying 386 ATSA[4] members who used victim clarification sessions in the context of intrafamilial sexual offending. The clinicians' ratings indicated there was high agreement that victim clarification empowered the child, that victims gained understanding from the process, and that it did not retraumatize the victims. The study identified the essential elements of clinician best practices when preparing for and conducting victim clarification, which have already been incorporated into the *Adult and Juvenile Standards and Guidelines*. In another study, victim clarification sessions were also emphasized as a critical and therapeutically powerful part of the reunification process by professionals involved in family reunification following intrafamilial sibling sexual abuse (Harper, 2012).

A qualitative study that explored whether victims of intrafamilial child sexual abuse benefited from later contact with the abusive parent outside of any formal system is also informative (Paige & Thornton, 2015). The study recruited participants via the internet and conducted in-depth interviews to identify themes in the experiences of contact. It reported victims found planned contact more manageable and less destabilizing than contact that occurred in unanticipated or accidental ways. The quality of the apology from the parent and the extent it concurred with the victim's experience also affected whether the contact was positive or negative. Contact that was sought for personal growth and that answered fundamental questions (e.g., "why me") was more beneficial. Many of the themes

[4] Association for Treatment of Sexual Abusers (since renamed the Association for Prevention and Treatment of Sexual Abuse).

to emerge in this study associated with beneficial contact for the victim are also reflected in victim clarification as part of offense-specific treatment.

One of the only studies of restorative justice conferencing with victims of adult sexual violence was reported by Koss (2014). The program offered adult victims of sexual assault the opportunity to participate in a restorative justice conference where the offender also agreed, with the program also providing extensive preparation to ensure the victim's emotional safety. Over 90% of victims who took part reported being satisfied with the program. The most common reasons reported by victims for choosing restorative justice were "to make the responsible person accountable" and "to have an opportunity to express how the incident affected me." Reasons reported by both the victims and offenders related to "ensuring the offender didn't perpetrate again against anyone else" and that "he got help for his offending." Doubts about the sincerity of the offender and whether justice had been achieved led some victims to feel dissatisfied with the process. The most satisfied group were the victims who attended their conference in person compared to video conferencing.

Although there are occasional descriptions of restorative justice programs being piloted for victims of sexual crimes, no other studies have rigorously examined the impact on the victims or the effectiveness for the offender. The main reason is due to serious crimes, especially sex offending, being excluded from restorative justice approaches.[5] It is also informative though that a restorative conferencing model used in an Australian juvenile court resulted in the juveniles more frequently acknowledging responsibility for sex offending and engaging in treatment than regular court processes (Daly, 2006). Other systematic reviews of restorative justice for non-sexual offending have also found victims received better apologies from offenders and expressed greater perceptions of fairness, satisfaction, and justice than in traditional court handling (Livingstone, McDonald, & Carr, 2013; Strang et al., 2013; Wilson, Olaghere, & Kimbrell, 2017).

Taken together, the research review to examine the impact on victims of participation in the victim clarification process identified the following:

- Professionals who use victim clarification in their therapeutic work have a high degree of agreement about best practices for victim clarification and a strong belief that when conducted properly, it benefits the victim.

- A restorative justice program for adult sexual assault crime victims found a high level of victim satisfaction with the process. Important elements for the victim included offender acknowledgment of responsibility, having a safe opportunity to express how the offense harmed them, and ensuring the offender is accountable for getting treatment to prevent further offending from being committed.

- Research highlights specific factors that are likely to influence the degree to which victim clarification is positive or negative. These include that it is important for the victim to be empowered to choose whether contact occurs, for offender apologies to be sincere and consistent with the victim's experience of the offense, and for the victim to have a safe opportunity to assert themselves and seek answers about

[5] For example, in Colorado, as per § 18-1.3-104 (b.5), C.R.S, to be eligible for restorative justice practices as a sentencing option, the defendant shall not have been convicted of unlawful sexual behavior, domestic violence, stalking, or violation of a protection order.

the offense. It also seems very relevant that the victim has a sense that justice is achieved and that the offender is accountable for addressing their offending.

- Unfortunately, there is little that can be drawn from the research about the intersection of victim clarification impacts and ethnicity-race or LGBTQ+ identity.

- Outside of sex offense-specific treatment, few other programs provide victims of sexual offenses the opportunity to participate in a victim clarification intervention. It is crucial that this specialized intervention is conducted with extreme care, sensitivity, and skill to ensure it is victim-centered and beneficial for the victim. For this reason, it is a multi-step process that requires flexibility, training, and competence. To be delivered ethically by clinicians, victim clarification interventions must also not cause harm to offenders and contribute to their treatment progress.

Highlight of SOMB Provider Survey Findings

The SOMB conducted an online survey of all SOMB Approved Adult and Juvenile Treatment Providers during March-April 2023. Participation was encouraged but optional. Participation was anonymous, with no identifying information recorded about those who responded.

The purpose of the survey was to learn about:

1. Implementation of victim clarification interventions in offense-specific treatment, and

2. Treatment provider perspectives on the role of the victim representative within the Community Supervision and Multidisciplinary Teams.

In total, 74 treatment providers participated, which represented a 20% response rate. The survey sampled a good mix of adult and juvenile treatment providers from across Colorado with a range of years of experience.

Key Findings: Victim Clarification Interventions

The treatment providers (n=56) had a high level of experience with victim clarification procedures. All were experienced in having the offender prepare a clarification letter, 88% were experienced in sharing the letter with the victim, 77% had held in-person clarification sessions, and 30% had held virtual (video) clarification sessions. All agreed the important factors that determined the victim's involvement were the victim's wishes, concerns about the impact on the victim, and/or readiness of the victim. Two-thirds also indicated the readiness of the offender was important.

Treatment providers reported the frequency that different clarification interventions were *always or often* used as follows: 96% have the offender prepare a victim clarification letter, 54% offer the victim clarification letter to the victim, and 16% have the offender engage in victim clarification sessions. The reasons given for not using these victim clarification interventions were that the offender was discharged from the service prior to this intervention being completed, client responsivity issues (e.g., mental illness or refusal), lack of access to or involvement of the victim, the victim declining participation, and safety concerns.

Treatment providers indicated victim clarification helped achieve a range of offense-specific goals, most notably increasing empathy for the victim and increasing acceptance of responsibility, as shown in **Figure 1**. Treatment providers also described a range of benefits and drawbacks for victim clarification, as summarized in **Table 1**. In addition to increasing empathy and accountability, victim clarification was seen as generally beneficial and potentially healing for the victim. Some treatment providers (n=16) offered ideas about potential equity, diversity, and inclusion issues. These centered on possible lack of trust in the criminal justice system, differing cultural priorities or preferences, and accessibility challenges that affect which victims participate and benefit from the victim clarification intervention.

Figure 1. Offense-Specific Treatment Goals Consistently Achieved with Victim Clarification (% Endorsed by Treatment Providers; n=56). For data table, see Appendix A.1.

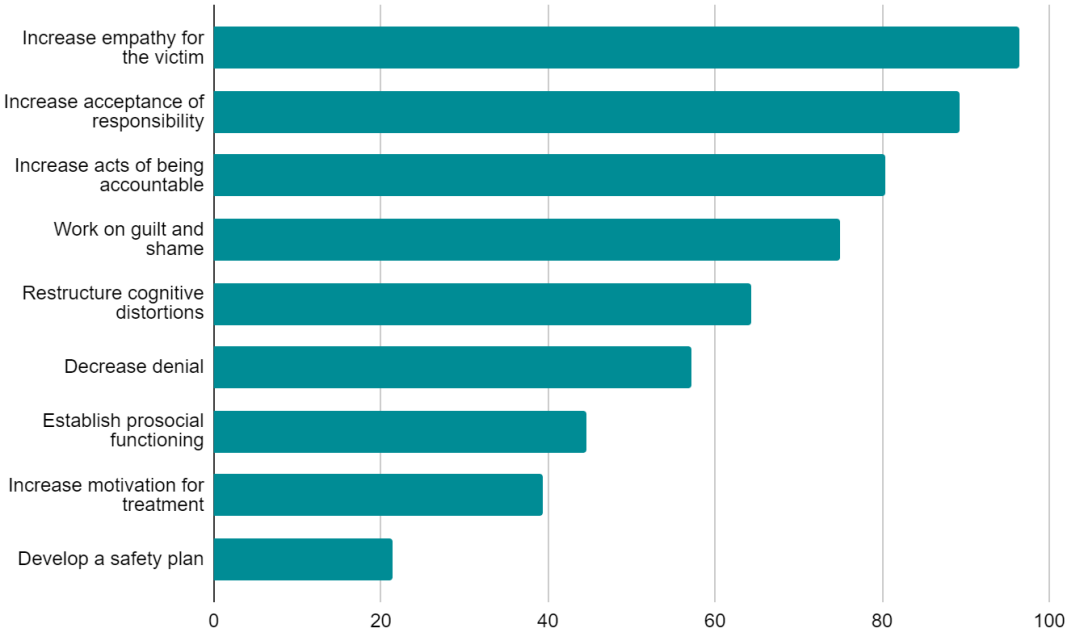


Table 1. Themes Present in Treatment Provider Comments About Victim Clarification (n=28).

Benefit Themes	Drawback Themes
• Generally beneficial • Develops victim empathy and understanding of victim impact • Involves accountability • Can be part of victim healing • When done well, incredibly healing for both parties	• Potentially harmful, some clients lack empathy, not always helpful • Letter can lack genuineness, letter can suffer from being a 'form' letter or checklist, and letter can be over scrutinized • Diverse ideas about the letters across Victim Representatives • Limited opportunity to conduct in-person clarification, lack of victim information, and difficult to conduct with a portrayed minor victim • Client can feel 'forced' to complete clarification, and integrity of process compromised sometimes due to lack of experience-knowledge • External factors are barriers (e.g., victim being unable to participate due to work and transport issues)

Key Findings: Role of Victim Representative

The treatment providers (n=62) indicated they met with their victim representatives at various frequencies: 21% met weekly or biweekly, 26% monthly, 34% bimonthly or quarterly, 15% as needed, and 5% rarely. Over 75% of treatment providers agreed the victim representatives benefited their work, provide an effective avenue for the victim's perspective, and keep a victim-centered approach central. The treatment providers indicated victim representatives were utilized in offense-specific treatment in multiple ways, as shown in **Figure 2**. The treatment providers described positive and negative impacts concerning the victim representative role, as summarized in **Table 2**.

Treatment providers (n=22) suggestions for enhancing the role of victim representatives, included:

- Increase training to understand the *Standards and Guidelines* and sex offending dynamics
- Increase training on victim clarification best practices and the victim representative role
- Increase access to victim information
- Have a greater role in connecting with victims
- Clarify and manage who wants letters and advocating for the victim
- Increase the availability of victim representatives and victim therapists
- Earlier involvement of victim representatives in evaluation or as a speaker in group sessions
- Funding to assist small agencies in hiring victim representatives
- Provide guidance on how best to address issues if there are tensions with victim families or about client confidentiality

Figure 2. Treatment Providers Utilization of Victim Representatives (% Endorsed by Treatment Providers; n=62). For data table, see Appendix A.2.

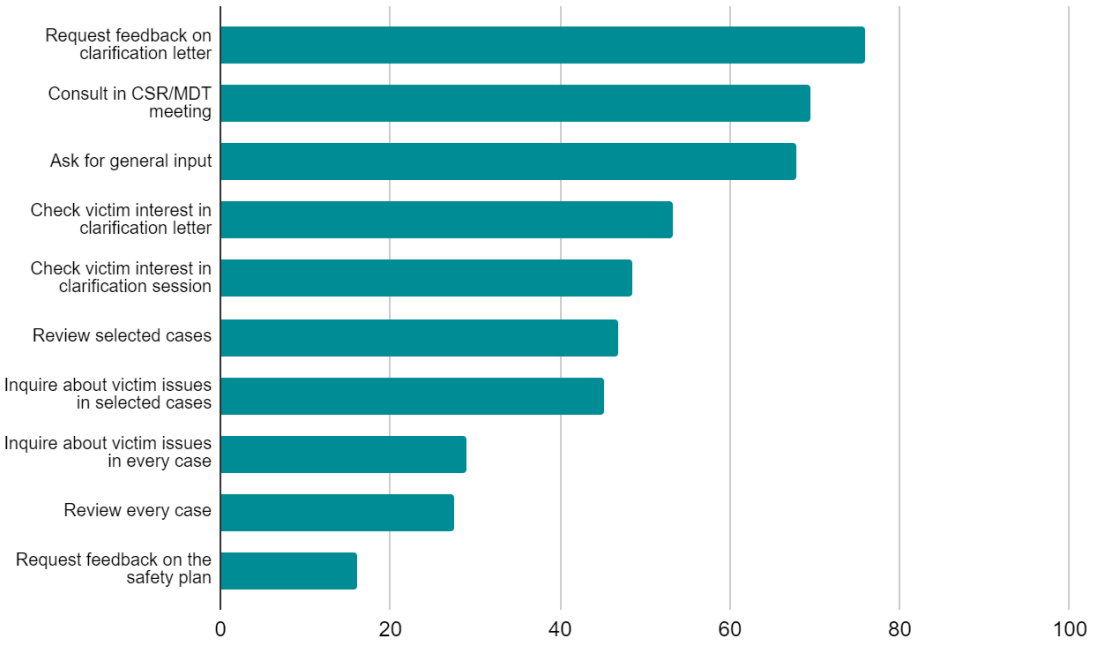


Table 2. Themes in Treatment Provider Comments About Victim Representative Impact (n=37).

Positive Themes	Negative Themes
• Helps understand another perspective, prevents tunnel vision, insight into victim issues, and ensures victim-centered • Another perspective for the client to hear from and learn from • Victim representatives who are therapists offer great professional insights and processes • Serves as a liaison	• Difficult to find Victim Representatives • Confidentiality issues can occur • Best if can work with victims' therapist where available • Knowledge and expertise across representatives can be inconsistent; some may not be well informed about SOMB standards or about victim clarification intervention • Creates work when Victim Representative is contracted from outside the agency • Helpful but not necessary on every case • Having a Victim Representative has a financial impact on small agencies

Summary and Conclusions

The SOMB successfully surveyed treatment providers about their use of victim clarification interventions and the role of the Victim Representative within the team. Highlights from the survey were:

- Overall, the survey confirmed the value of victim clarification interventions for the offender and victim.
- Treatment providers appear to be conducting victim clarification interventions in accordance with the *Adult and Juvenile Standards and Guidelines*.
- The major issues affecting the ability to maximize the impact of victim clarification interventions are the challenge of connecting with victims, engaging victims in the process, and ensuring a consistent level of understanding between all professionals involved.
- Victim representatives are viewed by treatment providers as adding value to offense-specific treatment not only through being the coordinator and support for any victim contact but also by bringing other victim-centered knowledge and skills.
- Treatment providers who engaged with the survey provided very detailed comments suggesting high investment in victim clarification interventions and working effectively with the victim representative.

Managing Clients in Denial

Denial is conceptualized in the *Adult Standards and Guidelines* as the failure to accept responsibility for sexual offending. It occurs along a spectrum and can relate to responsibility for different aspects of sexual offending, the harm caused to the victim, and the implications for treatment and risk management. At one extreme is categorical denial that the sexual offending occurred at all (e.g., it never happened, or it was consensual and not unlawful). Partial denial or minimization is less extreme, which involves denying particular aspects of the offense, rationalizing or justifying the offense, externalizing blame, and so forth. At the other end is acceptance of full responsibility for the sexual offending, the harm caused, and the future implications. In the *Adult Standards and Guidelines,* clients exhibiting at least some acceptance of responsibility for their sexual offending are suitable for offense-specific treatment. In contrast, clients exhibiting categorical denial are unsuitable and instead receive a Denier Intervention. Denier Intervention aims to assist the client to develop some responsibility for having offended and increase their readiness to enter offense-specific treatment. Denier Interventions are time-limited to prevent their misuse to avoid sanctions for not complying with probation offense-specific treatment conditions.

The SOMB Adult Standards Revision Committee requested a research update on client denial to inform its review of the *Adult Standards and Guidelines Section 3.500 Managing Clients in Denial*. The review was limited to adults convicted of sexual offending and was not intended to be generalized to juveniles. The review emphasized empirical research published in the last decade, although some review articles were included as they addressed gaps and summarized best practice approaches. To complement the research review, an analysis of SOMB Provider Data Management records pertaining to client denial was also conducted.

The following sections highlight key findings from the research review on client denial and the SOMB data analysis of client denial records.

Summary of Literature and Research

Empirical studies show that denial of offenses and minimization of offending behavior are prevalent for adults convicted of sexual offending at all stages of the criminal justice system (Dietz, 2020). For example, a study of males who had ultimately admitted to their sex offending found that 83% categorically denied the offense when first confronted, 53% categorically denied the offense at trial, 44% categorically denied when first interviewed in prison, and 33% categorically denied when first offered treatment (Lord & Willmot, 2004). Partial denial of the offense was present in another 25% at trial and 23% when first offered treatment. Another study found prior to treatment, 27% of the offenders categorically denied their offending, 68% minimized responsibility, and 5% admitted without denial or minimization (Malcolm, 2002). Thus, "some degree of denial is commonly observed in sex offenders presenting for treatment, ranging from absolute denial of the facts of the case, to minimization or justification of the offense, to distorted attributions of responsibility" (Levenson, 2011, p. 348).

A major factor in the high rates of denial and minimization, particularly pre-conviction, is the attempt to avoid the legal and social consequences that come with admitting (Rogers & Dickey, 1991; Sewell & Salekin, 1997). The high rates of denial post-conviction also highlight that psychological factors are important. Research indicates that denial and minimization function to mitigate against shame, reject stigma associated with being a 'sex offender', and help to maintain a positive identity and relationships with family and friends (e.g., Blagden, Winder, Gregson, & Thorne, 2014; Evans &

Cubellis, 2014; Ware, Blagden, & Harper, 2020). Denial may also be sustained through particular styles of grievance and constricted thinking (e.g., seeing oneself as the victim of an unjust system and avoiding thinking or talking about information that invalidates the denial) (Blagden et al., 2014). Distorted beliefs about the nature of sex offending, victim harm, and treatment are also often associated with higher levels of denial (e.g., Brown, Walker, Gannon, & Keown, 2013; Nunes & Jung, 2013). Researchers also recognize the potential that categorical denial may reflect truth-telling in some instances in light of high-profile instances of individuals being exonerated (Ware, Marshall, & Marshall, 2015).

Contrary to popular belief, meta-analytic studies have not found denial to be a significant risk factor for sexual recidivism (Hanson & Bussière, 1998; Hanson & Morton-Bourgon, 2005; Mann, Hanson, & Thornton, 2010). Some recent studies support this finding (e.g., Harkins et al., 2015), while others have produced mixed results (Harkins, Beech, & Goodwill, 2010; Langton et al., 2008; Nunes et al., 2007). Methodological issues that limit conclusions are the meta-analyses included studies on juveniles, denial is often measured pre-treatment, and most studies have not accounted for possible interactions with other risk factors (Langton et al., 2008; Lund, 2000). Also, research exploring desistance from sexual offending has found that accepting responsibility is an important part of offenders' narratives about their desistance process. In those narratives, it often also occurs alongside some externalization of responsibility purportedly to help manage shame, disavow deviance, and reinforce a prosocial identity (Farmer, McAlinden, & Maruna, 2015; Harris, 2014; Kras & Blasko, 2016). Thus, the clearest conclusion is that research shows denial and minimization do not necessarily increase risk, although there continues to be a need to increase understanding about how it may influence recidivism and desistance.

A consensus in research does exist that denial is a treatment responsivity factor that influences treatment engagement and rates of treatment completion (Craissati, 2015; Ly, Fedoroff, & Briken, 2020). Denial had a statistically small yet meaningful association with attrition from sex offender treatment in the only meta-analysis thus far to examine the issue (Olver et al., 2011). Of note, research shows that attrition from treatment (from all causes) is associated with higher rates of sexual, violent, and any recidivism (e.g., Carl & Lösel, 2021; McGrath, Cumming, Livingston, & Hoke, 2003; Sowden & Oliver, 2017). Other studies have shown denial and minimization are associated with negative perceptions of treatment, lower motivation for treatment, and less treatment readiness (Jung & Nunes, 2012; Mann, Webster, Wakeling, & Keylock, 2013). Denial may also interact with other treatment responsivity issues, such as lower intelligence and antisocial traits, to pose a cumulative challenge for treatment engagement and completion (Eastman, Craissati, & Shaw, 2019; Ware et al., 2020; Zara, Farrington, & Jung, 2020).

Offense-specific treatment is designed to work with individuals who minimize responsibility but nonetheless acknowledge the occurrence of a sex offense. Meta-analyses of these programs show that treatment positively reduces sexual recidivism rates (e.g., Gannon, Olver, Mallion, James, 2019; Hopler, Mokros, & Haberneyer, 2023). Studies have also shown that offense-specific treatment decreases minimization and increases acceptance of responsibility (e.g., Britton & Abulafia, 2020; Olver, Kingston, Nicholaichuk, & Wong, 2014). For example, one evaluation of a community-based cognitive-behavioral program showed program completers had substantial reductions in partial denial (61% to 18%) and increases in acceptance of responsibility (34% to 82%) between the start and finish of their treatment (Bitton & Abulafia, 2020). Other related improvements included increased victim awareness and empathy, and a decrease in offense-supportive attitudes.

Individuals who categorically deny their sex offenses present a greater challenge for treatment programs. They may refuse to attend any treatment for sex offending or, in many jurisdictions, are deemed unsuitable and excluded (Mann et al., 2013; Ware et al., 2015). Some jurisdictions, like Colorado, treat categorical denial in a pre-treatment denial intervention. Evaluations show that pre-treatment programs help about 50% of participants progress to partial denial or full admittance of responsibility by program completion (Ware et al., 2015). An alternate approach has involved integrating deniers into offense-specific programs and addressing their denial alongside participants who accept some responsibility (Ware et al., 2015; Watson, Harkin, & Parmer, 2016). Few evaluations of this approach are available, although it is well known that direct confrontation of denial often leads to resistance, disruption, and increased withdrawals from programs (Carrola, 2023; Ware et al., 2015). One evaluation of an integrative approach that explicitly avoided the direct challenge of categorical denial found about 50% acknowledged responsibility for offending by the end of treatment (Marshall, 1994, as cited in Ware et al., 2015). Other research has found that while integrated treatment works adequately for some clients, it can negatively impact group dynamics, be challenging to implement, and lead to little change in categorical denial (Watson et al., 2016).

To work around the issues of treatment refusal posed by offenders who categorically deny and are serving determinate prison sentences, another approach is exclusive deniers' programs that address offense-related criminogenic needs but do not attempt to alter denial (Marshall, Marshall, Serin, & O'Brien, 2011; Ware, 2017). These programs are presented "to these men as an opportunity for them to learn the skills and attitudes necessary to avoid placing themselves in the future position in which they could be falsely accused again" (p. 166, Marshall et al., 2017). The programs address background factors that create risk, relationships including healthy sexual behaviors, coping and mood management, general victim harm issues, and self-management and release planning. Although presented as being largely equivalent treatments to regular 'admitter' programs, it is important to note that they don't include some of the standard aspects of adult treatment found commonly in the United States, such as the use of polygraph, comprehensive review of the sex offending cycle, attention to risk-related sexual interest and arousal patterns, or consideration of the impact of the offending to their specific victims.

Very few evaluations of these types of categorical denier interventions exist. An exception is an evaluation of an Australian prison-based program, which found that a positive therapeutic alliance and positive changes in self-report measures could be attained over the course of the program (Ware, 2017, 2018). The study did not report changes in risk assessment scores or recidivism outcomes. The other exception was a preliminary evaluation of a Canadian prison-based program, which found the sexual recidivism rate of the 'deniers' program was similar to that of a regular 'admitters' program over a 3.5-year follow-up period (Marshall et al., 2011; Marshall, 2014, as cited in Ware et al., 2015). The recidivism evaluation did not include a true control comparison.[6] While some in the field have lauded this approach as a way to work with offenders in categorical denial prior to release to the community, others have raised criticisms that it ignores the importance of taking responsibility as part of treatment and may inadvertently collude with the client and promote secrecy (see Ware et al., 2015).

[6] To address the lack of control group, the evaluation showed that the expected sexual recidivism rate on a risk assessment instrument (i.e., RRASOR; Hanson, 1997, cited Ware et al., 2015) was greater than the observed official rate. However, in subsequent research that risk instrument has evolved into a more reliable and valid version (i.e., STATIC-99R; Helmus et al., 2021) and the expected recidivism rates have been adjusted downwards (Lee & Hanson, 2021). Thus, the expected rate used may now be inaccurate.

Finally, in keeping with the research on the characteristics of effective therapists, consensus has emerged that *traditional confrontation* of denial and minimization is an ineffective and potentially harmful technique particularly when applied early in treatment and used in isolation from other therapeutic strategies. Experienced counselors reported that it was more effective to build rapport and develop a positive therapeutic alliance to manage shame, facilitate engagement, and make treatment gains (Carolla, 2022). Others have recommended that treatment for clients in *categorical* denial focuses initially on engagement and the therapeutic relationship and avoid direct challenge of denial (Ware et al., 2020). A potential benefit to building an alliance is that the therapist can better evaluate the function of the denial and strategize to address the mechanisms maintaining it. Other studies have attested to the ability of polygraph examinations to increase disclosure of sex offending beyond that identified in the official record of sex crimes or previously self-reported (e.g., Drury, Elbert, & DeLisis, 2020; Gannon, et al., 2014; Grubin, 2010; Handler, Honts, & Nelson, 2013).

Taken together, the research review examining client denial identified the following:

- Denial and minimization of offending are prevalent among individuals convicted of sexual offenses. It serves a number of different functions, including shame management, rejection of being a 'sex offender', and maintenance of identity and relationships. Particular thinking styles and cognitive distortions may give rise to and sustain denial and minimization.

- Denial has not emerged as a consistent risk factor for sexual recidivism, although research limitations and exceptions highlight a need for a better understanding of how it may be important in risk and desistance.

- Denial is a treatment responsivity factor that influences treatment engagement and rates of treatment completion, in turn indirectly linking it to an increased risk of recidivism.

- Offense-specific treatment is designed to work with individuals who minimize responsibility but nonetheless acknowledge the occurrence of a sex offense. Research shows that offense-specific treatment has an overall positive effect on sexual recidivism and leads to decreases in the minimization of offending.

- Different approaches to managing clients who are in categorical denial of their sex offending have been tried, although there is limited evaluation to determine if one approach is better than another. Research on pre-treatment interventions, like those used in Colorado, shows they appear to reduce categorical denial in about half the participants. Integrating 'deniers' into offense-specific treatments appears to work for some individuals, particularly if denial is not directly challenged, but can have a negative impact on group dynamics, be challenging to implement, and may not lead to any greater reduction in denial than pre-treatment programs.

- 'Deniers' programs designed to address criminogenic needs but not modify denial have been used for imprisoned offenders who refuse offense-specific treatment but are serving determinate sentences and will be released to the community at some point. Initial evaluations show they appear to lead to treatment gains, but they also differ in important respects from the type of offense-specific treatment typically provided in the United States.

- Approaches continue to evolve about how to work therapeutically with denial and minimization. Research indicates polygraph examination can increase disclosure of sex crimes.

SOMB Data Analysis of Client Denial

The SOMB Provider Data Management System (PDMS) enables analysis of data regarding offenders who complete denier interventions and offense-specific treatment in Colorado according to the *Adult Standards and Guidelines*. Treatment providers enter client treatment data into the PDMS at the point of client discharge. The data used in this project were from 1,481 client case records entered between October 2019 and November 2022. Denial was recorded as No, Low, Moderate, or High (categorical) according to the definitions provided in the *Adult Standards and Guidelines*.[7] The data also included 365 optional provider comments. The project was conducted to help inform the Adult Standards Revision Committee as it considered potential revisions to the standards for managing adult clients in denial. A policy brief summarizing the findings is available on the SOMB website.

The analyses aimed to:

1. Describe client denial at the beginning and end of treatment contact.

2. Explore factors associated with client denial and progress addressing denial.

3. Explore approaches treatment providers use to manage denial.

Key Findings

The proportion of clients in each denial level at the beginning and end of treatment contact is shown in **Figure 3**. Treatment contact refers to both denier intervention treatments and offense-specific treatments. As shown, 13% of clients were in categorical denial at the beginning of treatment, which was reduced to 5% by the end of treatment. This was a 62% reduction in clients in categorical denial. Alongside this, 19% of clients had no denial at the beginning of treatment, which increased to 37% by the end of treatment. This was a 50% increase in clients accepting full responsibility for their sex offending.

To examine the degree that client denial changed across treatment, **Table 3** shows end denial levels by beginning denial levels. Teal cells show denial reduced from the beginning to end of treatment contact, white cells show there was no change, and brown cells show denial increased. Of those clients in categorical denial at the beginning of treatment, 65% accepted some or full responsibility by the end of treatment contact. These clients will have begun treatment in a denier intervention and progressed to enter an offense-specific treatment. In contrast, 35% did not progress by the end of treatment contact and will have been discharged from the denier intervention as unsuccessful. As shown by the brown cells, very few clients (1.3%) showed increased denial across treatment. The teal cells show over a third of clients (37%) decreased denial and increased acceptance of responsibility across treatment.

[7] The *SOMB Adult Standards and Guidelines* uses the following definitions of denial level: **No Denial** (accepts *full* responsibility, does not place blame elsewhere), **Low Denial** (accepts *most* responsibility, places some of the blame elsewhere), **Moderate Denial** (accepts *some r*esponsibility, places most of the blame elsewhere), and **High Denial** (accepts *no* responsibility, denies committing unlawful sexual behavior).

Figure 3. Beginning and End of Treatment Denial Levels of Clients.
For data table, see Appendix A.3.

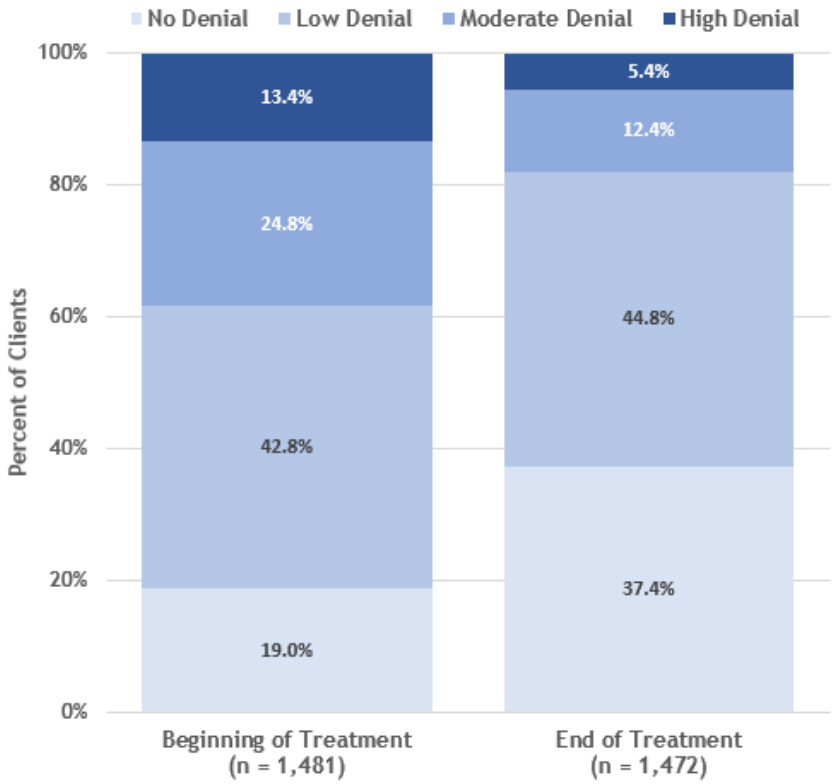


Table 3. Number and Percent of Clients by Combined Beginning and End Denial Levels (N=1472)

Beginning Denial Level	End Denial None	End Denial Low	End Denial Moderate	End Denial High
None	275 (99%)	2 (0.7%)	0	0
Low	185 (29%)	438 (69%)	6 (1%)	3 (0.5%)
Moderate	68 (19%)	163 (45%)	126 (35%)	8 (2%)
High	22 (11%)	56 (28%)	51 26%)	69 (35%)

*Teal cells represent decreased denial levels and brown cells represent increased denial levels from beginning to end of treatment.

Statistical analyses explored whether demographic, risk, and treatment responsivity factors were associated with beginning and end categorical denial, as shown in **Table 4**.[8] Further analyses found improvements in categorical and partial denial levels across treatment were associated we reductions in risk level, Hispanic-Latino race-ethnicity, having modified assignments, and having increased support. A lack of engagement with the community was associated with less improvement.[9]

Table 4. Client Characteristics Significantly Associated with Categorical Denial.[8]

Beginning of Treatment	End of Treatment
Female gender	Female gender
Less education (high school diploma or less)	African American race-ethnicity
African American race-ethnicity	Native American race-ethnicity
Having a higher risk level	Having an adult victim (> 18 years)
Having a contact offense	Having a contact offense
Having an adult victim (> 18 years)	Having a higher risk level
	Older age

To show more clearly the interaction between denial level, gender, and race-ethnicity, the distribution tables are provided. **Table 5** shows denial levels by female and male gender.[10] The proportion of female clients with categorical denial is proportionally greater than it is for males at the beginning of treatment, although many female clients also exhibit partial or no denial. At the end of treatment, most female clients with categorical denial have shown improvements.

Table 6 shows denial level by race-ethnicity at the beginning and end of treatment.[11] The proportion of clients with categorical denial is relatively greater for clients who are African American and Native American, although many clients with these race-ethnicities also exhibit partial or no denial. By the end of treatment, the great majority of clients (69-85%) from each race-ethnicity have low or no denial. Nonetheless, the Denier Interventions are not as successful with clients who are of African American or Native American race-ethnicity compared to those who are Hispanic-Latino or White.

---

[8] Logistic regression modelling was used as denial was measured as a binary variable (i.e., categorical denial present/absent). Logistic regression allows the unique association of each variable in the equation to be determined by holding the other variables in the equation constant. The contrast groups in the equation where the variables were non-binary were: education (college qualification), race-ethnicity (White), and risk (low). The logistic statistical model accounted for 16% of the variance in beginning categorical denial and 28% of the variance in end categorical denial. This indicates that while these variables help predict the presence of categorical denial, there are also other unaccounted for factors.

[9] Linear regression modelling was used as it the appropriate technique when denial level was measured as a continuous variable (i.e., no, low, moderate, or high) rather than a binary variable. The multiple regression model accounted for 12% of the variance in change in denial. This indicates that while these variables help predict change in denial from the beginning to end of treatment, there are other unaccounted for factors that explain much of the change that were not captured by the model.

[10] The PDMS also records "other" gender identities but these were excluded from the table due to low case numbers (less than 20), to ensure no cases could be identified from the data tables as per SOMB standard operating procedure.

[11] Asian-Pacific Islander and Other race-ethnicities were excluded from the table due to low case numbers (less than 20), to ensure no cases could be identified from the data tables as per SOMB standard operating procedure.

Table 5. Number and Percent (%) of Beginning and End Denial Levels by Female and Male Gender[10]

Denial Level	Beginning Female	End Female	Beginning Male	End Male
None	7 (16%)	14 (33%)	272 (19%)	533 (37%)
Low	19 (44%)	23 (54%)	611 (43%)	630 (44%)
Moderate	8 (19%)	4 (9%)	358 (25%)	179 (12%)
High	9 (21%)	2 (5%)	187 (13%)	77 (5%)
Total	43 (100%)	43 (100%)	1428 (100%)	1419 (100%)

Table 6. Number and Percent (%) of Beginning and End Denial Levels by Race-Ethnicity[11]

Denial Level	Beginning White	End White	Beginning Hispanic Latino	End Hispanic Latino	Beginning African Am.	End African Am.	Beginning Native Am.	End Native Am.
None	183 (21%)	351 (40%)	65 (17%)	135 (36%)	22 (15%)	41 (27%)	3 (12%)	10 (39%)
Low	379 (43%)	382 (43%)	170 (45%)	185 (49%)	59 (39%)	64 (42%)	10 (39%)	10 (39%)
Moderate	219 (25%)	105 (12%)	86 (23%)	42 (11%)	43 (29%)	30 (20%)	8 (31%)	2 (8%)
High	105 (12%)	43 (5%)	59 (16%)	14 (4%)	27 (18%)	16 (11%)	5 (19%)	4 (15%)
Total	894 (100%)	894 (100%)	385 (100%)	385 (100%)	152 (100%)	152 (100%)	26 (100%)	26 (100%)

Optional comments included by treatment providers provided insight into the therapeutic approaches that were being successfully used to manage client denial. Qualitative analyses indicated a wide range of approaches were used within the umbrella of the *Adult Standards and Guidelines*, RNR model, and contemporary CBT practice. A highlight of these strategies includes:

- Use of denier interventions
- Use of the group process
- Use of individual or adjunct treatment
- Use of a polygraph exam
- Addressing victim impact

- Developing a therapeutic relationship
- Decreasing stigma and shame
- Focusing on distorted thought patterns related to the offense
- Use of client support systems
- Addressing client trauma history
- Providing psychoeducation

Limitations

The project has a number of limitations that should be kept in mind when considering the confidence of the findings and their application going forward. One limitation is there was no information available about how reliable the denial ratings were between different treatment providers. Some variation in ratings between providers is expected, although the well-defined behavioral definition in the *Adult Standards and Guidelines* helps to lessen such an effect. The study also had low numbers of participants in specific demographic groups, such as Native Americans, which reduces the ability to detect differences in statistical analyses and can make any findings less reliable (e.g., more easily influenced by only a few cases). The qualitative comment data was also optional to enter, so it cannot be assumed to represent all treatment approaches being used by providers.

It is also important to recognize that the study had a limited scope that only focused on describing denial levels and exploring possible correlates. The analyses did not provide information about the motivation and function of denial or the processes leading to change. The data available does not yet have matched recidivism outcomes, so it was also not possible to examine how denial levels related to recidivism or desistance. Finally, as the data are entered after discharge from treatment, they do not represent clients currently in treatment, so they may not reflect very recent changes in the *Adult Standards and Guidelines* or newer approaches being tried by treatment providers.

Summary and Conclusions

- The majority of clients exhibited denial and minimization prior to treatment. However, the rates of categorical denial appeared lower than those reported in the research literature.
- About two-thirds of those who began treatment in categorical denial progressed to take some responsibility and enter offense-specific treatment. Although this rate is fairly consistent with other research, it also appears somewhat better than other pre-treatment programs reported in the research literature.
- Over one-third of all clients who undertake treatment accept full responsibility for their sex offending by the end of their treatment contact. Only 5% remain in categorical denial at the end of treatment contact.

- Female gender was associated with categorical denial, particularly at the beginning of treatment contact, perhaps because female sex offending is hard to acknowledge when it deviates so markedly from gender norms. African American race-ethnicity was associated with categorical denial at the beginning and end of treatment, while Native American race-ethnicity was associated with categorical denial at the end of treatment. In contrast, Hispanic-Latino race-ethnicity was associated with greater improvement in denial across treatment. These findings highlight important intersections between race and culture and the effectiveness of treatment.

- Treatment providers appear to use a range of effective approaches to working with client denial and minimization that reflect the responsivity principle and contemporary CBT practice. Additional emphasis on exploring cultural responsiveness and culturally sensitive interventions is warranted to improve the effectiveness of Denier Interventions with African American and Native American clients.

SOMB Data Collection Analysis

Introduction

The 2016 Sex Offender Management Board (SOMB) Sunset Review process led to a consensus among the SOMB, General Assembly and other stakeholders of the importance of gathering client service data to measure the efficacy of SOMB policies. As a result, the Colorado Legislature passed House Bill 16-1345. The Bill required the SOMB to identify a plan to collect data from SOMB Approved Evaluators, Treatment Providers, and Polygraph Examiners who provide services to adults convicted and juveniles adjudicated for a sex offense, and to begin collecting these data when funding was available. The SOMB completed the data collection plan and included it in the Annual Legislative Report issued in January 2017. Per the SOMB data collection plan, each Approved Provider was required to submit service information about the evaluation, treatment, or polygraph examination for each client at the time of service completion for that client, regardless of the outcome of the service. The data collection plan was in keeping with the Legislature's mandate for the SOMB's *Standards and Guidelines* to be evidence-based. The mandate required a review of the national research along with conducting original research using Colorado data collected and/or reviewed by the SOMB [see § 16-11.7-103 (4) (e), C.R.S.].

The SOMB continues to adjust the data collection process accordingly based on ongoing Approved Provider feedback. The SOMB released an online Jotform in November 2022 for all interested stakeholders to expediently request throughout the year a specific analysis or to suggest a new question for the SOMB Data Collection System. The SOMB received four suggestions by November 2023. At the same time, the SOMB continues to provide individual training and technical assistance to Approved Providers. The SOMB cannot identify who entered what data but can track who has yet to enter any data. Based on the reminder efforts of the SOMB staff, including in applications and letters, only a few Providers have yet to enter any data as of this fourth year of data entry (i.e., less than 20 compared to 63 last year). As an ongoing reminder, the SOMB staff continues to provide regular notices, particularly for newer Providers.

As of November 1st, 2023, all three types of Providers have entered a significantly higher amount of client service data. A higher percentage of consent forms were signed by clients also, reflecting greater acceptance and less resistance from Providers and clients. If a client refuses to allow their data

to be entered into the system, the SOMB still expects Providers to enter the declination so the SOMB can track the number of refusals. Approved Providers also have the option to skip entering some of the service information details to expedite data entry. Many Approved Polygraph Examiners use this option. The volume of polygraph results is significantly higher because Approved Polygraph Examiners can conduct as many as four exams per day, while treatment discharge and evaluation completion typically occur less frequently. As a result, the SOMB has lessened the burden for Approved Polygraph Examiners by minimizing the total number of questions and the pages they must navigate. As such, the SOMB has seen a rise in data submission this year across all three types of services. This may also be based on the SOMB refining the requirements within the *Standards and Guidelines* for data entry in 2022 (e.g., clearly delineating the timeframe for data entry).

Research Questions

The analysis of these data will occur in two phases. First, the SOMB will use this information to assess the extent to which the *Standards and Guidelines* are implemented as required. This baseline data will serve as a general evaluation of the *Standards and Guidelines* implementation. The second phase of the project will follow clients longitudinally and track recidivism.

The goal of Phase I is similar to a process evaluation, which is to provide a yearly snapshot of the services provided by Approved Providers and to determine whether these:

1) Adhere to the *Standards and Guidelines*

2) Are being implemented as required by the *Standards and Guidelines*

3) Are consistent with the RNR Principles and individualize services to client risk and need levels

Methodology and Sample

Regarding the fourth year of data collection, there were 486 evaluation records, 650 treatment records, and 3,142 polygraph exam records entered into the data collection system. The data collection period for the fourth year ran between November 2nd, 2022, and November 1st, 2023.

Similar to data collection in prior years, three separate questionnaires captured the different service types: evaluation, treatment, and polygraph. In addition, different versions are used for clients' subject to the *Adult Standards and Guidelines* and *Juvenile Standards and Guidelines*. It is important to note that some juveniles may be subject to the *Adult Standards and Guidelines,* and some adults may be subject to the *Juvenile Standards and Guidelines,* depending on the date of offense, date of the adjudication/conviction, and/or the court that handled the case (i.e., crossover cases). In addition, some young adults who were adjudicated in juvenile court for a sex crime may receive a subsequent adult criminal court conviction for a non-sex offense, making them subject to both sets of *Standards and Guidelines*. For the purposes of this analysis, juvenile clients are those clients, regardless of age, who were adjudicated in juvenile court, while adult clients are those clients, regardless of age, who were convicted in adult court.

The SOMB data collection project provides information to the SOMB, other affiliated professional stakeholders who may benefit from this critical information, and those who advocate on behalf of the clients who receive services. Approved Treatment Providers reported that approximately 30% of the

clients declined to participate in data collection (as compared to 40% from last year). This increase in participation rates is positive as the SOMB moves into Phase II analysis of client recidivism. Approved Polygraph Examiners reported that approximately 53% of clients declined data collection participation (as compared to 60% from last year). Notably, similar proportions of juvenile (59%) and adult clients (53%) declined to participate in the polygraph data collection (previously, juvenile clients declined at much higher rates). If a client declines to participate, service records can still be entered without a client identifier, but this limits the ability to match these records to study recidivism in Phase II.

Evaluation Results

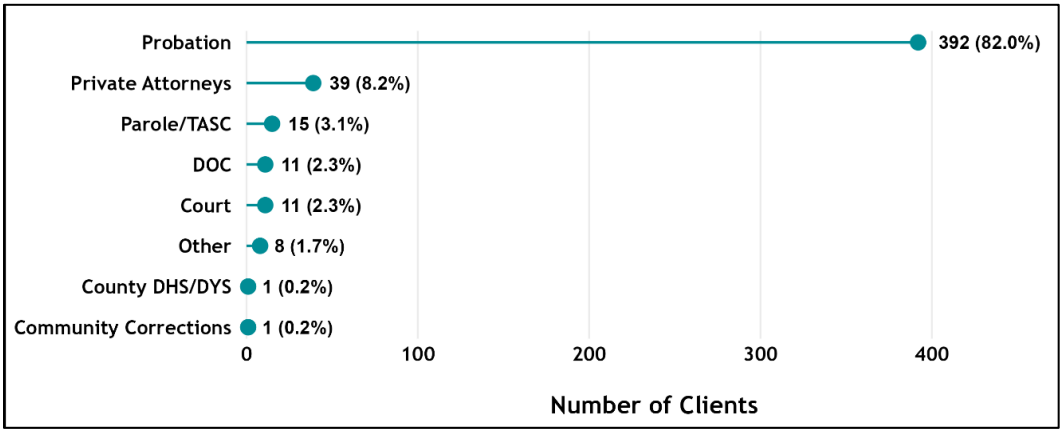
Providers entered 486 evaluation client records during the current reporting period. Of those, 406 (83.5%) were submitted for adult clients and 80 (16.4%) for juvenile clients. As displayed in **Table 7,** the majority of both adult and juvenile clients provided their consent to participate in data collection.

Table 7. Number of Evaluation Clients Providing Consent to Participate in Data Collection by Court Type (N = 486)

Consent Obtained	Adult Criminal Court (n = 406)	Juvenile Court (n = 80)
Yes	244 (60%)	44 (55%)
No	162 (40%)	36 (45%)

The referral sources for evaluation clients are displayed in **Figure 4.** Over 80% of clients who received an evaluation were referred by Probation.

Figure 4. Number of Colorado Evaluation Clients Referred by Referral Source (n = 478). For data table, see Appendix A.4.



Demographic characteristics for evaluation clients are presented in **Table 8.** The majority of clients identified as male. Client age at the time of evaluation ranged from 13 to 79, with a mean age of 36 years old. Over 80% of all evaluation clients were aged 18 years or older. The majority of clients held a high school degree or had a higher level of educational attainment.

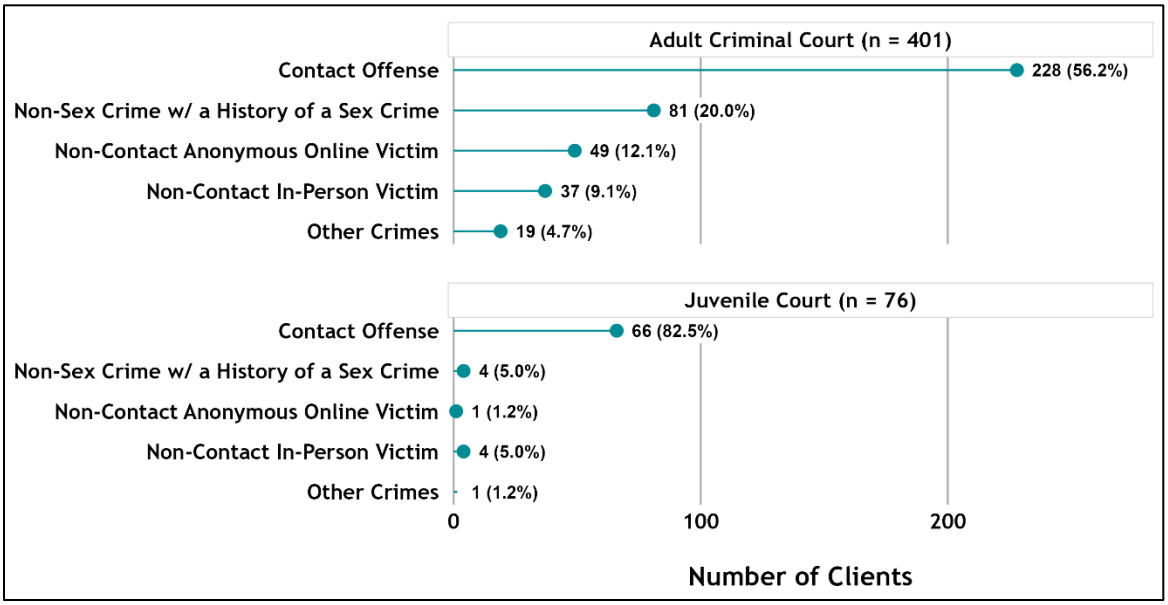
Table 8. Evaluation Client Demographics.

Client Characteristic (N = 486)	n (%) / Mean (Range)
Gender	
Male	466 (97%)
Female	10 (2.1%)
Other	2 (0.4%)
Missing	8
Race/Ethnicity	
White	255 (53%)
Hispanic or Latino	122 (26%)
Black or African American	60 (13%)
Other	14 (2.9%)
Unknown	10 (2.1%)
Asian or Pacific Islander	9 (1.9%)
Native American or American Indian	8 (1.7%)
Missing	8
Age (At Time Of Evaluation)	
Mean (Range)	36 (13 - 79)
Missing	8
Adjudication Age Category	
18 years or older	389 (82%)
Under the age of 18	88 (18%)
Missing	9
Developmental or Intellectual Disability Present	
No	462 (97%)
Yes	15 (3.1%)
Missing	9
Education	
High school degree or equivalent (e.g., GED)	208 (44%)
Less than high school degree	119 (25%)
Some college but no degree	101 (21%)
Associate degree	27 (5.6%)
Bachelor degree	15 (3.1%)
Graduate degree	8 (1.7%)
Missing	8

The distribution of offense types among evaluation clients is displayed in **Figure 5.** The majority of adult and juvenile clients had a contact sex offense[12] and 164 (34%) evaluation clients had previously been in sex offense-specific treatment.

[12] These include criminal offenses that have an element involving a sexual act or sexual contact with another. The offenses covered include all sexual offenses whose elements involve: (i) any type or degree of genital, oral, or anal penetration, or (ii) any sexual touching of or contact with a person's body, either directly or through the clothing. https://smart.ojp.gov/sorna/current-law#5-0 (Sex Offenses under SORNA, then Sexual Acts and Sexual Contact Offenses).

Figure 5. Offense Types for Evaluation Clients by Court (n = 477). For data table, see Appendix A.5.



The incorporation of the RNR Principles was evident among Approved Evaluators.

To match treatment to the level of risk, evaluators recommended the following:

- Adjunct non-sex offense-specific treatment (63% as compared to 49% last year)
- Adjustments to community access (e.g., level of restrictions) (33% as compared to 27%)
- Adjustments in frequency of treatment services (26%)
- Type of placement, length of stay, or step-down (22% as compared to 14% from last year)
- Adjustments to types of groups (20% as compared to 13% from last year)
- Recommended changes to supervision (15%)
- Other adjustments (6.8%)
- Implementing changes to supervision (3.7%)

A large majority of the evaluations (97%) reported specifically addressing the individual client's self-reported needs and reviewing past records and collateral data (94%). Other strategies used to support individualized treatment were having discussions with the Community Supervision and Multidisciplinary Team members (CST/MDT) (33%), and/or discussing with the client's support system (14%) or others (3.7%) about the client's needs.

To address client needs, the evaluators made treatment recommendations regarding:

- An individualized treatment plan (73%)
- Increased resources (42%, as compared to 35% last year)

- Increased support (41%)
- Used the sex offense history evaluation matrix (14.2% as compared to 8.2% last year)
- Modify supervision conditions (14.2%)
- Modified assignments (11%)
- Modified programming (10%)
- Modifications to treatment expectations (10%)
- Implemented modification to treatment modality (group, individual, telemental health, and adjunct treatment) (10%)
- Used the young adult modification protocol (7%)
- Other treatment such as domestic violence treatment, bilingual Spanish-speaking services (mentioned in 4 evaluations), denier's intervention, plethysmograph, or adjunct mental health treatment (6.4%)
- Flexible scheduling options (6% as compared to 3.3% last year)
- Implemented modification to supervision conditions (2.1%)
- Modified the *Standards and Guidelines* by the MDT/CST (6 cases, or 1.2%), or through a variance (2 cases, or .4%)

To address the client's responsivity to treatment, the evaluations recommended adjustments to:

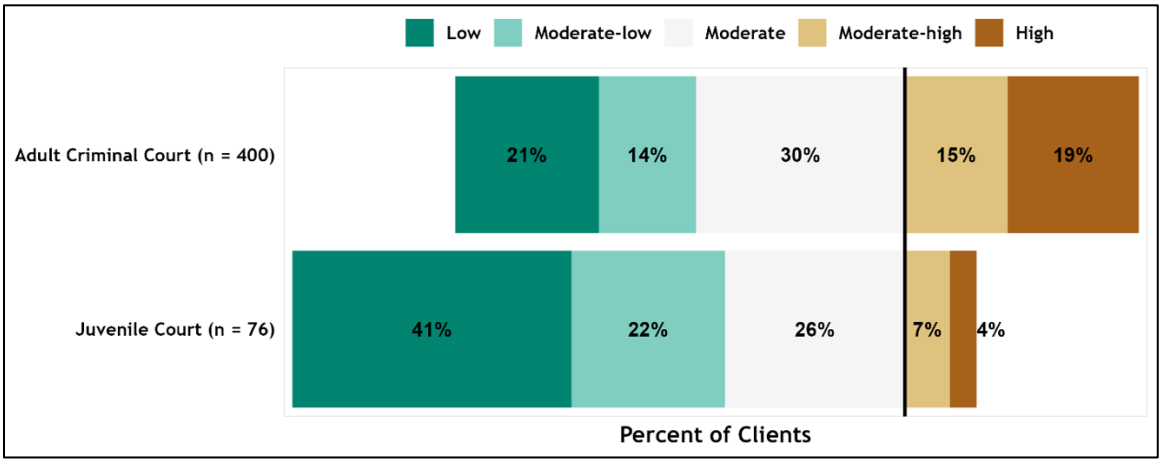
- Use of mental health related adjunct therapy (63%)
- Use of external supports (36%)
- Feedback from the client (36%)
- Use of specialized resources (27%)
- Adjustments in frequency or modality of treatment services (25% as compared to 8% last year)
- Assessment of intellectual/cognitive functioning with additional testing (19%)
- Modifications to increase progress (13%)
- Assessment of cultural/language/sexual orientation/gender identification and family needs (11%)
- Interventions to increase motivation for treatment (9%)
- Recommendation to modify supervision conditions (7.6%)
- Implemented modification to supervision conditions (6.2%)
- Other treatment such as mental health or substance abuse treatment (5.6%)
- Housing/transportation/treatment/polygraph/financial voucher provided by supervising officer (5%)

The top three recommended treatment settings for adult clients were a community provider (61%, which is a 2% increase from last year), community corrections (17%, which is a 5% decrease from last year), and the Department of Corrections (12%).

Finally, the evaluations included the use of standardized and validated risk assessment instruments as part of the evaluation process. Most evaluators used 3 to 4 instruments before reaching the final risk assessment decision. Regarding risk assessment instruments, the Sex Offender Treatment and Progress Scale (SOTIPS) and the Vermont Assessment of Sex Offender Risk-2 (VASOR-2) were the most commonly used instruments for adult evaluations. The Juvenile Sex Offender Assessment Protocol-II (J-SOAP-II) was the most commonly used instrument for juvenile evaluations.

As shown in **Figure 6**, most adult and juvenile clients were in the Low, Low-Moderate, or Moderate risk levels. Proportionally, there were more low-risk juvenile clients (41%) than adult clients (21%).

Figure 6. Percent of Evaluation Clients in Each Risk Level Category by Court (n = 476). For data table, see Appendix A.6.



Treatment Completion

Among the 650 treatment records entered during this reporting period, 582 were for adult clients, while the remaining 68 were for juvenile clients (compared to 55 from last year). **Table 9** displays the number of adult and juvenile clients who consented to participate in the data collection process.

Table 9. Number of Treatment Clients Providing Consent to Participate in Data Collection by Court Type (N = 650)

Consent Obtained	Adult Criminal Court (n = 582)	Juvenile Court (n = 68)
Yes	427 (73%)	26 (38%)
No	155 (27%)	42 (62%)

The referral sources for treatment clients are displayed in **Figure 7.** Probation and Parole/TASC were the most commonly reported referral sources for treatment clients.

Figure 7. Number of Colorado Treatment Clients Referred by Referral Source (n = 644). For data table, see Appendix A.7.

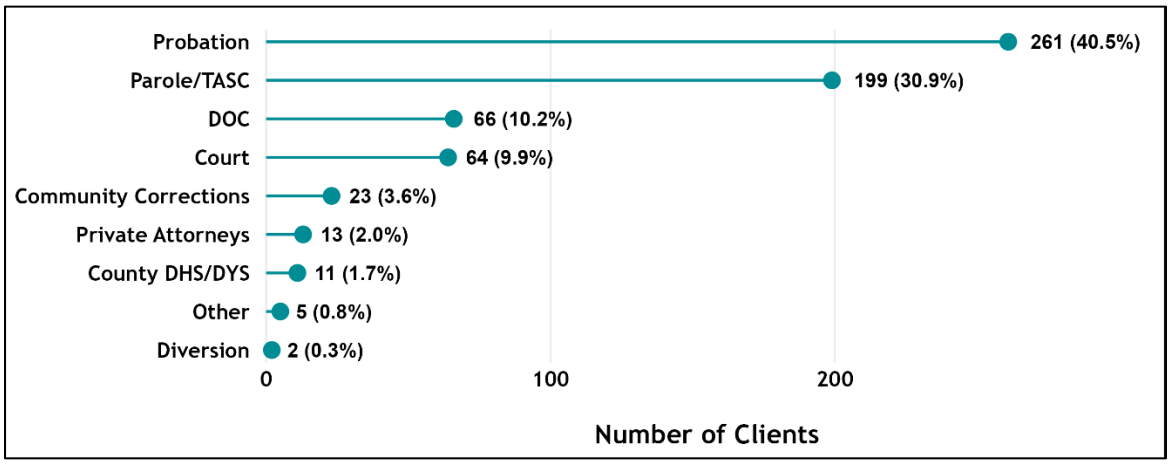


Table 10 displays the demographic characteristics of treatment clients. While most clients identified as male, there were proportionally more female clients this year compared to year three (4.2% compared to 2.6%). Of those with race-ethnicity information available, most clients (59%) identified their race as White. As providers are limited to selecting one category per client, this data will not accurately represent clients who identify as more than one race-ethnicity. Client age ranged from 13 to 88 years, with a mean age of 42 years. Among this sample, the majority (more than 85%) of clients had a high school degree (or equivalent) or some other higher level of education obtained.

A total of 36 crossover treatment cases were recorded. Of those, 21 were clients under 18 at adjudication but convicted in adult criminal court (thus, following the *Adult Standards and Guidelines*) and 15 were clients 18 years or older at adjudication but adjudicated in juvenile court (thus, following the *Juvenile Standards and Guidelines*). As previously noted, for purposes of this analysis, adult cases include juveniles convicted in adult criminal court, and juvenile cases include those clients who are now adults but were adjudicated in juvenile court for a juvenile sexual offense.

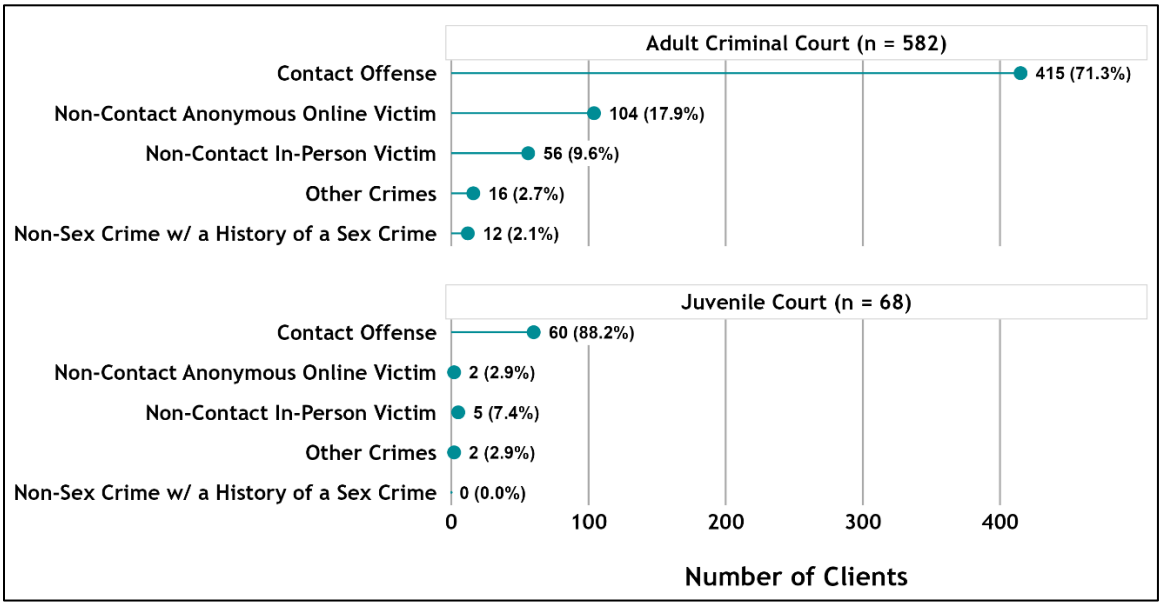
Table 10. Treatment Client Demographics.

Client Characteristic (N = 650)	N (%) / Mean (Range)
Gender	
Male	606 (94%)
Female	27 (4.2%)
Other	10 (1.6%)
Missing	7
Race/Ethnicity	
White	380 (59%)
Hispanic or Latino	159 (25%)
Black or African American	71 (11%)
Native American or American Indian	13 (2.0%)
Other	8 (1.2%)
Asian or Pacific Islander	6 (0.9%)
Unknown	6 (0.9%)
Missing	7
Age (At Time Of Offense)*	
Mean (Range)	42 (13 - 88)
Missing	11
Age Category (At Time of Adjudication)	
18 years or older	569 (89%)
Under the age of 18	72 (11%)
Missing	9
Developmental or Intellectual Disability	
No	600 (93%)
Yes	43 (6.7%)
Missing	7
Education	
High school degree or equivalent (e.g., GED)	359 (56%)
Some college but no degree	128 (20%)
Less than high school degree	86 (13%)
Bachelor degree	37 (5.8%)
Associate degree	23 (3.6%)
Graduate degree	9 (1.4%)
Missing	8

*2 records were added to the 'Missing' category as the number entered was an invalid age.

Figure 8 displays the offense types of adult and juvenile treatment clients. More than 70% of both juvenile and adult clients committed a contact offense. Approximately 49% of the clients had prior sex offense-specific treatment.

Figure 8. Number of Treatment Clients by Offense Type in the Adult and Juvenile Courts (n = 650). For data table, see Appendix A.8.



Most of the client needs were identified by self-report (96%), followed by discussion with CST/MDT (88.5%), review of past records or collateral data (87.7%), and discussion with support systems (40%). Once a client's needs were identified, treatment consisted of:[13]

- An individualized treatment plan (94%)
- Modified assignments (44%)
- Increased support (40%),
- Flexible scheduling (33%)
- Increased resources (33%)
- Modification to treatment modality (group, individual, telemental health, and adjunct treatment) (24.5%)
- Modified treatment expectations (19%)
- Recommendation to modify supervision conditions (10%)
- Modified programming (11%)
- Young adult protocol (7%)
- Modifications to the *Standards and Guidelines* by the MDT/CST (2.5%)
- Implemented modification to supervision conditions (2.3%)
- Sex offense history evaluation matrix (1.1%)

[13] Note that a client's treatment record could contain more than one of these choices, and therefore, the percentages do not equal 100%.

- Modifications to the *Standards and Guidelines* through a variance (0.8%)
- Other (2.2%)

In terms of barriers (responsivity factors) to progress identified during the course of treatment, 65% of providers listed client factors and 25% listed lack of supports, followed by client's substance use (21%), lack of engagement with the community (20%), housing (20%), terms of supervision (5.7%), specific resources (3.5%), or community limitations (5.5%). A very small proportion, 3.4%, listed the SOMB *Standards and Guidelines* as barriers for progress, or other factors, such as health or lack of positive support. Approximately 10% of the treatment records listed none or N/A on barriers for progress.

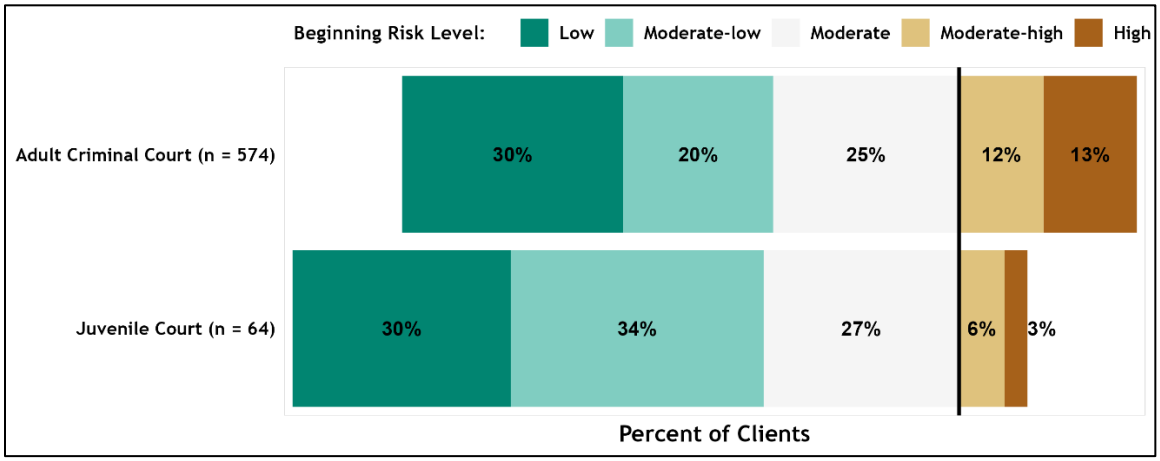
In terms of how the client's responsivity was assessed, 96% of providers considered client's feedback, 81% used topics in treatment sessions, 45% used collateral contacts, and 5% used other channels such as discussion with parole, probation, or the Community Supervision Team (CST).

In terms of how the treatment was adjusted to address the client's responsivity factors, providers have made efforts in the following ways:

- Feedback from client (74%)
- Adjustments in frequency or modality of treatment services (53%)
- Use of external supports (26%)
- Use of mental health related adjunct therapy (25%)
- Interventions to increase motivation for treatment (21%)
- Assessment of cultural/language/sexual orientation/gender identification and family needs (18%)
- Modifications to increase progress (18%)
- Housing/transportation/treatment/polygraph/financial voucher provided by supervising officer (17%)
- Assessment of intellectual/cognitive functioning (e.g., additional screening/testing) (13%)
- Implemented modification to supervision conditions (7%)
- Use of specialized resources (7%)
- Recommendation to modify supervision conditions (6.5%)
- Other efforts such as using other group members to help the client, changing therapists, etc. (3%)

As displayed in **Figure 9,** at the beginning of treatment, the majority of both adult and juvenile clients were classified as Low, Low-Moderate, or Moderate risk. Proportionally, there were more juvenile clients classified as Low-Moderate risk (34%) than adult clients (20%). Conversely, a larger percentage of adult clients were classified as Moderate-High (12%) or High risk (13%) than juvenile clients (6% and 3%, respectively).

Figure 9. Percent of Treatment Clients in Each Risk Level Category at the Beginning of Treatment by Court (n = 638). For data table, see Appendix A.9.



The overall aggregate distribution of risk among treatment clients remained relatively consistent at the end of treatment, as displayed in **Figure 10.** There were slightly fewer clients, proportionally, classified as Moderate-High or High risk at the end of treatment among both adult and juvenile clients.

Figure 10. Percent of Treatment Clients in Each Risk Level Category at the End of Treatment by Court (n = 638). For data table, see Appendix A.10.

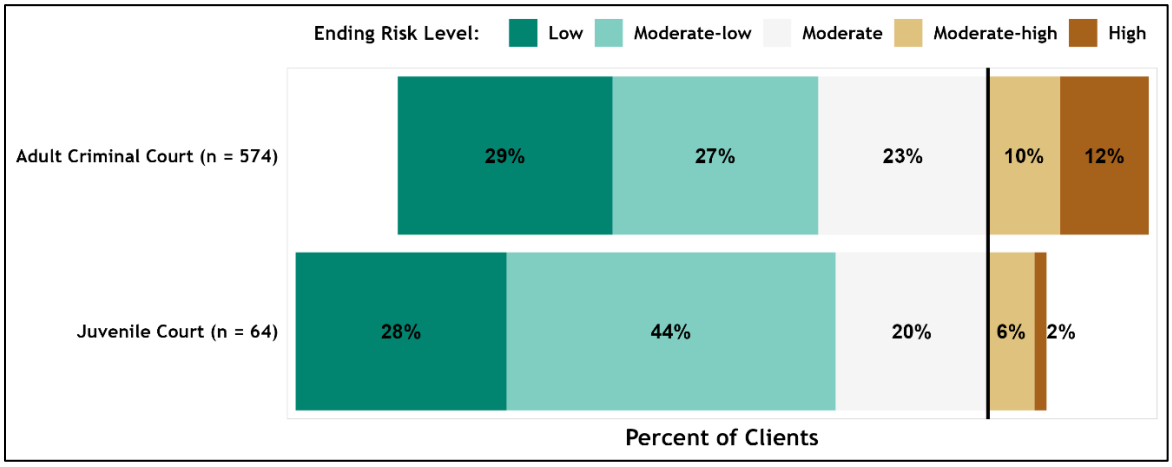
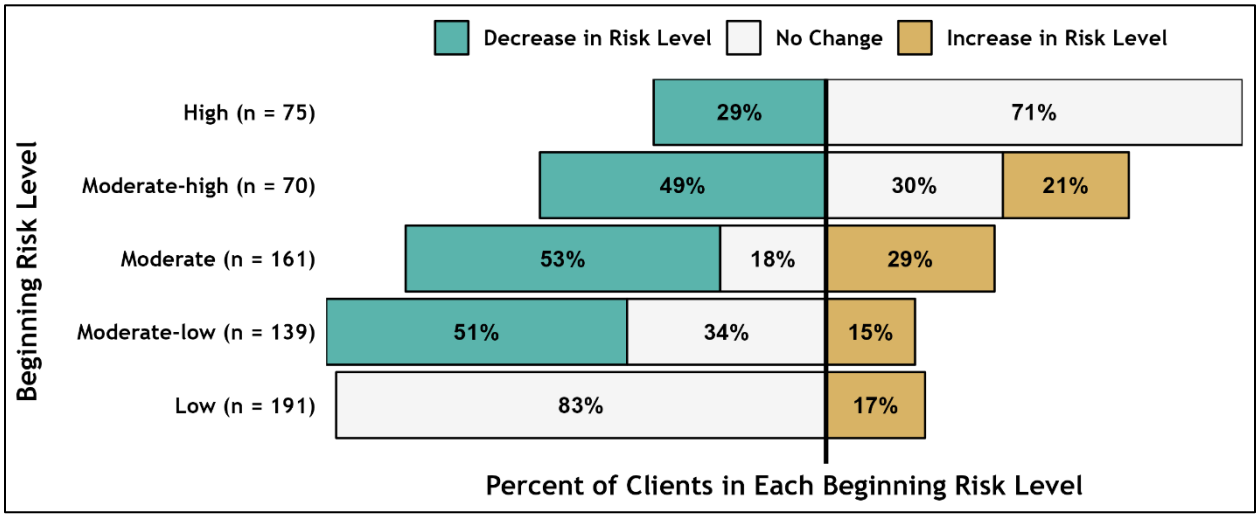


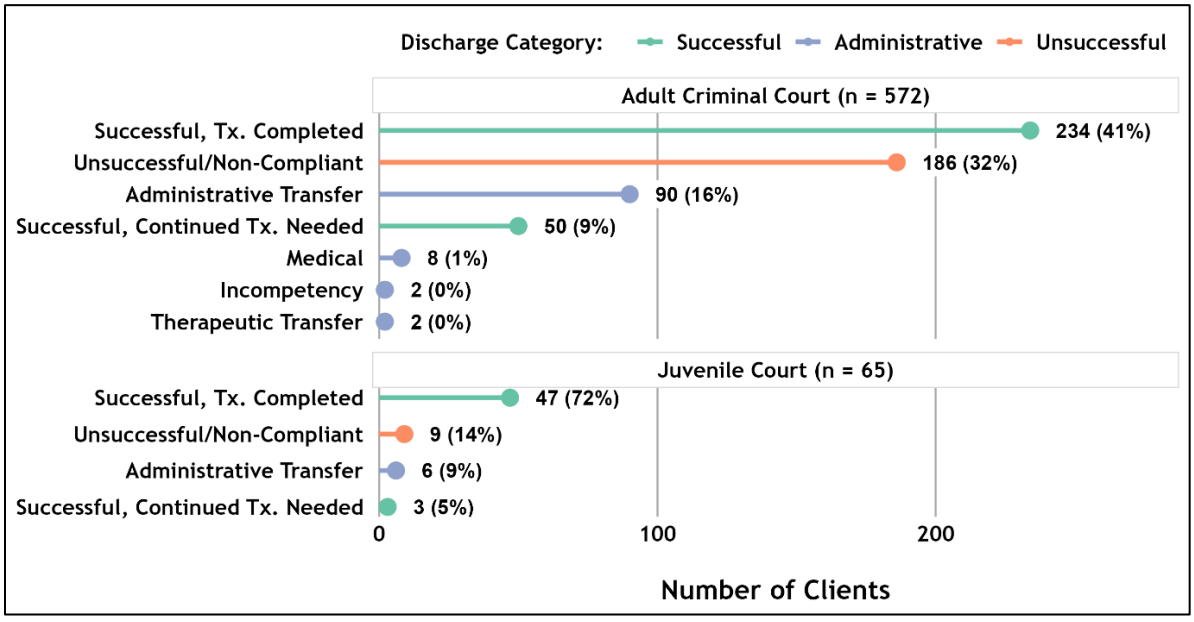
Figure 11 displays the percent of clients in each beginning risk level who decreased, maintained, or increased their risk level following treatment. Due to the small sample size of juvenile treatment clients, this figure combines both adult and juvenile clients. Approximately half of all clients classified as Low-Moderate, Moderate, or Moderate-High at the beginning of treatment decreased their risk level by the end of treatment. This percent was lower (30%) for clients with High risk level at the beginning of treatment.

Figure 11. Percent of Treatment Clients (from both Adult and Juvenile Courts) in Each Beginning Risk Level that Decreased, Maintained, or Increased Risk Levels by the end of Treatment (n = 638). For data table, see Appendix A.11.



Client treatment outcomes for each court are shown in **Figure 12**. A total of 284 adult clients (50%) and 50 juvenile clients (78%) successfully completed treatment. Overall, this equates to 52% of all clients successfully completing treatment, an increase over the 48% successful treatment completion rate from year three. One important change in the data collection system was to separate successful discharges into treatment still needed[14] (53, 8.2%) and treatment completed (281, 43.2%). A total of 32% of adult clients and 14% of juvenile clients had unsuccessful/non-compliant discharge types.

Figure 12. Treatment Outcomes by Court Type (n = 637). For data table, see Appendix A.12.



[14] For example, clients leaving treatment in the Department of Correction can successfully complete the program but are still required additional treatment in the community.

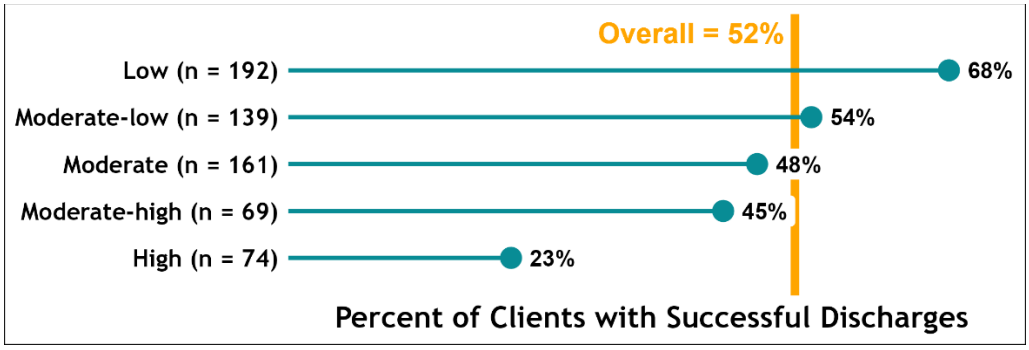
Providers documenting unsuccessful/non-compliant discharges are required to note at least one discharge reason per client. **Table 11** displays the discharge reasons for the 195 clients with unsuccessful/non-compliant discharges. The majority of clients had a violation of treatment contract/terms and conditions of supervision, and/or resistance to treatment/a lack of investment in treatment goals. The latter option was added to the data collection system in February of 2022. A total of 35 clients (17.9%) were discharged from treatment due to a new non-sexual crime, while 11 clients (5.6%) were discharged due to a new sex crime.

Table 11. Discharge Reasons for Treatment Clients with Unsuccessful/Non Compliant Discharges

Discharge Reasons (n = 195)	Number of Clients (%)
Violation of treatment contract or terms and conditions of supervision	170 (87.2%)
Client resistant to treatment / lack of investment in treatment goals	99 (50.8%)
New non-sexual crime	35 (17.9%)
Other	18 (9.2%)
New sex crime	11 (5.6%)
Maximum sentence time reached	5 (2.6%)

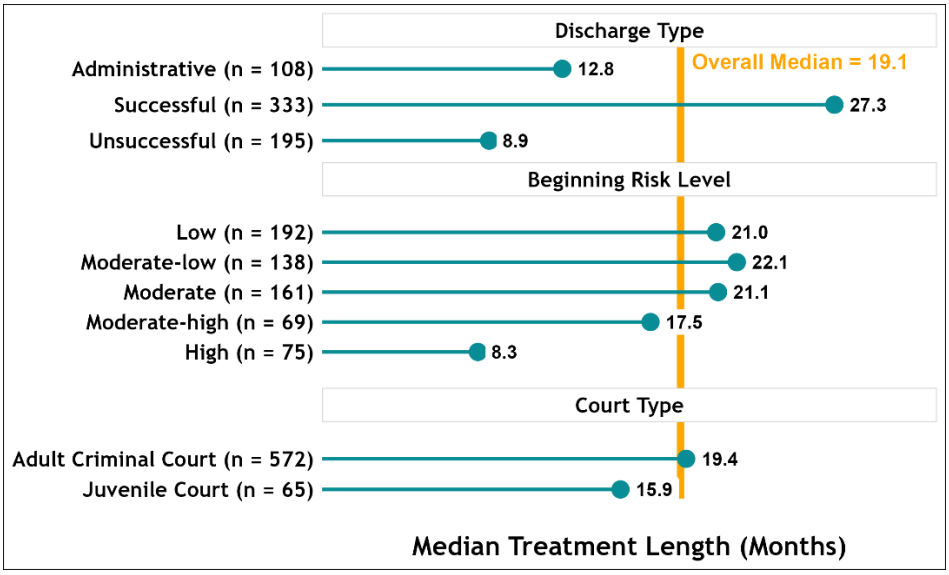
Understandably, as showcased in **Figure 13**, clients who were Higher risk had lower successful discharge rates as compared to clients of Lower risk. This figure combines all clients due to the small juvenile sample size.

Figure 13. Percent of Clients with Successful Discharges by Beginning Risk Level (n = 635). For data table, see Appendix A.13.



Finally, treatment clients spent a median of 19.1 months in treatment. As displayed in **Figure 14,** clients who had successful discharges also had a much longer median treatment length (27.3 months) than clients with administrative (12.8 months) or unsuccessful (8.9 months) discharge types. Additionally, Moderate-High and High risk clients had slightly shorter median treatment lengths than those with Lower risk levels. This is not surprising, as clients with higher levels of risk also had higher unsuccessful discharge rates, and clients with unsuccessful discharge rates (on average) spend less time in treatment. Adult clients had a longer median treatment length (19.5 months) than juvenile clients (15.9 months). However, it is worth noting that this difference may be influenced by the lower proportion of High risk juvenile clients, as well as the much smaller sample size of juvenile clients.

Figure 14. Median Treatment Lengths for Treatment Clients by Discharge Type, Beginning Risk Level, and Court Type (n = 637). For data table, see Appendix A.14.



Polygraph Assessment

Providers submitted a total 3,142 records during this reporting period. However, 90 records were excluded as they did not include any relevant data due to lack of client consent, resulting in a total of 3,052 Polygraph records included in the data analysis. Of these, 2,993 (98%) records were for adult clients, and 59 (1.9%) were for juvenile clients. As displayed in **Table 12,** 47% of adult clients and 41% of juvenile clients provided their consent to participate in data collection.

Table 12. Number of Polygraph Clients Providing Consent to Participate in Data Collection by Court Type (N = 3052)

Consent Obtained	Adult Criminal Court, (n = 2,993)	Juvenile Court (n = 59)
Yes	1,409 (47%)	24 (41%)
No	1,584 (53%)	35 (59%)

Referral source information was entered for approximately half of all polygraph clients and is displayed in **Figure 15**. The majority of polygraph clients were referred by Probation (67%). An additional 27% of clients were referred by Parole/TASC.

Figure 15. Number of Polygraph Clients by Referral Source (n = 1,688).
For data table, see Appendix A.15.

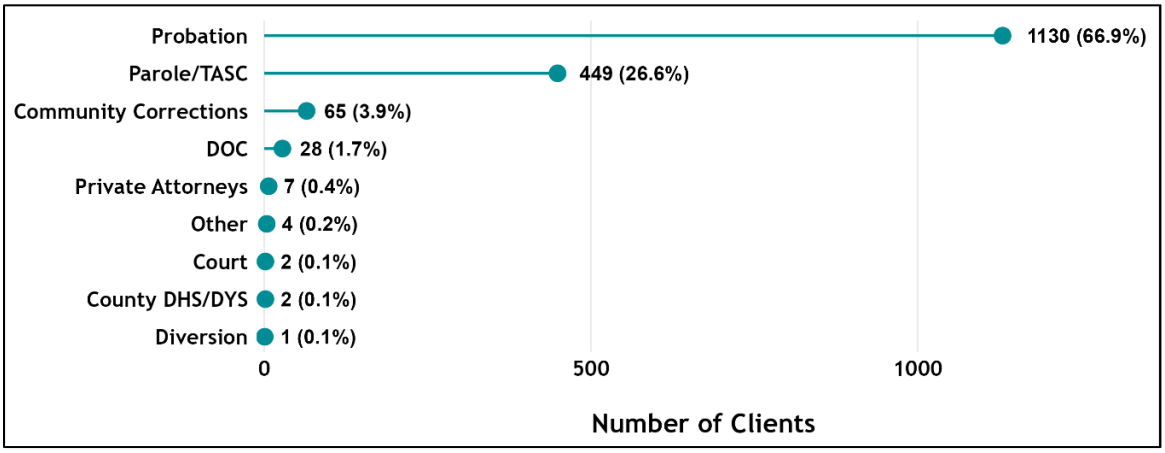


Table 13 displays the demographic characteristics among polygraph clients. Most polygraph clients were male and identified as White (64%). The data may not accurately represent clients who identify with more than one race/ethnicity. The age range was from 13 to 86, with a mean age of 41 years.

Table 13. Polygraph Client Demographics.

Client Characteristic (N = 3,052)	n (%) / Mean (Range)
Gender	
Male	1,643 (98%)
Female	31 (1.8%)
Other	4 (0.2%)
Missing	1,374
Race/Ethnicity	
White	1,078 (64%)
Hispanic or Latino	398 (24%)
Black or African American	141 (8.4%)
Unknown	23 (1.4%)
Native American or American Indian	19 (1.1%)
Asian or Pacific Islander	18 (1.1%)
Other	6 (0.4%)
Missing	1,369
Age (At Time of Exam)	
Mean (Range)	41 (13 - 86)
Missing	1,371
Developmental or Intellectual Disability	
No	1,633 (97%)
Yes	52 (3.1%)
Missing	1,367
Language	
Spanish	19 (0.6%)
Not Listed	3,033 (99%)

Among the types of polygraph exams conducted, 2,367 (78%) were initial exams while 685 (22%) were retests. Retests are used to clarify initial exams that resulted in significant responses indicative of deception (SR/Deception), no opinion resulting in an inconclusive test result (NO/Inconclusive), or when there was an attempt to manipulate the test results. **Table 14** displays the number of each specific exam type conducted among adult and juvenile clients during the reporting period.

Table 14. Number of Exams Conducted for Adult and Juvenile Polygraph Clients by Court Type

Exam Types (n = 3,051)	Adult Criminal Court (%)	Juvenile Court (%)
Maintenance/Monitoring Exams	2148 (71.8%)	37 (63.8%)
Sex History Exam	654 (21.9%)	15 (25.9%)
Specific Issue	139 (4.6%)	1 (1.7%)
Instant/Index Offense Exams	47 (1.6%)	5 (8.6%)
Child Contact Screening Exam	9 (0.3%)	NA
Other	1 (0.0%)	NA

Regarding the use of countermeasures during a polygraph exam, about 1% (30 cases) used such measures during the polygraph exam, and 1.6% (48 cases) were suspected of using countermeasures, both of which were similar to the number from last year.

As shown in **Table 15,** 44% of exams conducted on adult clients and 59% of exams conducted on juvenile clients resulted in clinically significant disclosures (multiple disclosures can be made during one exam) in the pre-test, during the test, or in the post-test. Providers were also able to enter information about the type of clinically significant disclosure a client made during a polygraph exam. A total of 1,358 client records contained information about disclosure type. The specific types of disclosures made can be seen in **Figure 16.**

Table 15. Number of Adult and Juvenile Polygraph Exams by the Presence of a Clinically Significant Disclosure

Disclosure Type (N = 3,052)	Adult Criminal Court - n (%)	Juvenile Court - n (%)
Disclosure Made	1,323 (44%)	35 (59%)
No Disclosure Made	1,670 (56%)	24 (41%)

Finally, a total of 2,219 (73%) polygraph exams were classified as No Significant Reactions (NSR)/Non-Deceptive (this includes both 'No Deception Indicated/No Significant Response' and 'No Deception Indicated/No Opinion' categories). According to **Figure 17**, the majority of both adult and juvenile clients were classified as non-deceptive. As seen in **Figure 18**, specific Issue exams and index offense exams had the greatest rates of Significant Reactions (SR)/Deception Indicated results. This is not a surprise given that they most likely involve denial of the offense for which the client was convicted. The SR/Deception Indicated responses were slightly higher among repeat exams as compared to initial exams (33% vs. 19%).

Figure 16. Types of Disclosures Made During Adult and Juvenile Polygraph Exams (N = 3,052). For data table, see Appendix A.16.

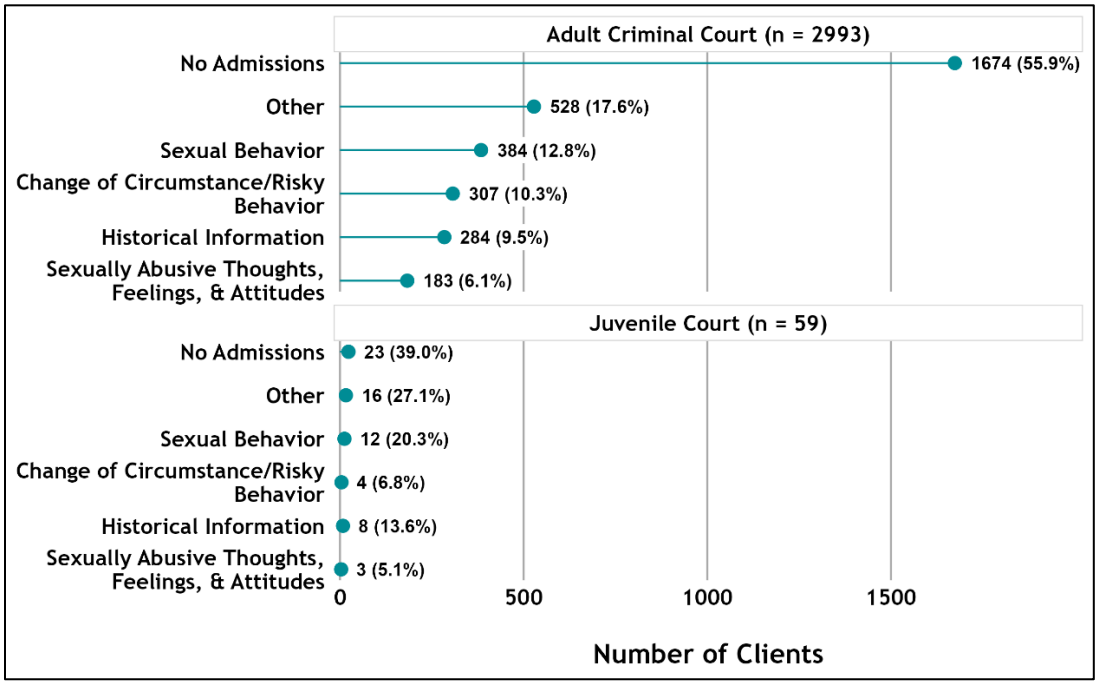


Figure 17. Polygraph Exam Outcomes by Court Type (n = 3,050). For data table, see Appendix A.17.

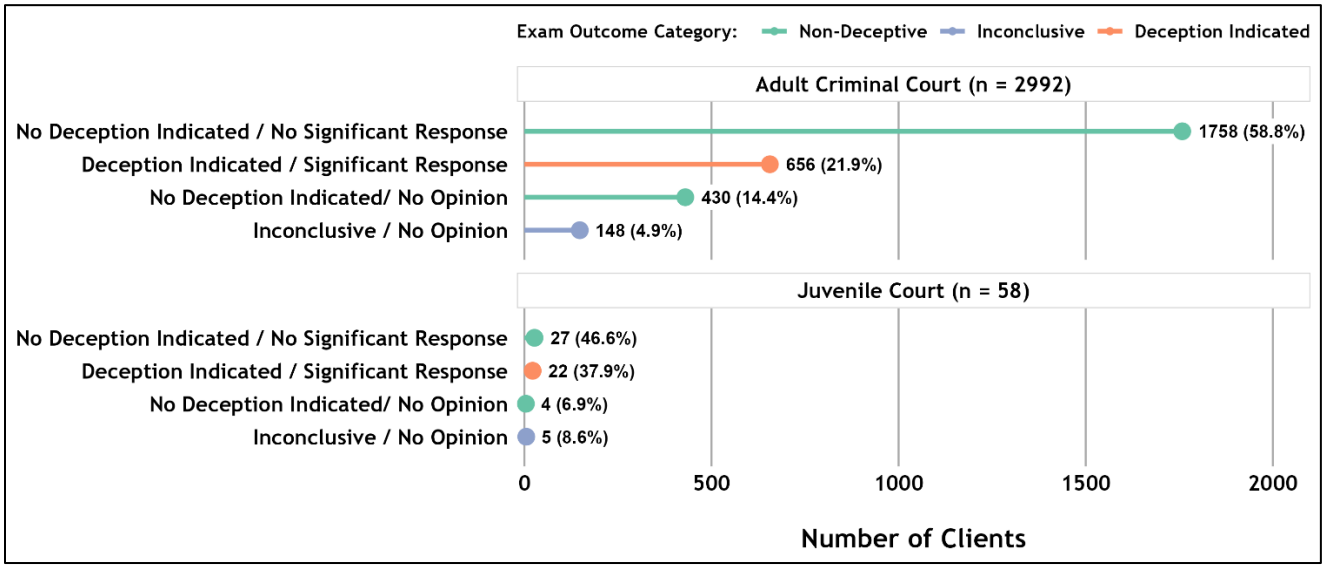
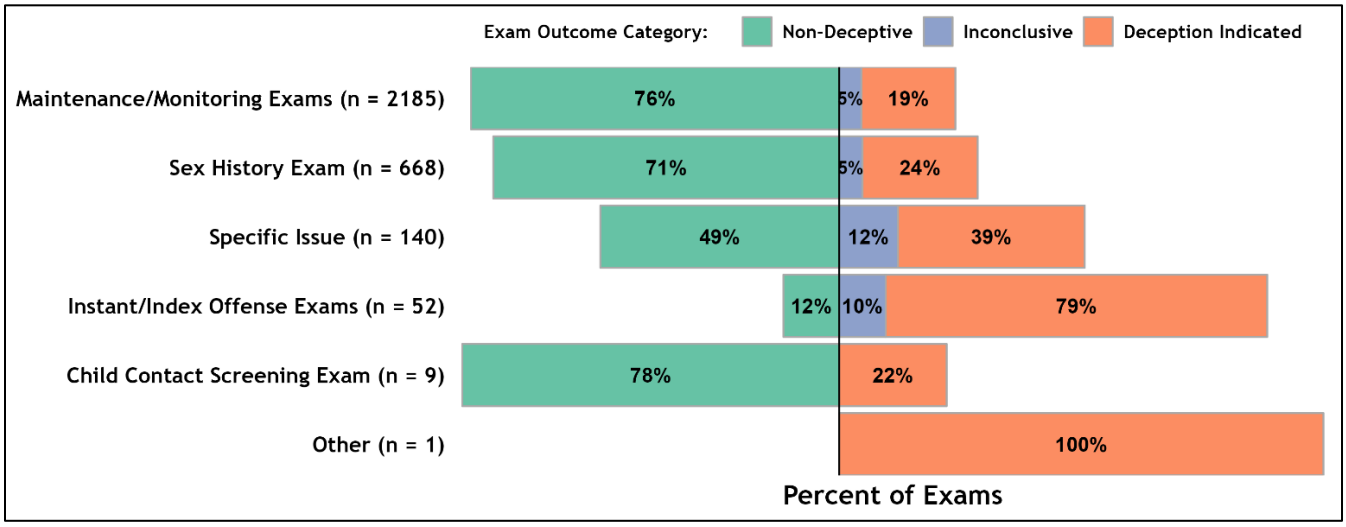


Figure 18. Polygraph Exam Outcomes by Exam Type (n = 3,050).
For data table, see Appendix A.18.



Comparing Results Across the Four Years of Data Analyses

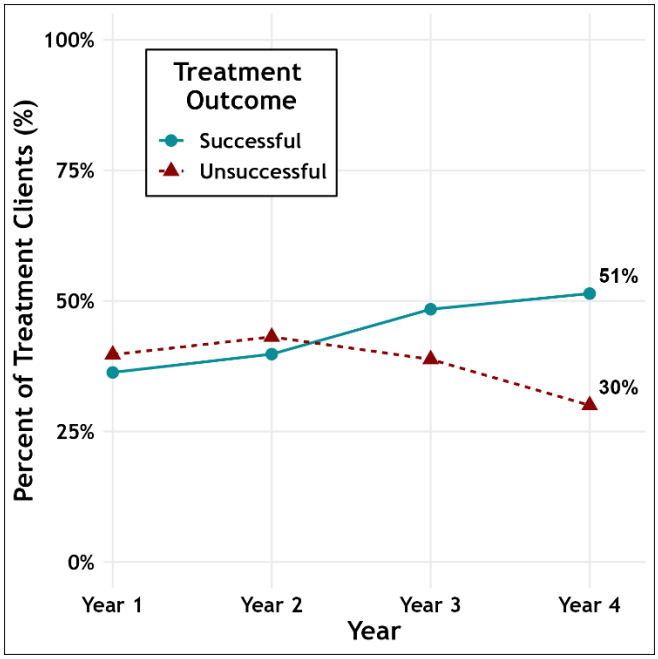
As displayed in **Table 16**, year one data was entered between October 18, 2019 and November 25, 2020, which resulted in 383 evaluation records, 411 treatment records, and 4,950 polygraph exam records. Year two data was entered between November 26, 2020 and November 30, 2021, during the period of time where COVID led to a significant change in service delivery. There were 670 evaluation records, 836 treatment records, and 3,743 polygraph exam records in year two. There were 427 evaluation records, 539 treatment records, and 2,992 polygraph exam records in year three, during which the COVID pandemic receded and service provision resumed more as normal.

Table 16. Total Number of Records entered into the data collection system from Year 1 through Year 4

	Y1	Y2	Y3	Y4	Total
Evaluation	383	670	427	486	**1,966**
Treatment	411	836	539	650	**2,436**
Polygraph	4,950	3,743	2,992	3,142	**14,827**

Over the past four years, Approved Providers appear to be following the *Standards and Guidelines* and utilizing RNR to individualize evaluation and treatment. Overall, the pattern and trends identified during year four were consistent with those found in prior years. Encouragingly, the successful treatment discharge rates have been increasing over each successive year (see **Figure 19**). Further, the volume of treatment and evaluation records entered by juvenile providers have increased and therefore, the data seems to suffer from less selection bias (while all juvenile clients were discharged successfully last year, there is a full spectrum of outcomes this year). More clients also seem to be benefiting from the RNR Principles as supported by there being more modifications to supervision and increased support compared to the corresponding numbers from the previous two years.

Figure 19. Percent of all Treatment Clients with Successful and Unsuccessful Discharge Types Over Years 1 through 4 of Data Collection. For data table, see Appendix A.19.



Limitations

The results of this review should not be generalized to all Approved Providers as a small number still have not yet entered any data into the system. Data fatigue could be an issue, especially for Approved Polygraph Examiners. The data entered also suffered from some missing data issues, as providers were able to skip certain questions, or all of the questions, when the client declined to participate. Quite a few Approved Polygraph Examiners took advantage of this option. In terms of Approved Treatment Providers, most still entered baseline data without a client identifier, even when the client declined to participate. Because missing data impacts the overall conclusions, the SOMB encouraged all Approved Providers to enter baseline data.

Summary and Conclusions

The SOMB has received a significant amount of data in the past year, which demonstrates continued commitment on the part of Approved Providers to support evidence-based research for the *Standards and Guidelines*, as well as fidelity in implementing them. Of note, the SOMB had more clients who successfully completed treatment during this reporting period. Improvements in the *Standards and Guidelines* to clearer classification of the discharge outcomes may have aided this outcome.

The SOMB Data Management System also provides an avenue for Approved Providers to track service provision and communicate issues directly to the SOMB. It includes comment boxes throughout that Approved Providers use to note individualized treatment approaches and share issues implementing the standards. The SOMB uses this data to inform revisions to the *Standards and Guidelines*, improve implementation processes, provide training and technical assistance opportunities, and develop Policy Briefs to provide further clarification to all stakeholders. For example, many Approved Polygraph Examiners used the comment boxes to explain exam specifics, client countermeasures, or disclosures.

Similarly, many Approved Treatment Providers described their denial interventions and other strategies being utilized.

As expected, unsuccessful discharge from treatment appeared to correlate with engaging in risk-related behaviors (treatment contract violation) or a new offense. The new non-sex crime rates and sex crime rates increased slightly compared to last year, but given the absolute low number of new sex crimes, these percentage changes can be substantially influenced by one or two additional events. The increase is consistent with an overall increase in crime rates in Colorado but will be monitored in the upcoming year.

Based on this fourth year of review, Approved Providers appear to be following the *Standards and Guidelines* and utilizing RNR to individualize evaluation and treatment. The SOMB Data Management System allows the SOMB to have an evidence-based, data-driven perspective for ongoing improvement to the *Standards and Guidelines*. The SOMB is also committed to making data entry a stress-free and user-friendly process and, to that end, seeks feedback from all stakeholders. Discharge outcome questions have been updated based on feedback from those advocating for offender treatment interests, and polygraph questions have been streamlined to reduce the data entry burden to providers. Finally, in the upcoming year, the SOMB will begin to move to Phase II of the analysis by studying the long-term outcomes of treatment, including recidivism.

Section 2: Relevant Policy Issues and Recommendations

Background

Starting in 2011, as part of the SOMB Sunset renewal, the SOMB was required to make policy recommendations in addition to implementing the *Standards and Guidelines* based on evidence and research. Each year in the annual legislative report, the SOMB makes policy recommendations formulated from research, highlights recent court cases that affect the SOMB, and discusses research trends on pertinent or emerging topics that may interest the Legislature. The recommendations of the SOMB do not necessarily reflect the recommendations of the Department of Public Safety.

Recent Court Cases

People vs. Vigil (2023COA12)

The Colorado Court of Appeals gave a decision on February 9, 2023, upholding the right of a defendant on probation to invoke the Fifth Amendment privilege against self-incrimination where the conviction is final but the initial period for seeking postconviction relief has not run.[15] In § 16-5-402(1) C.R.S. 2002, the periods for post-conviction relief from the date of conviction are 18 months for misdemeanors, three years for felonies (excluding Class 1), and unlimited for Class 1 felonies. In juvenile adjudications, it is the juvenile's eighteenth birthday. Of note, most sex offense crimes are felonies (excluding Class 1).

At issue in the Court of Appeal case was whether the State could revoke a defendant's sex offender intensive supervision probation (SOISP) based on his refusal to sign a treatment contract that included the acknowledgement that treatment was for victimizing others through sexually offensive behavior. Signing the treatment contract was a condition of entry into the program such that his refusal prevented him complying with his probation treatment condition and led to revocation. The court ruled that the requirement to sign the treatment contract with the specified wording implicated his Fifth Amendment privileges. It noted that his "initial period for seeking timely postconviction relief as set forth in section 16-5-402(1), C.R.S. 2022, had not expired" and that "acknowledging that he was in treatment for victimizing others through sexually offensive behavior presented a possibility of prosecution that was 'more than fanciful'". The decision found that in the absence of any grant of immunity, the statements of concern constituted incriminating information that could be used at a retrial on the original charges in the event postconviction relief was granted. The decision also found that the threat and imposition of revocation for not signing the treatment contract amounted to unconstitutional compulsion.

[15] The Colorado Supreme Court declined to hear the case for review on September 25, 2023.

In the decision, the Court of Appeal directly addressed the community safety concern that the ruling could allow some defendants seeking post-conviction relief to avoid certain aspects of treatment. The decision stated that "the SOMB has recognized this predicament and outlined specific guidance for treatment providers to obtain a variance from the SOMB and continue treatment under these conditions." The variance referred to is found in the *Adult Standards and Guidelines Section 3.162 Clients Who Have Filed an Appeal* and currently indicates,

- Where a court or parole board has ordered a client to participate in treatment, and the client has subsequently filed a direct appeal or post-conviction motion of the sex crime conviction, the client may assert a right against self-incrimination such that the client cannot comply with certain requirements outlined in the *SOMB Adult Standards and Guidelines*.

- Once the treatment provider has obtained verification or written documentation of a direct appeal or post-conviction motion, the provider may modify the following standards: (A) not discussing the offense of conviction, (B) not completing clarification work specific to the offense of conviction, and (C) not discussing Sex History questions specific to the offense of conviction. The treatment provider shall require the client to adhere to all other components of treatment per the *Adult Standards and Guidelines* unless a variance from the Board is in place.

- A client cannot be successfully discharged from treatment (under *Section 3.200*) or be approved for supervised contact with secondary and non-victim minor children (under *Section 5.735*) without a variance from the SOMB. Relevant here are the core sex offense-specific treatment concepts that shall be included in treatment (under *Section 3.160(B)*). Included as core treatment concepts are accepting responsibility for offending and abusive behavior, identifying the thoughts-feelings-and-behaviors that led up to the offending, and gaining knowledge of victim impact and empathy via clarification work. Thus, it is difficult to envision a situation where a client asserting their Fifth Amendment rights could complete the required sex offense-specific treatment components and be successfully discharged from treatment.

In the decision, the Court of Appeal also addressed the danger that, given this situation, there may be a hesitancy to grant probation to individuals convicted of sexual offenses for fear that their denial and refusal to sign such pre-treatment acknowledgments will result in them being in the community but not in treatment. The decision stated, "But nothing in our holding today prevents the prosecution from offering a defendant use immunity so that they can continue to receive the full panoply of sex offender treatment without fear that their statements could be used against them should their postconviction challenge result in a retrial". The 'use immunity' that is referred to is discussed in the *Adult Standards and Guidelines Section 3.126* and addressed specifically in *Appendix S*. These currently indicate,

- In rare instances, clients under appeal may be granted 'Use Immunity', a court-ordered agreement between the defendant and the prosecutor that the defendant's statements and any evidence derived from those statements will not be used against them during a future prosecution.

- Where a treatment provider can verify that a Use Immunity agreement is in place, they can discuss the crime of conviction without those statements violating the client's Fifth Amendment right against self-incrimination.

- The Use Immunity provision allows clients who wish to fully engage in offense-specific treatment and avoid delays in completing treatment that arise consequent to asserting their Fifth Amendment rights and avoiding discussing the offense of conviction. Clients can seek a Use Immunity agreement through the prosecution officer who puts the request to the judge.

One implication of the Court of Appeal decision is that the wording in the relevant sections of the SOMB *Adult Standards and Guidelines* needs to be updated to indicate that Fifth Amendment rights exist throughout the period that post-conviction relief runs and not only once a post-conviction motion is filed. Although the Court of Appeal case concerned an adult, a similar update is needed to the *Juvenile Standards and Guidelines (Section 3.130 Content of Sex Offense Specific Treatment Discussion Point 2 Juveniles Have a Right Against Self-Incrimination*). The practical implementation of these changes by adult and juvenile treatment providers also requires due consideration. Work to address this will occur in 2024 at the committee level.

During the consideration of this decision, one issue that may arise is the potential professional and ethical dilemma created for treatment providers, who are licensed mental health professionals, offering sex offense-specific treatment to clients who deny having committed a sex offense. The *Adult Standards and Guidelines Section 3.500 Managing Clients in Denial* states that individuals who do not accept any responsibility for any unlawful sexual behavior are not appropriate to participate in sex offense-specific treatment. Instead, a separate Denier Intervention is offered with the goal of progressing the client to accept some responsibility and enter offense-specific treatment.[16] Denier Interventions are time-limited to provide a safeguard against clients using them to avoid probation sanction for not complying with offense-specific treatment conditions. It is foreseeable, therefore, that some clients asserting their Fifth Amendment rights throughout their post-conviction relief period will be in categorical denial yet attending offense-specific treatment. While this scenario existed previously for clients under appeal, it now applies to the full post-conviction relief period and may be used more often. As treatment providers have the right not to accept a referral (under *Section 3.162 Discussion Point 3*), and these cases involve complex legal and ethical issues, it is unclear whether there will be any impact on the availability of treatment providers in these instances.[17]

People vs. Silvanic (2023COA16)

The Colorado Court of Appeals gave a decision on February 16, 2023, that before imposing a condition that subjects a probationer to ongoing, unfettered monitoring of their electronic devices and internet usage, the district court must (i) make sufficient factual findings concerning the extent of the electronic monitoring necessary to accomplish the legitimate purposes of the probationary sentence, and (ii) evaluate whether less restrictive means are available to achieve those ends.[18]

[16] The Juvenile Standards and Guidelines Section 3.130(7) also addresses the importance of acceptance of responsibility for offending and abusive behaviors and the expectation that a juvenile will be able to take accountability and acknowledge their abusive behavior as part of successfully completing treatment.

[17] The SOMB surveyed adult treatment providers in 2022 about their experience of working with clients under appeal and their experience with Use Immunity agreements. Of the 24 responses, about a quarter (9/24) had accepted one or more clients into treatment within the prior two years who were under appeal. Very rarely were Use Immunity agreements in place. The survey indicated Use Immunity agreements were generally not well understood without SOMB staff assistance and some providers disagreed with accepting referrals for offense-specific treatment while the client was appealing their sex offense conviction.

[18] The Colorado Supreme Court declined to review the case on October 9, 2023.

At issue in the case was whether a probation officer's order for a defendant on sex offender intensive supervision probation (SOISP) to enroll in a program to continuously monitor his electronic devices had established that this was necessary and the least restrictive means available to comply with his probation conditions. The defendant had used his cell phone as part of grooming the victim to facilitate his sexual offending.

In the decision, the Court of Appeal noted that as a probationer, the defendant "has a significantly diminished expectation of privacy and liberty" and that the sentence of sex offender intensive supervision probation gives "a clear mandate to subject those convicted of sexual offenses to the highest level of supervision that is available for probation" consistent with constitutional rights and the law. However, the Court of Appeal referred to the breadth of the monitoring agreement as "remarkable" and scrutinized that it "would capture substantial amounts of information for which there may be no legitimate probationary purpose", including potential privileged communication with his attorney. The Court of Appeal decision does not prohibit subjecting probationers to continuous monitoring of electronic communications or internet activity outright. Instead, it requires that the probation officer and the district court consider and establish that such continuous monitoring is necessary to accomplish the legitimate ends of the probation sentence and that no less restrictive options are available.

The case has implications for probation monitoring of risk-related behaviors as part of sex offender intensive supervision probation, which in turn intersects with the *Adult Standards and Guidelines Section 5.000 Standards and Guidelines for Community Supervision Teams Working with Adult Sex Offenders*. Supervising officers are one member of the Community Supervision Team (CST) formed for each client, alongside treatment providers, evaluators (as applicable), polygraph examiners (as appropriate), victim representatives, and others involved in treatment and management. The supervising officer is responsible for promptly reporting any lack of compliance with probation conditions to the CST. Although monitoring compliant and safe use of electronic devices and the internet falls within the broader area of monitoring individual risk and behavioral change emphasized in the CST model, it is not explicitly highlighted in the *Adult and Juvenile Standards and Guidelines*. It is an issue that may need to be more clearly highlighted, so it will be raised at the committee level.

Children with Problematic Sexual Behavior

The SOMB Best Practices Committee convened a subcommittee to study and recommend best practices for children with problematic sexual behavior. The issue was initially raised with the Best Practices Committee by juvenile treatment providers who provide clinical services to children and families experiencing these problems. The treatment providers had a range of concerns, including that many of the children with problematic sexual behavior problems were not under the purview of the *Juvenile Standards and Guidelines*, that some providers offering services in this area were not SOMB Approved and did not appear to be tailoring interventions to the risks and needs of the case, and that insufficient integrated or follow-up services were being offered. The juvenile treatment providers and stakeholders also noted that there was an increase in the incidence of children presenting with problematic sexual behavior both in school settings and the community. At the same time, the General Assembly was considering House Bill 22-1131 designed to reduce justice involvement for young children and which was examining increasing the age of adjudication for sex crimes from 10 to 13 years.

The SOMB subcommittee on children with problematic sexual behavior was tasked with identifying best practices for children 12 years old and under who present with problematic sexual behavior that has

led to adjudication, involvement of the Department of Human Services, or identification through the school system. The subcommittee met regularly throughout 2022 and researched to prepare a SOMB White Paper in the form of a resource document. The resource document was seen as the best format for providing guidance and recommendations to SOMB Approved Providers and other professionals working with these cases. The resource document went through the required SOMB review processes and was approved on February 17, 2023. The document is available on the SOMB website, Children with Problematic Sexual Behavior Resource Document.

In the following sections, the legal framework in Colorado and key research findings related to children with problematic sexual behaviors is highlighted. The policy and treatment recommendations made by the subcommittee are summarized.

Legal Framework

In 2000, pursuant to Section 16-11.7-103(4)(j)(l), C.R.S., the SOMB (i) established a standardized set of procedures for the evaluation and identification of juveniles who have committed sexual offenses, and (ii) developed standards and guidelines for the treatment of juveniles who have committed sexual offenses. The resulting *Juvenile Standards and Guidelines* apply when juveniles 10-17 years are adjudicated for a sexual offense, receive deferred adjudication for a sexual offense (including Diversion), and when charges include an underlying factual basis of a sexual offense. The SOMB also provided guidance that the *Juvenile Standards and Guidelines* may be used as best practices when a juvenile has committed a sexual offense or sexually abusive behavior but for various reasons is not under the purview of the SOMB.[19]

In 2023, the Colorado legislature passed HB 23-1249 concerning measures to reduce juvenile justice involvement for young children and increase alternative community-based services. The bill identifies an existing system of collaborative management programs that can be improved to ensure young children at risk of juvenile justice involvement or currently facing delinquency charges receive appropriate services outside of the juvenile justice system.[20] As part of implementing HB 23-1249, the Department of Human Services has responsibility for training the counties that participate and is required to consult with the SOMB in "developing the training and strategies to integrate treatment service for children who have engaged in behavior which the underlying factual basis involves unlawful sexual behavior" (Section 24-1.9-102.7).

Thus, children with problematic sexual behavior may be seen in various systems operating under different statutes and policies. Some aged 10-12 years are under the purview of the SOMB, while others may be referred to collaborative management programs, have child welfare services involved if the

[19] The Juvenile Standards and Guidelines may be used as best practice when: (i) there are concerns of abusive, harmful, or illegal sexual behavior, (ii) juveniles and families are seeking intervention regarding sexually abusive behavior that has been disclosed through self-report or evaluation, (iii) a comprehensive evaluation identifies a concern related to sexualized behavior for juveniles who have been adjudicated for a non-sexual offense, placed on Diversion without a Deferred Adjudication, or who are the subject of a Dependency and Neglect (D&N) order, (iv) a juvenile who has committed a sexual offense is either found incompetent to stand trial or is not charged with an offense, but rather the case is opened on a D&N Petition, or (v) a juvenile is receiving services for sexualized behavior provided by a County Department of Human Services/Social Services (DHS/DSS) without a legal requirement.

[20] The local collaborative management programs are to establish individualized service and support teams that accept referrals for children and families from a range of sources (e.g., law enforcement, District Attorney, and County Department of Human or Social Services). The individualized service and support teams are to integrate inter-agency involvement through establishing service and support plans and referral to appropriate services (Sections 24-1.9-102(III)(f) and 24-1.9-102.3 C.R.S)

sexual abuse is intrafamilial, or be seen independently in the community. When a child is under the purview of the SOMB, the provider must be an SOMB Approved Provider and conduct the evaluation and treatment according to the *Juvenile Standards and Guidelines*. When a child is not under the purview of the SOMB, providers do not need to be SOMB Approved and the Juvenile Standards and Guidelines do not apply but *may* be used as a guide to best practices. In those instances, it seems SOMB Approved Providers would be those most likely to appropriately use the *Juvenile Standards and Guidelines* as they are familiar with them. Hence, a best practices resource document may help support a consistent and evidence-informed approach to the evaluation and treatment of children with problematic sexual behavior who are not under the purview of the SOMB. It will also be helpful for the new consultative task required as part of HB 23-1249.

Key Characteristics of Child Problematic Sexual Behavior

Children can exhibit a broad range of typical, atypical, and problematic sexual behaviors during development (Malvaso, Proeve, Delfabbro, & Cale, 2020). For problematic sexual behaviors, it is generally accepted that these fall well outside acceptable societal limits and involve "children ages 12 and younger who initiate behaviors involving sexual body parts that are developmentally inappropriate or potentially harmful to themselves or others" (p. 200, Chaffin et al., 2008).[21] Key features include whether the behavior is common or rare for the child's developmental stage and culture, whether the behavior continues despite normal corrective efforts, and whether the behavior is harmful. In determining harm or abuse, the age or developmental differences between the children involved, any use of coercion or force, the presence of emotional distress, and if there is any physical injury are all critical considerations (Chaffin et al., 2008).[22]

Estimating the prevalence of children with problematic sexual behavior is difficult, as most data relates to adjudicated juveniles and underrepresents those in preadolescence and with less severe problems (Malvaso et al., 2020; Pelech, Tickle, & Wilde, 2021). Parents' reluctance to report these problems also likely skews available research (Grant & Lundeberg, 2009). Nonetheless, some research suggests the rates of non-normative, intrusive, or sexually explicit behaviors are relatively rare in children under 12 years of age (Elkovitch, Latzman, Hansen, & Flood, 2009; Friedrich et al., 2001; Larsson, Svedin, & Friedrich, 2000; Lussier et al., 2018; Sandfort & Cohen-Kettenis, 2000). For example, a longitudinal study found that it was relatively common for children to want to look at people who were nude or undressing but extremely rare for them to attempt to have oral or sexual intercourse with another child (Lussier et al., 2019).

Research on the causes of child problematic behavior in preteen children is converging on three different developmental processes of importance (Allen, 2023). One involves sexual abuse victimization in which 'traumatic sexualization' leads to significant problematic sexual behavior (Finklehor & Brown, 1985). Another is the development of childhood mental and behavioral disorders, often in the context of broader childhood adversities, that predispose a child to problematic sexual behaviors (Frick & Viding, 2009; Steinberg & Drabick, 2015). The third is social learning of sexualized behavior from exposure to sexual behavior in the family, peer, or community (Cale & Lussier, 2017; Friedrich et al.,

[21] This working definition of problematic sexual behavior was developed by a task force of experts convened by the Association for the Treatment of Sexual Abusers (since renamed Association for the Prevention and Treatment of Sexual Abuse).

[22] Although problematic sexual behaviors can include behaviors that are entirely self-focused, those that are of most concern and lead to juvenile justice involvement are typically intrusive and involve other children.

1991, 1993, 2003). From this perspective, exposure to sexually explicit media is of significant concern. For example, a recent study found most children between 4 and 18 years of age displaying problematic sexual behavior reported exposure to sexually explicit media such as online pornography (De Lago et al., 2020). One of the complexities of child problematic sexual behavior is that these different causal processes may be relevant for different children, or they may interact, particularly in more severe presentations.

Colorado Data on Child Problematic Sexual Behavior

No single source or study provides data on the incidence or nature of child problematic sexual behavior in Colorado. Rather, insight can be gleaned via several sources of information.

Colorado Child Welfare data over a 17-month period from January 2020 through May 2022 showed 307 unique referrals for sexual abuse with a person responsible for the abuse under age 13. The referrals related to 339 unique victims and 298 unique children responsible for abuse. The severity level of the abuse was classified as minor (83%), moderate (15%), and severe (2%) based upon consideration of the type of contact, duration of contact, and the emotional impact upon the child.

The Colorado District Attorney's Council collated information from all 22 judicial districts in Colorado for cases involving children ages 10-12 adjudicated for sex crimes over the ten-year period between 2011 and 2021. A total of 1,501 cases were registered as follows:

- 223 cases (15%) for Incest including the crimes of Incest (C.R.S. 18-6-301) and Aggravated Incest (C.R.S. 18-6-302)
- 819 cases (55%) for Sexual Assault on a Child including the crimes of Sexual Assault on a Child (C.R.S. 18-3-405), Sexual Assault on a Child by One in Position of Trust (C.R.S. 18-3- 405.3), and Sexual Assault on a Child - Pattern of Abuse (C.R.S. 18-3-405.3(2)(b))
- 331 cases (22%) for Unlawful Sexual Contact (C.R.S. 18-3-404), and
- 128 cases (8%) for Sexual Assault (C.R.S. 18-3-402)

The SOMB surveyed SOMB Approved Juvenile Providers in November 2022 to gather information from those who had worked with children (12 and under) with problematic sexual behavior at any point during the previous three years.[23] The survey received 23 responses.[24] Approximately half of those who responded had worked with 1-5 clients, 20% had worked with 6-10 clients, and 30% had worked with greater than 10 clients. At a minimum, this indicated 118 children or more with problematic sexual behavior had been seen by Approved Juvenile Providers in Colorado over the last three years.[25] Most referrals were coming from Human Services, while Diversion, Probation, and Parent-Caregivers also referred. Very few referrals were coming from schools. In general, less than a quarter of those children 12 and under seen by Approved Juvenile Providers were adjudicated. The greatest proportion of

[23] The survey was sent to all SOMB Approved Juvenile Providers but responses were voluntary and anonymous. No information was collected that would identify specific cases.

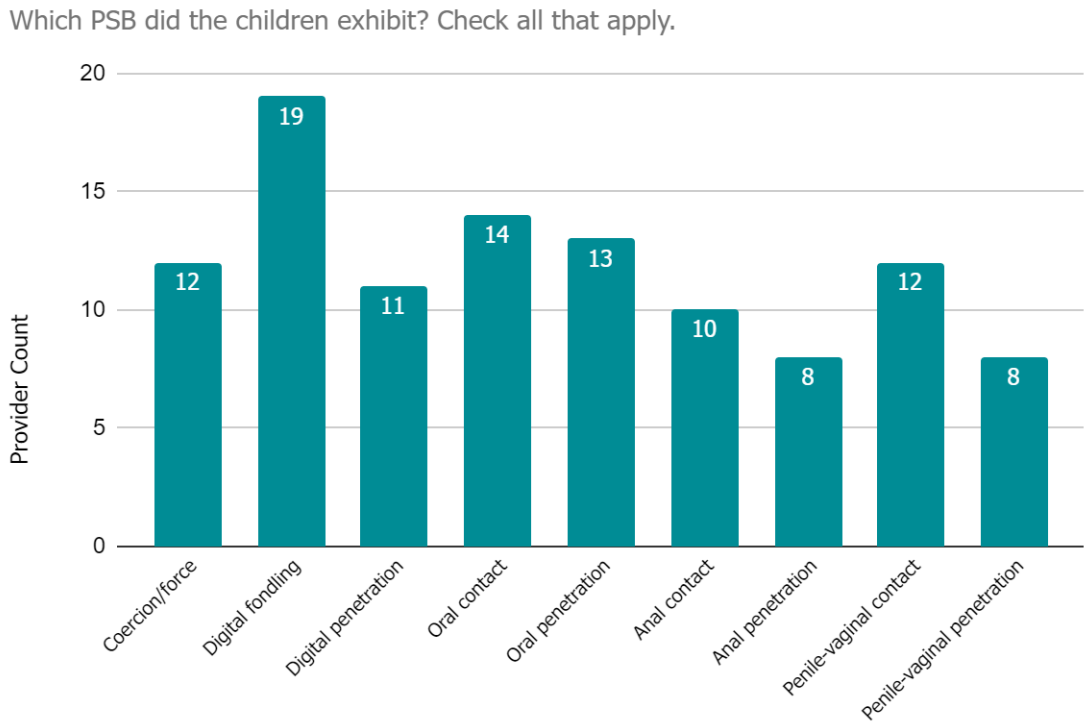
[24] The response rate indicated at least 14% (or 1 in 7) of the total SOMB Approved Juvenile Providers had worked with children with problematic sexual behavior.

[25] These referral numbers may overlap with the data reported by Colorado child welfare services and the Colorado District Attorney's Council.

referred children were 9 to 12 years of age, while a smaller proportion were 5 to 8 years, and very few were younger. The most common gender of the children was male, although female, transgender, and non-binary gendered children were seen also. The children were from all racial-ethnic identities.

The range of problematic sexual behaviors exhibited by the referred children was extensive, as shown in **Figure 20**. These problematic sexual behaviors are intrusive and severe, such that they would qualify as sexual crimes if the children were of the age of criminal responsibility and subject to justice-system involvement. Most of the referred children's problematic sexual behavior was against one child, while a smaller proportion had acted against 2 to 3 children. Most of the children acted against were 5 to 8 years of age, while about half were either younger or older. The gender of the victimized child was most commonly female, although a substantial proportion were also male. Most of the problematic sexual behavior occurred in the home setting and was directed at siblings, step siblings, and cousins. Between 25-75% of the children worked with by the Approved Juvenile Providers were identified as being victims of sexual abuse themselves.

Figure 20. Range of Problematic Sexual Behaviors Exhibited by Referrals to Approved Juvenile Providers. For data table, see Appendix A.20.



In summary, the data from multiple sources indicates that a significant number of Coloradan children 12 years and younger are being identified with problematic sexual behavior either through notifications to child welfare services, adjudications, and/or referral to SOMB Approved Juvenile Providers. Of those notified to child welfare services, the greater proportion (but not all) are at the minor end of severity. Of those referred to SOMB Approved Juvenile Providers, the greater proportion are older children (9-12 years of age) who have exhibited severe problematic sexual behavior but are not adjudicated. As well, an average of about 150 children aged 10-12 are adjudicated for sex crimes each year; assessment and intervention with these children will be subject to the SOMB *Juvenile Standards and Guidelines*. Taken

together, it is apparent there are a range of systems and professional standards that apply to the identification and treatment of children with problematic sexual behavior, with no one system or agency having responsibility for the oversight of best practices.

Evidence-Informed Evaluation

Essential to the assessment and treatment of any child with problematic sexual behavior is the ability to identify the factors related to the initiation and continuation of the problematic sexual behavior. Simply applying models and instruments developed with juveniles 13-17 years is not appropriate as there are important developmental differences between children 12 and under and adolescents.[26] Some assessment tools have been developed that draw from empirically-informed risk and protective factors that are suitable as a clinical guide for use within an overall clinical evaluation. The clinical evaluation must also consider the child and family's history of trauma and trauma-related events, internalizing psychological symptoms (e.g., anxiety, depression), externalizing psychological symptoms (e.g., disruptive-conduct problems, substance abuse), and caregiver related factors (Allen, 2023). Assessment instruments may be helpful in differentiating children's severity of problematic sexual behavior, level of risk factors, and need for treatment services, but they cannot be used to 'predict' the children's future behavior.[27] Rather, concerns about safety should always be incorporated into ongoing assessment and monitoring.

Evidence-informed Treatment Interventions Based on Risk and Needs

Recent research shows that many children respond well to evidence-informed treatment approaches for problematic sexual behavior. A meta-analysis that evaluated 18 specific interventions found many elements that worked were directed at the parents, including parent behavior management skills, establishing rules about sexual behavior, improving sex education, and implementing abuse prevention practices (e.g., supervision). Other effective elements involved teaching the child self-control skills, having family involvement, and the child being younger and more directly under the parents' control (St Amand, Bard, & Silovsky, 2008).

A specific treatment approach that has been evaluated for its impact on problematic sexual behavior is Trauma-Focused Cognitive Behavioral Therapy (TF-CBT; Cohen, Mannarino, & Deblinger, 2017). In this treatment approach, children are provided therapy for their own child sexual abuse victimization to reduce the experience of traumatic symptoms and increase coping skills, while parents are also provided parenting training. Evaluation studies find significant improvements for both post-traumatic symptoms and problematic sexual behavior (e.g., Allen & Hoskowitz, 2017; Cohen, Deblinger, Mannarino, & Steer, 2004), although one study suggested it was the parenting training and child coping skills development that were the most effective elements for reducing problematic sexual behavior

[26] As well, while some of the children who present with problematic sexual behavior are also adjudicated as juveniles for a sexual offense, many will not be represented in the juvenile research as they do not continue problematic sexual behavior from childhood to adolescence (Chouinard-Thivierge, Lussier, & Daignault, 2022; Ensink et al., 2018; Friedrich, Trane, & Gully, 2005; Lévesque, Bigras, & Pauzé, 2012; Lussier et al., 2019). Also, as much of the research has involved adjudicated male adolescents there is much less known about the recidivism patterns for non-adjudicated youth, females, transgender youth, and youth with low intellectual functioning.[26]

[27] The instruments are not supported by sufficient research to determine how accurate they are at identifying ongoing risk of problematic sexual behavior. As well, children's behavior naturally changes over time due to their physical, emotional, and cognitive development, as well in response to the impact of the social environment and any positive treatment effects (Rich, 2015).

(Deblinger et al., 2011). It is also yet to be shown that this treatment is effective with more clinically significant or severe problematic sexual behavior (Allen, 2023).

Parent-Child Interaction Therapy (PICT; McNeil & Hembree-Kiggin, 2011) is a well-established behavioral parent training intervention that has been adapted to target problematic sexual behavior (Friedrich, 2007; Shawler et al., 2018). PICT is supported by evidence that shows it can generally reduce parental stress (e.g., Thomas et al., 2017), decrease the use of harsh discipline practices (e.g., Hurlburt et al., 2013), increase children's behavioral self-regulation (e.g., Lieneman et al., 2020), and be effective at treating children's disruptive behavior disorders (e.g., Kaminski & Claussen, 2017). An initial evaluation of an adapted PICT program for problematic sexual behavior found it substantially reduced children's sexual concerns (both problematic sexual behaviors and rumination about sexual topics), while being effective for children with and without a history of child sexual victimization (Allen, Timmer, & Urquiza, 2016).

A treatment developed specifically for child problematic sexual behavior is PSB-CBT (Bonner et al., 1999; Carpenter, Silvosky, & Chaffin, 2006; Silovsky, Niec, Bard, & Hecht, 2005). It involves structured group treatment for the children that addresses behavioral self-control techniques, emotion regulation, sex education, and abuse prevention skills, and parallel group treatment for the parents-caregivers that addresses parent behavior management, sex education, and abuse prevention. Evaluation studies have found significant improvement in problematic sexual behavior across treatment and at 1-to-2-year follow-up (Bonner et al., 1999; Dopp et al., 2020; Silovsky et al., 2007, 2019). An extended 10-year study found children who attended had significantly fewer sex offenses than a comparison intervention (2% vs. 10%) and did not differ from children who attended an outpatient clinic for other psychological-behavioral problems (2% vs. 3%). A modified version of PSB-CBT suitable for individual treatment and integration with other interventions (called Phase-Based Treatment for PSB; Allen et al., 2018; Dickman et al., 2018) has also been developed with a pilot study supporting its potential effectiveness.

In summary, research confirms that treatment for children's problematic sexual behavior can be effective and contribute to the resolution of these difficulties. Treatments that have shown success target trauma-related symptoms when these are present, parenting training, children's behavioral self-regulation, and the problematic sexual behavior itself. Despite there being an evidence base, there is also a need for more treatment studies to inform what works best given the variability present in children with problematic sexual behavior (e.g., problem severity, co-occurring symptomatology, and developmental maturity). Consideration of how to adapt or tailor treatments to be sensitive and responsive to gender and cultural factors is also important so treatments are both appealing and effective across the diverse range of children and families that require assistance.

Public Policy Implications

Public policy should promote the appropriate treatment for children with problematic sexual behavior and make this accessible where clinical assessment suggests it is needed. Assessment should be conducted by an experienced, licensed clinician with specialized training in children's problematic sexual behavior.[28] The decision of whether to place a child in out-of-home placement is not automatic, even in cases where a child has sexually victimized another child in the same home. Rather, a thorough case-by-case assessment by clinical professionals trained in evaluating children with problematic sexual behavior and their families is needed. To prioritize community safety and reduce further potential for victimization, policymakers should be most appropriately concerned with the subset of children who engage in the most serious and victimizing behaviors. In these cases, formal multi-system involvement may be necessary to secure the needed services, protect communities, or as an appropriate response to particularly egregious behavior. Within this smaller subset of children, legal proceedings may be undertaken in certain high-risk cases, if necessary, to ensure receipt of needed specialized services.

It is important to emphasize that the subpopulation of higher-risk children with more harmful problematic sexual behaviors is small, but it is critical to community safety to be able to detect and treat these children and their families effectively. The prognosis is good if these behaviors are recognized early, accurately, and responsibly handled, and the involved systems respond with evidence-based and scientifically guided evaluation and treatment. It is necessary for all involved systems to collaborate openly and coordinate their responses for the child and family. Lastly, it is paramount that the involved professionals consider that these are merely children, whose behaviors serve as a barometer for the environment in which they are developing. A compassionate approach can lay the groundwork for positive outcomes.

Recommendations for Treatment of Children with Problematic Sexual Behavior

The Children with Problematic Sexual Behavior Sub-Committee of the SOMB Best Practices Committee offers the following recommendations regarding children with problematic sexual behavior:

1. When a child with problematic sexual behavior is identified by a child-serving systems agency as in need of services, it is essential that the system immediately intervene, refer to the appropriate treatment services, and ensure compliance with all treatment requirements. A systems agency may include the juvenile justice system, child welfare agencies, schools, and other child-serving organizations. Actors should be mindful of and attempt to mitigate the potential for their intervention to traumatize or retraumatize impacted families.

2. A multidisciplinary approach is important to provide the best outcomes for children with problematic sexual behavior. These children with problematic sexual behavior and their families may be involved with multiple different government and private agencies, and it is essential that there be cross-collaboration among professionals working with the child. In particular, it is also essential that all agencies, particularly those that require and fund services, stay engaged with the child and the child's family until treatment is completed.

[28] Assessment and treatment should be provided by mental health professionals who are licensed, registered, or certified through the Colorado Department of Regulatory Agencies pursuant to the articles contained in C.R.S §12-43-303, 1243-403, 12-43-503, 12-43-601.5 and 12-43-803.

3. A range of treatment services should be available for children with problematic sexual behavior from less intensive psychoeducation-based interventions to more intensive treatment for children with problematic sexual behavior. Practitioners working with this population should have proper training and experience, and although not required for non-adjudicated children, an SOMB Approved Juvenile Treatment Provider may be a suitable resource.

4. Treatment services for children with problematic sexual behavior can be expensive and unaffordable for a family. Support and financial assistance from agencies involved with the child and family may be helpful to ensure the child and other family members are able to complete treatment when it is warranted.

5. Treatment for children with problematic sexual behavior should be assessment-driven and should be individualized for each child. Not all children have the same treatment needs. A good assessment can determine what level of risk the child poses for future problematic sexual behavior and the level and intensity of the recommended intervention. All treatment interventions provided to children with problematic sexual behavior should be based on treatment needs, and treatment approaches should follow research-informed best practices.

6. School personnel are often the first point of contact for a child with problematic sexual behavior. The SOMB School Resource Guide provides helpful information for school personnel dealing with this population. School personnel may also be included in the multidisciplinary approach for working with children with problematic sexual behavior.

7. Parental and/or guardian involvement is critical in working with children with problematic sexual behavior. Agencies who are overseeing these cases should identify mechanisms to ensure supervisory adult participation where possible.

8. Given the potential negative outcomes associated with labeling children with problematic sexual behavior as "sex offenders" and "perpetrators," care should be utilized by agencies and systems to avoid administrative and legal actions that may label these children. One way to accomplish this may be to look at alternatives to adjudication for children ages 10-12 with problematic sexual behavior such as diversion and informal adjustment. Adjudication may be suitable for a small subset of children with problematic sexual behavior who exhibit the most severe behaviors and pose the highest risk to the community for future problematic sexual behavior, but care should be exercised in decisions to prosecute such cases.

Section 3: Milestones and Achievements

Overview of 2023 Accomplishments

In 2023, the SOMB was reauthorized in Senate Bill 23-164 for another five years. The reauthorization bill accepted the recommendations of the DORA Sunset Review and added additional requirements. The most substantial addition was the creation of a treatment solutions subcommittee that included the Department of Corrections (DOC) and other stakeholders. The SOMB/DOC treatment solutions subcommittee has met regularly to identify potential solutions and existing barriers with the aim of increasing treatment access for sex offenders in the custody of the Department of Corrections. The goal is to have offenders complete or be close to completing their required treatment before their parole eligibility date. The written report outlining the work of the subcommittee is due by February 1, 2024.

The SOMB has also made progress in fulfilling the other requirements of the reauthorization bill while continuing to meet its other mandates and prioritize several quality improvement initiatives. Of note, the SOMB managed 15 committees and working groups that focused on ensuring the *Standards and Guidelines* and their implementation were based on research evidence and best practices. The SOMB continues to manage a large number of provider applications related to its varied listing statuses to ensure that providers are appropriately qualified and competent for the services they offer. Additionally, the SOMB hosted its annual conference, where over 580 providers and other stakeholders participated. The SOMB provided more than 26 other standalone training events and a range of implementation support opportunities.

Implementation of SOMB Reauthorization Bill (SB 23-164)

Following the Sunset Review of the SOMB by the Colorado Department of Regulatory Agencies (DORA) in October 2022, the SOMB was reauthorized in Senate Bill 23-164 in June 2023 for five years, until September 1, 2028. A sunset review is a periodic assessment of a state board or program to determine if that organization is meeting its statutory mandates and whether the state legislature should continue the organization. The reauthorization bill adopted the recommendations in Sunset Review and further added other mandates. Major work undertaken by the SOMB to implement the requirements in the bill is outlined below. A summary of the additions and repeals made in the bill is provided in **Appendix B.**

SOMB/DOC Treatment Solutions Subcommittee

The SOMB convened a subcommittee in August 2023 with representatives from the Board, community sex offender treatment providers, the Department of Corrections (DOC), the division of adult parole in the Department of Corrections, and the State Parole Board. The subcommittee's purpose was to study and develop potential solutions to address treatment resources for sex offenders who are in the custody of the Department of Corrections.

The specific legislative questions to be addressed by the subcommittee were:

- Identify inmates who are eligible to receive treatment;
- Among those eligible inmates, identify those who are past parole eligibility date (PED) and have not been provided a treatment opportunity;
- Identity all barriers DOC faces in providing timely access to treatment;
- Identify which, if any, Standards and Statutes (e.g., Lifetime Supervision Act of Sex Offenders, C.R.S. 18-1.3-1004 and C.R.S. 18-1.3-1006) are barriers to providing timely access to treatment;
- Review DOC policies and administrative regulations to prevent unnecessary backlog in making treatment accessible to inmates who require treatment to meet their PED.

The SOMB coordinated and hosted five subcommittee meetings between August and November 2023. All meetings were in a hybrid format to maximize accommodations for members and guests to attend. All meetings were open to the public. The subcommittee took public testimony at the second meeting, held on September 6, 2023, which could be delivered in person, via the hybrid virtual meeting format, or in written form. The subcommittee requested that additional public testimony be provided in written form thereafter.

The staff of the SOMB worked with the subcommittee to obtain and analyze the data provided by the Department of Corrections, as well as data provided by the Judicial Department. The staff of the SOMB assisted the subcommittee in identifying if any SOMB *Adult Standards and Guidelines* are barriers to the Department of Corrections providing timely access to treatment or recruiting staff to provide treatment services. The staff of the SOMB also assisted the subcommittee in developing the written report of the findings that are due to be submitted to the House and Senate Judiciary Committees on or before February 1, 2024.

Updates to Adult and Juvenile Standards and Guidelines

Several additions and repeals included in the reauthorization bill require the SOMB to update the wording used in the *Adult and Juvenile Standards and Guidelines* without necessitating substantive changes to the current meaning or required practices contained within the *Standards and Guidelines*. The SOMB is working on addressing each of these needed updates through the appropriate committees. In brief, these include: clarifying that Supervising Officers are required to follow the *Standards and Guidelines*; directing supervising agencies to provide a complete list of treatment providers to adults and juveniles when they are choosing a provider, except for the Division of Youth Services; updating the language about fingerprint collection to reflect current practice; updating the definitions for "adult sex offender", "juvenile who committed a sexual offense", and "sex offender"; and ensuring, to the extent possible, that treatment provided under the *Adult and Juvenile Standards and Guidelines* is responsive to the developmental status of the client at the time of treatment as well as their linguistic, cultural, religious, and racial characteristics; and sexual orientation, gender identity, and gender expression (per § 24-34-301, C.R.S).

Greater detail about each of these requirements is included in **Appendix B**.

State Parole Board Release Guideline Instrument

The SOMB, in collaboration with the State Parole Board, is required to revise the specific sex offender release guideline instrument used with sex offenders with determinate sentences. The revised release guideline must incorporate the concepts of Risk-Need-Responsivity or another evidence-based correctional model and be as flexible as possible to ensure that offenders have timely access to the necessary programs to prevent the offender harming victims or potential victims. The release guideline must not include the inability to access treatment during incarceration (when determined to be eligible) as a basis for denying parole.

The representative from the State Parole Board on the SOMB/DOC Treatment Solutions Subcommittee has identified key risk indicators that can be used to assess determinately sentenced offenders for parole consideration. This information needs to be accessible to the Parole Board and cannot rely on the Sex Offender Treatment and Monitoring Program (SOTMP) within the Department of Corrections, as some determinately sentenced offenders may be considered for parole prior to participating in treatment. The Parole Board is in the process of revising these risk criteria for use in such cases.

Compliance Reviews

Beginning September 1, 2024, and every two years thereafter, the Board shall conduct compliance reviews on at least 10% of Approved Treatment Providers. The SOMB has an existing administrative policy and practice for Standard Compliance Reviews. Staff of the SOMB are beginning work to adapt the existing policy and practices to ensure they are fit for purpose for the required 10% compliance review requirement.

Efforts toward Equity, Diversity, and Inclusion

The SOMB has continued to prioritize equity, diversity, and inclusivity (EDI) issues within the SOMB and provider community. The efforts include ensuring the language in the *Standards and Guidelines* is inclusive, explicitly acknowledging limitations in research, and providing training and resources to improve the responsiveness and effectiveness of services for individuals of minority race-ethnicity and LGBTQ+ identities.

Initiatives undertaken in 2023 include:

- Full-day training on the impact of racial and generational trauma
- ODVSOM 2023 Annual Conference had a keynote address on a culturally responsive framework for all and individual sessions on missing and murdered indigenous relatives, an examination of violence against Native American women, and the intersection of gender-inclusive care with transgender youth.
- Presentation on human trafficking and its negative impact on African American communities.
- Presentation by the Asian Pacific Development Center on collaborative language services.
- Presentation on Latino offenders who commit sexual assault.

- Revision of the sex history packet with particular attention to rewriting of concepts and language regarding normative sexual behavior that was inclusive of people with LGBTQ+ identities.

- Addition of language in the *Adult Standards and Guidelines* to emphasize the need for clinical awareness and judgment when using assessment instruments that are not normed or validated for the client's race or gender.

- Addition of language in the *Juvenile Standards and Guidelines* to emphasize the need for particular clinical sensitivity and judgment when working with clients from different social, cultural, and religious backgrounds.

- Recruitment and retention communication plan has an emphasis on attracting future providers of more diverse, underrepresented identities.

- Research projects consider if findings are applicable across diverse groups.

Victim Resource Guide

The SOMB Victim Advocacy Committee completed and published "*Understanding Sex Offender Treatment and Supervision in Colorado: A Resource Guide for Victims of Sexual Assault*" in September 2023. The resource guide reflects the combined effort of many members of the committee, stakeholders, and staff of the SOMB. The resource provides information to victims of sexual assault regarding Colorado resources for support, offense-specific evaluations, offense-specific treatment, sex offender supervision, sex offender registration and notification, Victim Representatives, and clarification, contract, and reunification. The resource guide is intended to help inform and empower victims, answer common questions they may have, and simplify the policies and practices that inform how sex offending treatment and supervision is managed in Colorado.

Provider Recruitment and Retention

The Office of Domestic Violence and Sex Offender Management (ODVSOM) is engaged in a multi-phase process to develop a marketing and communication strategy to increase recruitment and retention of providers within the Colorado domestic violence and sex offender management treatment field. In 2022 an initial research project was completed in partnership with Orange Circle Consulting. The research project identified the key factors that attract new providers to the domestic violence and sex offender treatment fields and retain existing providers. The research project included an emphasis on understanding what would increase recruitment and retention of providers from minority groups as part of efforts to increase the responsivity of the field to EDI issues. The findings of the research project were presented to the SOMB and stakeholders at a monthly Board meeting early in 2023 and can be found in the 2023 SOMB Annual Legislative Report. Both the SOMB and stakeholders showed a high degree of engagement with the aims and findings of the project.

Building upon the first phase, the ODVSOM has further engaged Orange Circle to develop specific messaging, outreach strategies, and resource materials as part of a recruitment and retention communication plan. The intention is to have the communication plan finalized by the end of FY2023-24 with the production of messaging materials and outreach being undertaken in FY2024-25.

Provider Applications Fully Online

The transition of the provider application process from a paper-based system to a fully online system became operational on January 1st, 2023. All applicant materials are now submitted through the SOMB Provider Data Management System. Training and technical support have been provided by the SOMB Application Review Coordinator and Implementation Specialists.

Policy and Regulatory Work

Committees

Most of the work conducted by the SOMB occurs at the committee level. Within these committees, a variety of policy and implementation-related work is proposed, discussed, and reviewed by relevant stakeholders with proposals then forwarded to the SOMB for consideration. The committee work includes considering advancements in the field of sex offender management and changes to the *Adult and Juvenile Standards and Guidelines* that are needed to reflect current research findings, best practices, and to ensure issues of equity, diversity, and inclusivity are properly addressed. The committees also suggest methods for educating practitioners and the public to implement effective offender management strategies. As needed, the committees establish workgroups to address specific topics that then report back to the governing committee.

The SOMB staffed 15 active committees and workgroups during 2023 to work on statutorily mandated duties. All committees were open to all stakeholders. The committees were:

1. Executive Committee
2. Best Practices Committee
3. Application Review Committee
4. Adult Standards Revisions Committee
    a. Sex History Packet Workgroup
    b. Treatment Provider Workgroup
    c. Denial Workgroup
5. Juvenile Standards Revision Committee
6. Specialized Committees
    a. Victim Advocacy Committee
        i. Victim Handout Workgroup
    b. DV/SO Training Committee
    c. Sex Offender Surcharge Allocation Committee
    d. Polygraph Examiner Workgroup
    e. SOMB/DOC Treatment Solutions Subcommittee

Figure 21 provides a visual depiction of the major committees. A summary of the main work of each committee in 2023 is provided in **Appendix C**.

Figure 21. Organizational Chart of SOMB Committees and Workgroups.

Applications for Listings on the SOMB Approved Provider List

During the calendar year of 2023[29], the SOMB Application Review Committee managed 187 applications for new listings, move up in status, and renewals to the Approved Provider list. The Application Review Committee approved 148 applications, which included applications that were pending from the previous 12-month period as well as new applications received during these 12 months. A total of 31 applications were pending at the end of the 12 months. The SOMB count of approved applications report for 2023 is shown in **Table 17**.

[29] The 12-month period was 11/1/2022 to 10/31/23.

Table 17. SOMB Count of Approved Applications Report for 2023.

Application Type	Number Submitted	Number Approved	Number Pending
Application 1 (Initial)	52	46	5
Application 2 (Advancement)	72[a]	53	14
Application 3 (Renewal)	63[b]	49	12
Total	187	148	31

a. Three applications to the ARC were missing information, which was in the process of being sought.
b. Two applications to the ARC were missing information, which was in the process of being sought.

Current Availability of SOMB Approved Providers

As of November 2023, the SOMB has 358 Approved Providers in total. Within that overall total, **246** are adult treatment providers and **185** are juvenile treatment providers.[30] There are **25** polygraph examiners of whom all **25** are adult polygraph examiners and **14** are also juvenile polygraph examiners. Providers may apply to hold multiple listings such that some are approved to only work with adults or juveniles, while others are approved to work with both adults and juveniles. Providers can pursue additional specializations to work with individuals with developmental and intellectual disabilities, or to offer clinical supervision services. As a result, an Approved Provider may have up to eight listings. **Table 18A** shows the current numbers of Adult Approved Providers in Colorado by service listing and **Table 18B** shows the current numbers of Juvenile Approved Providers in Colorado by service listing. Of note, the italicized categories contain Providers who are approved to provide additional services and are not used to calculate the totals.

In addition, each Approved Provider has specific counties in which they have applied to provide services. **Figures 22 through 27** show the distribution of Approved Adult and Juvenile Evaluators, Treatment Providers, and Polygraph Providers across Coloradan counties. See **Appendix D** for this data presented in table format.

On average, each Approved Provider operated in three different counties. In total, the SOMB has Approved Providers located in all 22 judicial districts in the state.

[30] Providers can be approved to work with adult, juvenile, or adult and juvenile populations, hence the discrepancy between the total number of approved providers and the sum of the adult and juvenile treatment providers.

Table 18A. Number of Approved Adult Sex Offender Service Providers in Colorado, 2023.[31]

Service Listing	Associate Level	Full Level	Total
Adult Treatment Provider	**89**	**157**	**246**
Treatment Provider DD/ID	*24*	*34*	*57*
Clinical Treatment Supervisor	*N/A*	*91*	*91*
Clinical Treatment Supervisor DD/ID	*N/A*	*23*	*23*
Adult Evaluator	**39**	**75**	**114**
Evaluator DD/ID	*10*	*12*	*22*
Clinical Evaluator Supervisor	*N/A*	*46*	*42*
Clinical Evaluator Supervisor DD/ID	*N/A*	*12*	*12*
Adult Polygraph Examiner	**6**	**19**	**25**
Polygraph Examiner DD/ID	*2*	*10*	*12*

Note: DD/ID indicates the Provider has met the standards to provide that service to individuals with developmental disability/intellectual disability.

Table 18B. Number of Approved Juvenile Sex Offender Service Providers in Colorado, 2023.[32]

Service Listing	Associate Level	Full Level	Total
Juvenile Treatment Provider	**63**	**112**	**185**
Treatment Provider DD/ID	*6*	*21*	*27*
Clinical Treatment Supervisor	*N/A*	*57*	*58*
Clinical Treatment Supervisor DD/ID	*N/A*	*14*	*14*
Juvenile Evaluator	**16**	**44**	**60**
Evaluator DD/ID	*3*	*9*	*14*
Clinical Evaluator Supervisor	*N/A*	*25*	*21*
Clinical Evaluator Supervisor DD/ID	*N/A*	*7*	*7*
Juvenile Polygraph Examiner	**4**	**10**	**14**
Polygraph Examiner DD/ID	1	5	6

Note: DD/ID indicates the Provider has met the standards to provide that service to individuals with developmental disability/intellectual disability.

[31] The numbers show a snapshot of Provider data from the SOMB Provider Data Management System on 11/1/2023.

[32] The numbers show a snapshot of Provider data from the SOMB Provider Data Management System on 11/1/2023.

Figure 22. Number of SOMB Adult Treatment Providers by County.
For data table, see Appendix A.22-27.

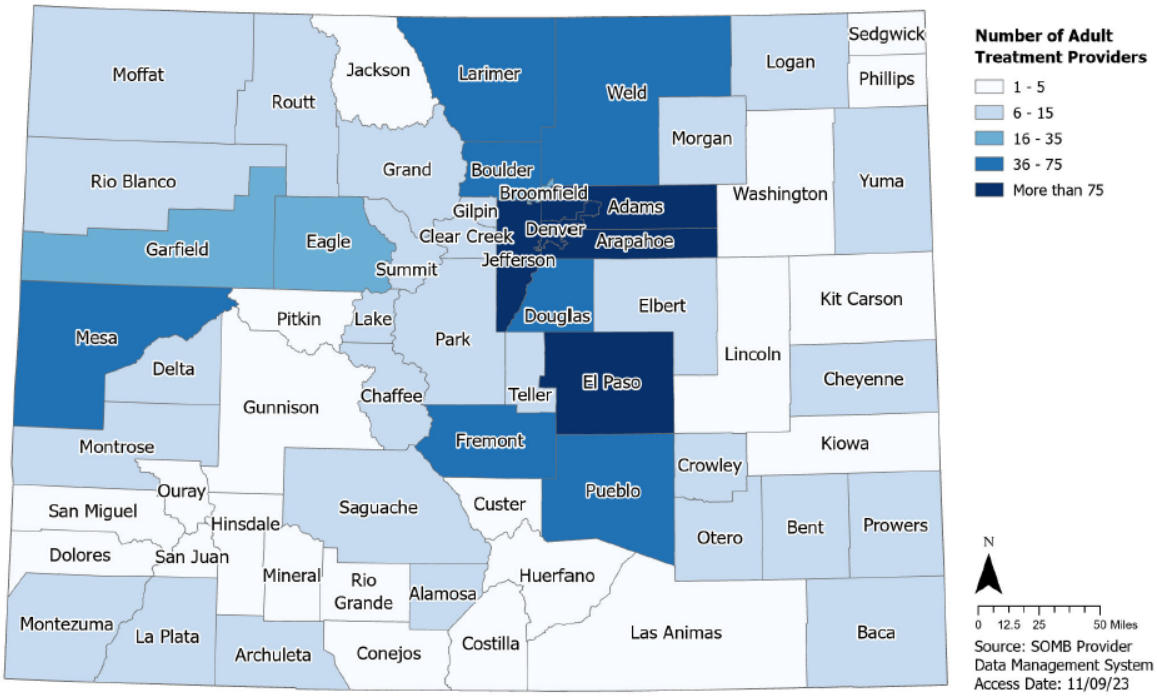


Figure 23. Number of SOMB Juvenile Treatment Providers by County.
For data table, see Appendix A.22-27.

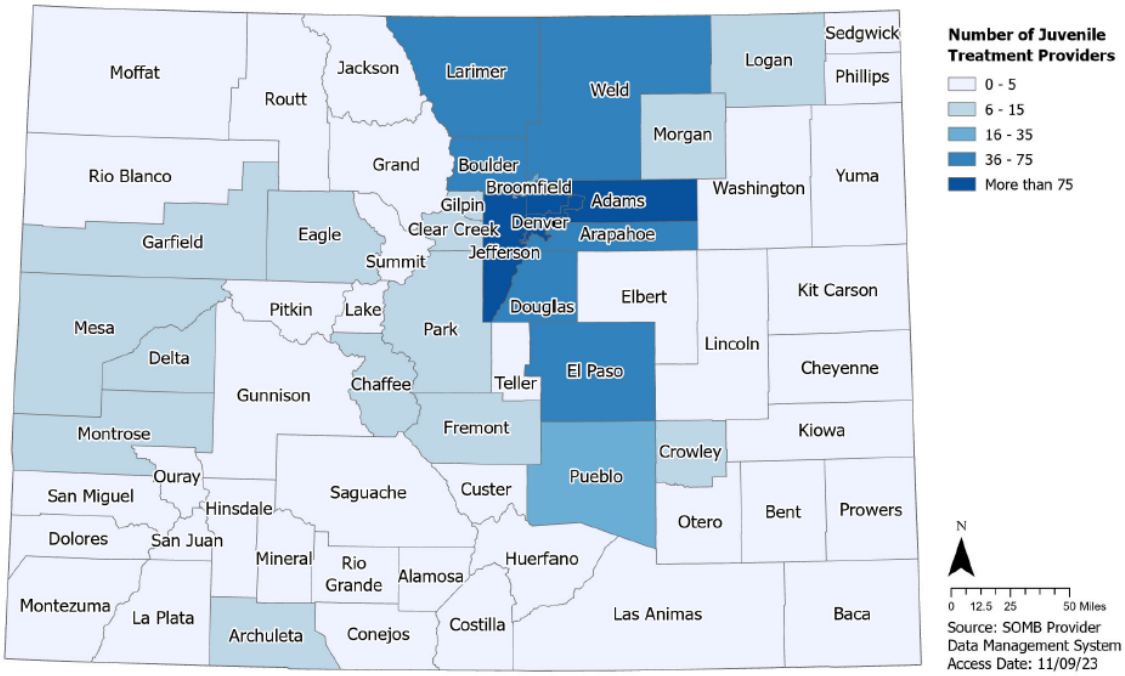


Figure 24. Number of SOMB Adult Evaluators Providers by County.
For data table, see Appendix A.22-27.

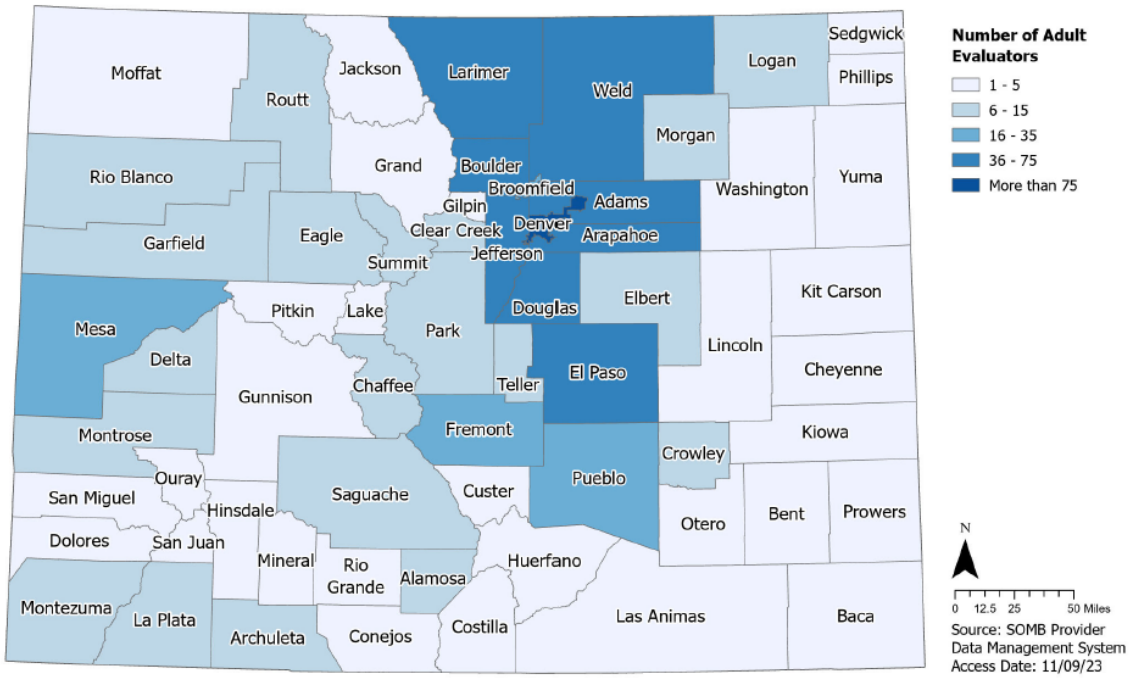


Figure 25. Number of SOMB Juvenile Evaluators by County.
For data table, see Appendix A.22-27.

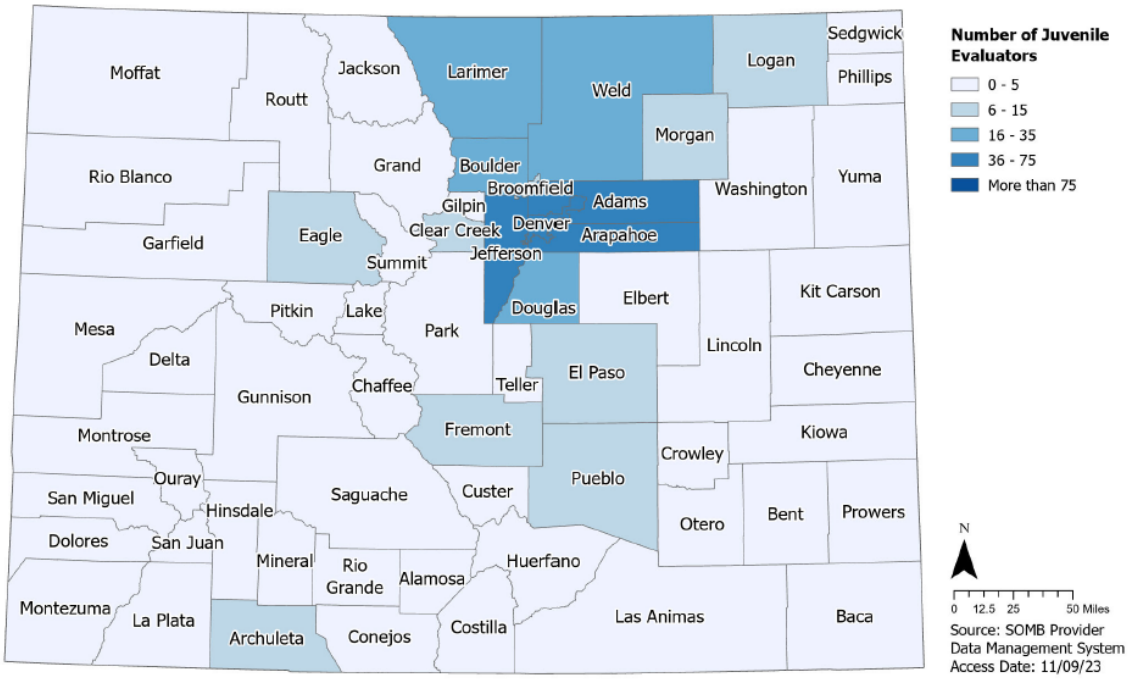


Figure 26. Number of SOMB Adult Polygraphers by County.
For data table, see Appendix A.22-27

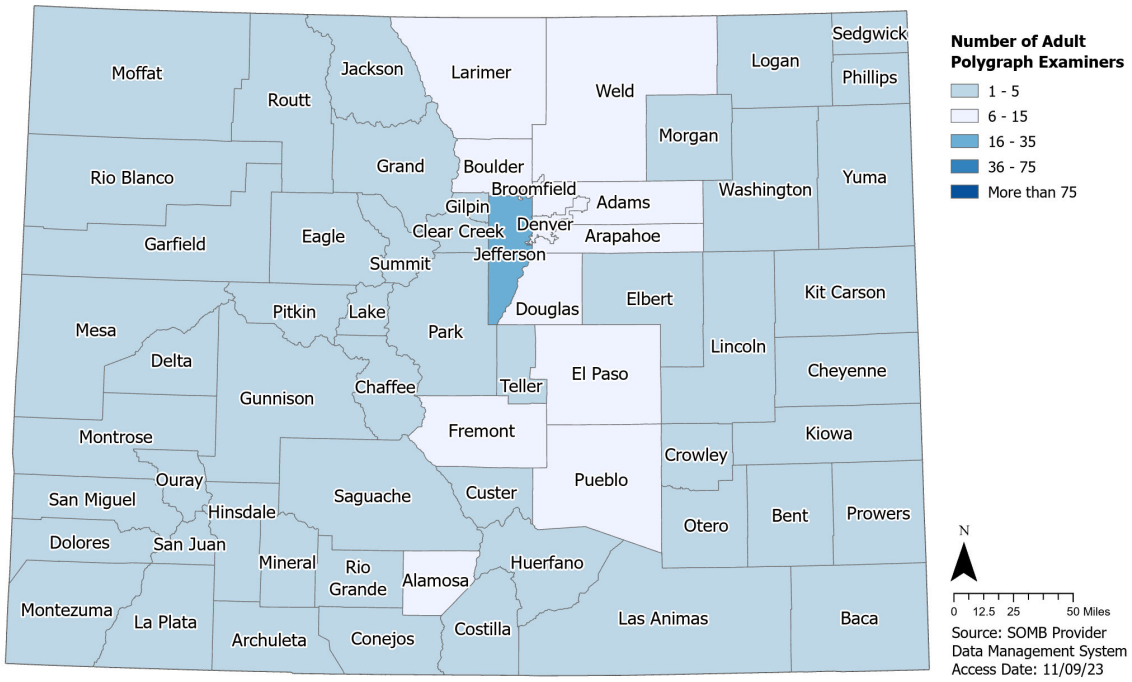
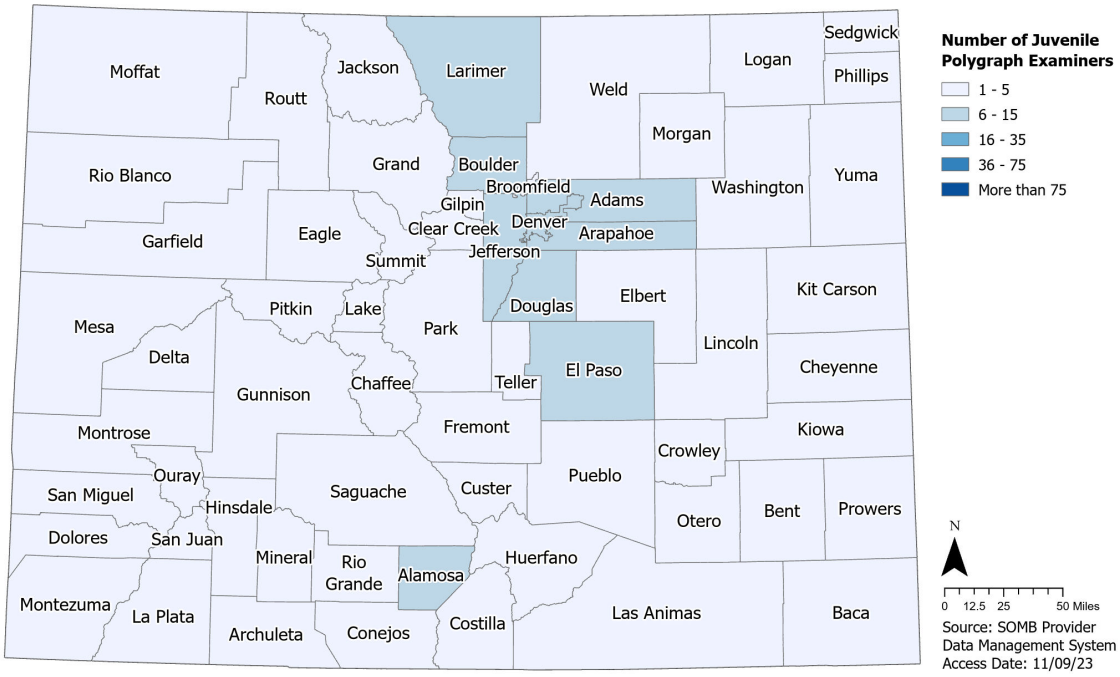


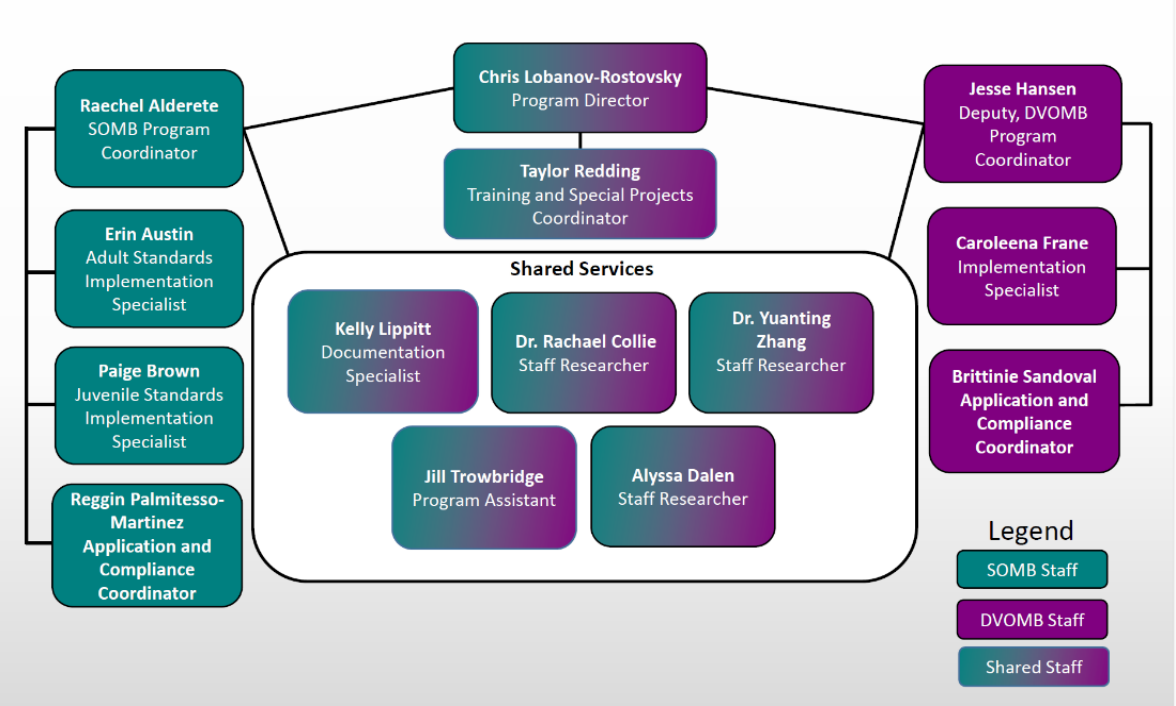
Figure 27. Number of SOMB Juvenile Polygraphers by County.
For data table, see Appendix A.22-27.



Update on the ODVSOM Shared Services Model

Staff responsible for supporting the SOMB work in the Office of Domestic Violence and Sex Offender Management (ODVSOM), which also supports the Domestic Violence Offender Management Board (DVOMB). The staff for each Board were combined into one office in 2016. Although each Board is defined separately by law, they are structured similarly and possess similar guiding principles and mandates. The consolidation of offices presented an opportunity to simplify administrative procedures, improve role specialization, and meet the challenges posed by the increasing requirements for program implementation, compliance monitoring, and research. The ODVSOM conducted a comprehensive review of its organizational structure and explored options to integrate staff roles in a more purposeful and systematic way. The result of this process led in 2022 to a revamp of staff responsibilities and produced a new staffing configuration referred to as the Shared Services Model, shown in **Figure 28**. Implementation of the model began in 2022 and has continued with expansion in 2023.

Figure 28. ODVSOM Shared Services Model and Organizational Chart 2023. See Appendix A.28.



Ongoing Implementation

Ongoing implementation refers to the steps taken by the SOMB to help providers apply the *Standards and Guidelines* correctly and consistently. The SOMB prioritizes implementation support through staff positions as Implementation Specialists, a range of communication strategies, training, and research. A key resource is the training and technical assistance hub on the SOMB website which describes the SOMB core and specialty trainings and where these can be accessed or requested. Some trainings are available in pre-recorded webinars. The SOMB is always willing to consider training requests from subject matter experts who wish to deliver relevant training and providers or stakeholders who identify a training need.

Other highlights of implementation efforts in 2023 included:

- Enhancing the accessibility of documents on the SOMB website.
- Streamlining the implementation timeline for revisions to the *Standards and Guidelines*.
- Continuing to notify Approved Providers and stakeholders of the work of the Board and its implications for Approved Providers in monthly Bulletins and a Quarterly Newsletter that are emailed to all providers and interested stakeholders.
- Providing regular training through a series of introductory trainings (accessible in-person and online), 90-minute bi-monthly lunch-and-learn webinars, and an advanced series of full-day trainings.
- Hosting monthly technical assistance hours where providers can network and consult with the Implementation Specialists.
- Providing research literature reviews and conducting research analyses to inform the ongoing work of the Committees and Board.

Training Delivery

In 2023 the SOMB provided 26 standalone training events to over 1500 attendees using a mix of in-person, online, and hybrid formats. The events were delivered by SOMB staff and other subject matter experts. The SOMB as part of the Office of Domestic Violence and Sex Offender Management also hosted its annual conference in July 2023 that was attended by 586 providers and stakeholders. The conference is a four-day event comprised of a day of pre-conference workshops and three days of proceedings. The conference proceedings were available for 90 days post-conference to allow attendees to access the multiple sessions that were offered and to give access to those who chose a virtual-only attendance.

Training topics included:

- Racial and Generational Trauma: Evidence-based Somatic Interventions for BIPOC Clients
- *SOMB 100 Introduction to Colorado Sex Offender Management*
- *Adult* and *Juvenile Standards and Guidelines* Booster
- Introductory Training on the VASOR-2 and SOTIPS Risk Assessment Instruments
- Booster Training on the VASOR-2 and SOTIPS Risk Assessment Instruments
- Sex Offender Needs Integrated Communication System (SONICS)
- Revised Sex History Packet
- Offense-Supportive Attitudes
- Evaluation Guidelines for Clients with Sex Offense History and Current Non-Sex Crime
- Standards and Guidelines Regarding Child Contact
- Standards and Guidelines Regarding Approved Supervision
- Continuity of Care

- Revised Standards for Sex Offense-Specific Evaluations
- Sex Offender Registration
- Clinical Supervision
- Victim Representation on Community Supervision and Multidisciplinary Teams
- Booster Training for Judicial Staff
- Data Collection and Success in Treatment
- Making Research Accessible and Applicable to Practitioners

In addition, the SOMB included presentations at each monthly board meeting that focused on a range of issues and provided another option for free training credit to providers who attended in person or virtually. Topics included:

- Human Trafficking Awareness
- Human Trafficking, its Effect on the Black Community, and Our Continued Quest for Freedom
- Victim Clarification Panel Discussion
- Negative Impacts from High Potency THC
- Victim Perspective on Working with Individuals Convicted of Internet-Facilitated Crime
- Asian Pacific Development Center Collaboration for Language Services
- Latinos and Sexual Assault: Characteristics, Offense Patterns, and Treatment Challenges

Summary of Year-End Accomplishments

The following highlights some of the many achievements of the SOMB in 2023:

- Progress implementing the SOMB reauthorization bill, SB 23-264, including establishing and completing work of the SOMB/DOC Treatment Solutions Committee.
- Continued priority given to equity, diversity, and inclusivity (EDI) issues within the SOMB and provider community.
- The SOMB Victim Advocacy Committee published a resource guide on *Understanding Sex Offender Treatment and Supervision in Colorado: A Resource Guide for Victims of Sexual Assault.*
- Further progress on the ODVSOM recruitment and retention marketing and communication project to attract and retain providers in the sex offender management field, particularly professionals from underrepresented groups.
- Fully implemented the online provider application system.
- Managed 15 SOMB committees and workgroups.

- Conducted multiple research reviews and data analysis projects to support the work of the SOMB committees and inform the provider community.
- Managed 187 applications for placement or continued placement on the SOMB Approved Provider List.
- As of November 2023, there are **246** adult treatment providers and **185** juvenile treatment providers approved by the SOMB in Colorado. There are **25** adult polygraph examiners and **15** juvenile polygraph examiners.
- Every Colorado county has an adult evaluation, treatment, and polygraph examiner SOMB Approved Provider.
- Fully implemented the ODVSOM shared services model.
- Prioritized ongoing implementation of the Standards and Guidelines through the SOMB training hub, staff positions as Implementation Specialists, a range of communication strategies, training, and research.
- Office of Domestic Violence and Sex Offender Management hosted its annual conference in July 2023, which was attended by 586 providers and stakeholders.
- Conducted 26 training events with over 1,500 attendees from across Colorado.
- Published the 2024 SOMB Annual Legislative Report and the 2023 Lifetime Supervision of Sex Offenders Annual Report.

Section 4: Future Goals and Directions

The mission of the SOMB, as written in its enabling statute, is to have a continuing focus on public safety. To carry out this mission for communities across the state, the SOMB strives toward the successful rehabilitation of offenders through effective treatment and management strategies while balancing the welfare of victims of sexual crimes, their families, and the public at large. The SOMB recognizes that over the past 20 years, much of the knowledge and information on sexual offending has evolved. Since the creation of the SOMB, the *Adult* and *Juvenile Standards and Guidelines* for the evaluation and treatment of sexual offenders have been a 'work in progress.' Thus, periodic revisions to improve the *Adult* and *Juvenile Standards and Guidelines* remains a key strategic priority for the SOMB through its process of adopting new research and evidence-based practices as they emerge from the literature and the field. The SOMB will continue to recognize the key role that the RNR model plays in the successful rehabilitation and management of adults and juveniles who commit sexual offenses.

Strategic goals and initiatives

Over the next year, the SOMB will continue its focus on executing its statutory duties and supporting Approved Providers to implement the *Adult and Juvenile Standards and Guidelines* with fidelity. The SOMB will continue to emphasize efforts toward achieving equity, diversity, and inclusivity within the SOMB and provider community to maximize the effectiveness of treatment and protection of victims and potential victims. The SOMB will begin implementing the new requirement to conduct compliance reviews on 10% of Approved Providers every two years. The SOMB will continue to work toward implementing Phase II of the data collection project, which is going to examine longer-term outcomes, including recidivism, for individuals who received offense-specific treatment in Colorado. Revisions and changes to the SOMB *Standards and Guidelines* will continue to keep pace with emerging research and literature. The SOMB consistently demonstrates and fulfills its statutory authority and mandate to ensure that a community safety and victim-centered approach is the focus of its work. To that end, the SOMB will continue supporting current projects led by the Victim Advocacy Committee.

References

Allen, B (2023). Etiological perspectives on problematic sexual behavior of preteen children: Implications for treatment. *Clinical Child & Family Psychology Review, 26*(1), 50-64.

Allen, B., & Hoskowitz, N. A. (2017). Structured trauma-focused CBT and unstructured play/experiential techniques in the treatment of sexually abused children: A field study with practicing clinicians. *Child Maltreatment, 22*, 112-120.

Allen, B., Berliner, L., Shenk, C. E., Bendixsen, B., Zellhoefer, A., Dickmann, C. R., Arnold, B., & Chen, M. J. (2018). Development and pilot testing of a phase-based treatment for preteen children with problematic sexual behavior. *Evidence-based Practice in Child and Adolescent Mental Health, 3*, 274-285.

Allen, B., Timmer, S. G., & Urquiza, A. J. (2016). Parent-Child Interaction Therapy for sexual concerns of maltreated children: A preliminary investigation. *Child Abuse & Neglect, 5*, 80-88.

Bitton, M. S., & Abulafia, J. (2020). A community-based treatment center for sex offenders in Israel: A treatment evaluation of the treatment completers. *Israel Journal of Psychiatry, 57*(2), 11-22).

Blagden, N., Winder, B., Gregson, M., & Thorne, K. (2014). Making sense of denial in sexual offenders: A qualitative phenomenological and repertory grid analysis. *Journal of Interpersonal Violence*, *29*(9), 1698-1731. https://doi.org/10.1177/0886260513511530

Bonner, B. L., Walker, C. E., & Berliner, L. (1999). *Children with sexual behavior problems: Assessment and treatment-final report* (Grant No. 90-CA-1469). Washington, DC: U.S. Department of Health and Human Services, National Clearinghouse on Child Abuse and Neglect.

Brown, S. J., Walker, K., Gannon, T. A., Keown, K. (2013). Creating a psychologically comfortable position: The link between empathy and cognitions in sex offenders. *Journal of Sexual Aggression, 19*(3), 275-294.

Cale, J., & Lussier, P. (2017). Sexual behaviour in preschool children in the context of intra-parental violence and sexual coercion. *Criminal Behaviour and Mental Health, 27*, 176-190.

Carl, L. C., & Lösel, F. (2021). When sexual offender treatment in prison-based social-therapeutic treatment is not completed: Relationship to risk factors and recidivism after release. *Criminal Behavior & Mental Health*, *31*(6), 421-435. https://doi.org/10.1002/cbm.2220

Carpentier, M., Silovsky, J., & Chaffin, M. (2006). 10 Year Follow-up Supports Cognitive- Behavioral Treatment for Children with Sexual Behavior Problems: Implications for Services, Treatment Implementation, and Future Directions. *ATSA Forum*. 1-21.

Carrola, P. A. (2023). Experiences addressing denial in sex offender counseling. *Journal of Forensic Psychology Research and Practice*, *23*(1), 1-20. https://doi.org/10.1080/24732850.2021.2013363

Chaffin, M., Berliner, L., Block, R., Johnson, T.C., Friedrich, W.N., Louis, D.J., et al. (2008). Report of the ATSA Task Force on children with sexual behavior problems. *Child Maltreatment, 13*, 199-218. doi:10.1177/10775595507306718

Chouinard-Thivierge, S., Lussier, P., & Daignault, I. (2022). A Longitudinal Examination of Developmental Covariates of Sexual Behavior Problems among Youth Referred to Child Protective Services. *Sexual Abuse 2022, Vol. 34(5)*. 537-567.

Cohen, J. A., Deblinger, E., Mannarino, A. P., & Steer, R. A. (2004). A multisite, randomized controlled trial for children with sexual abuse-related PTSD symptoms. *Journal of the American Academy of Child & Adolescent Psychiatry, 43*, 393-402.

Cohen, J. A., Mannarino, A. P., & Deblinger, E. (2017). *Treating trauma and traumatic grief in children and adolescents*. (*2nd ed.*). New York: Guilford Press.

Craissati, J. (2015). Should we worry about sex offenders who deny their offenses? *Probation Journal*, *62*(4), 395-405.

Daly, K, (2006). Restorative justice and sexual assault: An archival study of court and conferences cases. *British Journal of Criminology, 46*, 334-356.

Deblinger, E., Mannarino, A. P., Cohen, J. A., Runyon, M. K., & Steer, R. A. (2011). Trauma-focused cognitive behavioral therapy for children: Impact of the trauma narrative and trauma length. *Depression & Anxiety, 28*, 67-75.

DeLago, C., Schroeder, C. M., Cooper, B., Deblinger, E., Dudek, E., Yu, R., & Finkel, M. A. (2020). Children who engaged in interpersonal problematic sexual behavior. *Child Abuse & Neglect, 105*, 104260.

DeMaio, C. M., Davis, J. L, & Smith, D. W. (2006). The use of clarification sessions in the treatment of incest victims and their families: An exploratory study. *Sexual Abuse: A Journal of Research & Treatment, 18*(1), 27-39.

Dickmann, C. R., Zellhoefer, A., Arnold, B., & Allen, B. (2018). Implementing a phase-based treatment for preteen children with problematic sexual behavior: Case examples. *Evidence-based Practice in Child and Adolescent Mental Health, 3*, 286-293.

Dietz, P. (2020). Denial and minimization in sex offenders. *Behavioral Science & Law*, *38*, 571-585.

Dopp, A. R., Mundey, P., Silovsky, J. F., Hunter, M., & Slemaker, A. (2020). Economic value of community-based services for problematic sexual behaviors in youth: A mixed-method cost-effectiveness analysis. *Child Abuse & Neglect, 105*, 104043.

Drury, A. J., Elbert, M. J., & DeLisi, M. (2020). The dark figure of sexual offending: A replication and extension. *Behavioral Science & Law*, *38*, 559-570.

Eastman, O., Craissati, J., & Shaw, J. (2019). Young adult sexual offenders with emerging personality disorders: Developmental and offence-related characteristics and treatment engagement. *Journal of Sexual Aggression*, *25*(2), 105-115. https://doi.org/10.1080/13552600.2018.1551501

Elkovitch, N., Latzman, R. D., Hansen, D. J., & Flood, M. F. (2009). Understanding child sexual behavior problems: A developmental psychopathology framework. *Clinical Psychology Review, 29(7),* 586-598.

Ensink, K., Godbout, N., Bigras, N., Lampron, J., Sabourin, S., & Normandin, L. (2018). Persistent and transitory sexualized behavior problems in children. *Child Psychiatry and Human Development, 49*, 621-631

Evans, D. N., & Cubellis, M. A. (2015). Coping with stigma: How registered sex offenders manage their public identities. *American Journal of Criminal Justice, 40*(3), 593–619. https://doi.org/10.1007/s12103-014-9277-z

Farmer, M., McAlinden, A., & Maruna, S. (2015). Understanding desistance from sexual offending: A thematic review of research findings. *Probation Journal, 62*(4), 320-335.

Finkelhor, D., & Browne, A. (1985). The traumatic impact of sexual abuse: A conceptualization. *American Journal of Orthopsychiatry, 55*, 530-541.

Frick, P. J., & Viding, E. (2009). Antisocial behavior from a developmental psychopathology perspective. *Development & Psychopathology, 21*, 1111-1131.

Friedrich, W. N., Davies, W. H., Feher, E., & Wright, J. (2003). Sexual behavior problems in preteen children: Developmental, ecological, and behavioral correlates. *Annals of the New York Academy of Sciences, 989*, 95-104

Friedrich, W. N., Fisher, J. L., Dittner, C. A., Acton, R., Berliner, L., Butler, J., Damon, L., Davies, W. H., Gray, A., & Wright, J. (2001). Child Sexual Behavior Inventory: Normative, psychiatric, and sexual abuse comparisons. *Child Maltreatment, 6*(1), 37–49.

Friedrich, W. N., Trane, S. T., & Gully, K. J. (2005). Letter to the Editor: Re: It is a mistake to conclude that sexual abuse and sexualized behavior are not related: A reply to Drach, Wientzen, and Ricci (2001). *Child Abuse & Neglect, 29*, 297-302

Friedrich, W.N. (1993). Sexual victimization and sexual behavior in children: A review of recent literature. *Child Abuse & Neglect, 17*, 59-66.

Friedrich, W.N. (2007). *Children with sexual behavior problems: Family-based attachment- focused therapy*. New York: W. W. Norton.

Friedrich, W.N., Grambsch, P., Broughton, D., Kuiper, J., & Beilke, R.L. (1991) Normative sexual behavior in children. *Pediatrics, 88*(3), 456-464.

Gannon, T. A., Olver, M. E., Mallion, J. S., & James, M. (2019). Does specialized psychological treatment for offending reduce recidivism? A meta-analysis examining staff and program variables as predictors of treatment effectiveness. *Clinical Psychology Review, 73,* Article 101752. https://doi.org/10.1016/j.cpr.2019.101752

Gannon, T. A., Wood, J. L., Pina, A., Tyler, N., Barnoux, M. F. L., & Vasquez, E. A. (2014). An evaluation of mandatory polygraph testing for sexual offenders in the United Kingdom. *Sexual Abuse, 26*, 178–203.

Grant, R. K., & Lundeberg, L. H. (2009). *Interventions for children with sexual behavior problems: Research, theory, and treatment*. Civic Research Institute.

Grubin, D. (2010). A trial of voluntary polygraphy testing in 10 English probation areas. *Sexual Abuse, 22*, 266–278.

Handler, M. D., Honts, C. R., & Nelson, R. (2013). Information gain of the directed lie detector test. *Polygraph, 42*, 192-202.

Hanson, R. K., & Bussière, M. T. (1998). Predicting relapse: A meta-analysis of sexual offender recidivism studies. *Journal of Consulting and Clinical Psychology, 66*, 348-362.

Hanson, R. K., & Morton-Bourgon, K. (2005). The characteristics of persistent sexual offenders: A meta-analysis of recidivism studies. *Journal of Consulting and Clinical Psychology, 73*, 1154-1163.

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 & Treatment, 22, 78-94. doi.org/10.1177/1079063209358106

Harkins, L., Howard, P., Barnett, G. D., Wakeling, H., & Miles, C. (2015). Relationships between denial, risk, and recidivism in sexual offenders. *Archives of Sexual Behavior*, *44*(1), 157-166.

Harper, B. (2012). *Moving families to future health: Reunification experiences after sibling incest*. Dissertation submitted for Doctorate in Social Work Degree. University of Pennsylvania.

Harris, D. A. (2014). Desistance from sexual offending: Findings from 21 life history narratives. *Journal of Interpersonal Violence, 29*(9), 1554-1578.

Helmus, L. M., Seung, C. Lee, A. P., Hanson, K. & Thornton, D. (2021). *Static-99R and Static 2002-R evaluators' workbook*. SAARNA.

Holper, L., Mokros, A., & Habermeyer, E. (2023). Moderators of sexual recidivism as indictor of treatment effectiveness in person with sexual offense histories: An updated meta-analysis. *Sexual Abuse, advanced publication*, 1-37.

Hurlburt, M. S., Nguyen, K., Reid, J., Webster-Stratton, C., & Zhang, J. (2013). Efficacy of the Incredible Years group parent program with families in Head Start who self-reported a history of child maltreatment. *Child Abuse & Neglect, 37*, 531-543.

Jonas, J., Zebel, S., Claessen, J., & Nelen, H. (2022). The psychological impact of participation in victim-offender mediation on offenders: Evidence for increased compunction and victim empathy. Front. Psychol., 12, article 812629. Doi: 10.3389/fpsyg.2021.812629.

Jung, S., & Nunes, K. L. (2012). Denial and its relationship with treatment perceptions among sex offenders. *Journal of Forensic Psychiatry & Psychology, 23*(4), 485-496.

Kaminski, J. W., & Claussen, A. H. (2017). Evidence base update for psychosocial treatments for disruptive behaviors in children. *Journal of Clinical Child and Adolescent Psychology, 46*, 477-499.

Koss, M. P. (2014). The RESTORE program of restorative justice for sex crimes: Vision, Process, and Outcomes. *Journal of Interpersonal Violence, 29(9)*, 1623-1660.

Kras, K. R., & Blasko, B. L. (2016). Pathways to desistance among men convicted of sexual offenses: Linking post hoc accounts of offending behavior and outcomes. *International Journal of Offender Therapy and Comparative Criminology, 60*(15), 1738–1755. https://doi.org/10.1177/0306624X16668178

Langton, C. M., Barbaree, H. E., Harkins, L., Arenovich, T., McNamee, J., Peacock, E. J., Dalton, E., Luong, D., & Marcon, H. (2008). Denial and minimization among sexual offenders: Post treatment presentation and association with sexual recidivism. *Criminal Justice & Behavior, 35*, 69-98.

Larsson, I., Svedin, C. G., & Friedrich, W. N. (2000) Differences and similarities in sexual behaviour among preschoolers in Sweden and USA. *Nordic Journal of Psychiatry, 54*, 251–257.

Lee, S. C. & Hanson, R. K. (2021). Updated 5-year and new 10-year sexual recidivism rate norms for Static-99R with routine/complete samples. *Law & Human Behavior, 45*(1). 24-38.

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, 346-364. doi.org/10.1177/1079063210382048

Lévesque, M., Bigras, M., & Pauzé, R. (2012). Persistence of problematic sexual behaviors in children. *Journal of Clinical Child and Adolescent Psychology, 41*, 239-245.

Lieneman, C. C., Girard, E. I., Quetsch, L. B., & McNeil, C. B. (2020). Emotion regulation and attrition in parent-child interaction therapy. *Journal of Child and Family Studies, 29*, 978-996.

Livingstone, N., McDonald, G., & Carr, N. (2013). Restorative justice conferencing for reducing recidivism in young offenders (aged 7-21). *Cochrane Database of Systematic Reviews, 2*, Art. No: CD008898.

Lord, A., & Willmot, P. (2004). The process of overcoming denial in sexual offenders. Journal of Sexual Aggression, 10, 51-61. doi.org/10.1080/13552600410001670937

Lund, C. A. (2000). Predictors of sexual recidivism: Did meta-analysis clarify the role and relevance of denial? *Sexual Abuse: A Journal of Research & Treatment, 12*, 275-288.

Lussier, P., Chouinard-Thivierge, S., McCuish, E., Nadeau, D., & Lacerte, D. (2019). Early life adversities and polyvictimization in young persons with sexual behavior problems: A longitudinal study of child protective service referrals. *Child Abuse & Neglect, 88,* 37-50

Ly, T., Fedorroff, J. P., & Briken, P. (2020). A narrative review of research on clinical responses to the problem of sexual offenses in the last decade. *Behavioral Sciences & Law, 38*, 117-134.

Malcolm, P. B. (2002). Child molester denial: Utilizing a multi-method assessment approach [Doctoral Dissertation, Carlton University Ottawa Canada]. Carlton University Institutional Repository. https://repository.library.carleton.ca/concern/etds/6w924c18m

Malvasso, C. G., Proeve, M., Delfabbro, P., & Cale, J. (2020). Characteristics of children with problem sexual behavior and adolescent perpetrators of sexual abuse: A Systematic Review. *Journal of Sexual Aggression, 26*(1), 36-61.

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, 191-217. doi.org/10.1177/1079063210366039

Mann, R. E., Webster, S. D., Wakeling, H. C., & Keylock, H. (2013). Why do sexual offenders refuse treatment? *Journal of Sexual Aggression, 19*(2), 191-206.

Marshall, W. L., Marshall, L. E., Serran, G. A., & O'Brien (2011). Rehabilitating sexual offenders: A strength-based approach. Washington, DC: American Psychological Association. doi.org/10.1037/12310-000

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 behavior change. Journal of Sexual Aggression, 9, 25- 30. doi.org/10.1080/355260031000137940

McGrath, R. J., Cumming, G., Livingston, J. A., & Hoke, S. E. (2003). Outcome of a treatment program for adult sex offenders: From prison to community. *Journal of Interpersonal Violence, 18*(1), 3–17. https://doi.org/10.1177/0886260502238537

McNeil, C. B., & Hembree-Kigin, T. L. (2011). *Parent-Child Interaction Therapy* (2nd ed.). New York: Springer.

Mills, L. G., Barocas, B., Butters, R. P. & Ariel, B. (2019). A randomized controlled trial of restorative justice-informed treatment for domestic violence crimes. *Nature & Human Behavior, 3*(12), 1284-12

Nunes, K. L., & Jung, S. (2013). Are cognitive distortions associated with denial and minimization among sex offenders? *Sexual Abuse: Journal of Research and Treatment, 25*(2), 166–188. https://doi.org/10.1177/1079063212453941

Nunes, K. L., Hanson, R. K., Firestone, P., Moulden, H. M., Greenberg, D. M., & Bradford, J. M. (2007). Denial predicts recidivism for some sexual offenders. Sexual Abuse: A Journal of Research and Treatment, 19, 91- 106.

Olver, M. E., Christofferson, S. M. B., Grace, R. C., & Wong, S. C. P. (2014). Incorporating change information into sexual offender risk assessments using the Violence Risk Scale–Sexual Offender version. *Sexual Abuse: Journal of Research and Treatment, 26*(5), 472–499. https://doi.org/10.1177/1079063213502679

Olver, M. E., Kingston, D. A., Nicholaichuk, T. P., & Wong, S. C. P. (2014). A psychometric examination of treatment change in a multisite sample of treated Canadian sexual offenders. *Law & Human Behavior, 38*(6), 544-559.

Olver, M., Stockdale, K. C., & Wormith, J. S. (2011). A meta-analysis of predictors of offender treatment attrition and its relationship to recidivism. *Journal of Consulting & Clinical Psychology*, *79*, 6-21. https://doi.org/10.1037/a0022200.

Paige, J. & Thornton, J. (2015). Healing from intrafamilial child sexual abuse: The role of relational processes between survivor and offender. Children Australia, 40(3), 242-259.

Pelech, J., Tickle, A., & Wilde, S. (2021). Professionals' experiences of working with children and young people with harmful sexual behaviour: A systematic review using meta-ethnographic synthesis. *Journal of Sexual Aggression, 27,* 264-284.

Rich, P. (2015). The Assessment of Risk for Sexual Re-offense in Juveniles Who Commit Sexual Offenses. *SOMAPI Research Brief: Sex Offender Management Assessment and Planning Initiative*.

Rogers, R., & Dickey, R. (1991). Denial and minimization among sex offenders: A review of competing models of deception. Annals of Sex Research, 4, 49-63. doi.org/10.1007/BF00850139

Sewell, K. W., & Salekin, R. T. (1997). Understanding and detecting dissimulation in sex offenders. In R. Rogers (Ed.), *Clinical assessment of malingering and deception* (pp. 328–350). Guilford Press.

Shawler, P. M., Bard, M. E., Taylor, E. K., Wilsie, C., Funderburk, B., & Silovsky, J. F. (2018). Parent-Child Interaction Therapy and young children with problematic sexual behavior: A conceptual overview and treatment considerations. *Children and Youth Services Review, 84*, 206-214.

Silovsky, J. F., Hunter, M. D., & Taylor, E. K. (2019). Impact of early intervention for youth with problematic sexual behaviors and their caregivers. *Journal of Sexual Aggression, 25*, 4-15.

Silovsky, J. F., Niec, L., Bard, D., & Hecht, D. B. (2007). Treatment for preschool children with interpersonal sexual behavior problems: A pilot study. *Journal of Clinical Child and Adolescent Psychology, 36*, 378-391.

Sowden, J. N., & Olver, M. E. (2017). Sexual offender treatment readiness, responsivity, and change: Linkages to treatment completion and recidivism. *Journal of Forensic Nursing, 13*(3), 97–108. https://doi.org/10.1097/JFN.0000000000000160

St. Amand, A., Bard, D. E., & Silovsky, J. F. (2008). Meta-analysis of treatment for child sexual behavior problems: Practice elements and outcomes. *Child Maltreatment, 13*, 145-166.

Steinberg, E. A., & Drabick, D. A. G. (2015). A developmental psychopathology perspective on ADHD and comorbid conditions: The role of emotion regulation. *Child Psychiatry & Human Development, 46*, 951-966.

Strang, H., Sherman, L. W., Mayo-Wilson, E., Woods, D., & Ariel, B. (2013). Restorative Justice Conferencing using face-to-face meetings of offenders and victims: Effects on offender recidivism and victim satisfaction. A Systematic Review. *Campbell Systematic Reviews, 9*(1), 1-59.

Thomas, R., Abell, B., Webb, H. J., Avdagic, E., & Zimmer-Gembeck, M. J. (2017). Parent-child interaction therapy: A meta-analysis. *Pediatrics, 140*, e20170352.

Ware, J. (2017). Understanding and treatment of convicted sex offenders who are in categorical denial. *[Doctoral Thesis, University of New South Wales]. UNSW Library Open Access*. https://unsworks.unsw.edu.au/entities/publication/1257f70a-b5c1-47f7-af36-65819e28710c

Ware, J. (2018). Therapeutic climate within a treatment program for categorical deniers. *International Journal of Offender Therapy and Comparative Criminology, 62*(8), 2216-2235.

Ware, J., Blagden, N., & Harper, C. (2020). Are categorical deniers different? Understanding demographic, personality, and psychological differences between denying and admitting individuals with sexual convictions. *Deviant Behavior*, *41*(4), 399-412. https://doi.org/10.1080/01639625.2018.1558944

Ware, J., Marshall, W. L., & Marshall, L. E. (2015). Categorical denial in convicted sex offenders: The concept, its meaning, and its implications for risk and treatment. *Aggression & Violent Behavior*, *25*(Nov-Dec), 215-226.

Watson, S., Harkins, L., & Parmer, M. (2016). The experience of deniers on a community sex offender group program. *Journal of Forensic Psychology Practice*, *16*(5), 374-392.

Wilson, D. B., Olaghere, A., & Kimbrell, C. S. (2017). *Effectiveness of restorative justice principles in juvenile justice: A meta-analysis*. US Department of Justice Office of Justice Programs OJJDP.

Zara, G., Farrington, D. P., & Jung, S. (2020). Denial in sex offending treatment: Examining criminal career diversity. *Journal of Forensic Psychology Research and Practice, 20*(5), 451–473. https://doi.org/10.1080/24732850.2020.1776050

Appendices

Appendix A: Accessible Tables

A.1. Offense-Specific Treatment Goals Consistently Achieved with Victim Clarification (n=56).

Offense-Specific Treatment Goal	Percent Providers (%)
Increase empathy for the victim	96.4
Increase acceptance of responsibility	89.3
Increase acts of being accountable	80.4
Work on guilt and shame	75.0
Restructure cognitive distortions	64.3
Decrease denial	57.1
Establish prosocial functioning	44.6
Increase motivation for treatment	39.3
Develop a safety plan	21.4

Return to Figure 1 main document

A.2. Treatment Providers Utilization of Victim Representatives (n=62).

Victim Representative Utilization	Percent Providers (%)
Request feedback on clarification letter	75.8
Consult in CSR/MDT meeting	69.4
Ask for general input	67.7
Check victim interest in clarification letter	53.2
Check victim interest in clarification session	48.4
Review selected cases	46.8
Inquire about victim issues in selected cases	45.2
Inquire about victim issues in every case	29.0
Review every case	27.4
Request feedback on the safety plan	16.1

Return to Figure 2 main document

A.3. Beginning and End of Treatment Denial Levels of Clients.

Denial Level	Beginning Treatment (%) (n = 1,481)	End Treatment (%) (n = 1,472)
No Denial	19.0	37.4
Low Denial	42.8	44.8
Moderate Denial	24.8	12.4
High Denial	13.4	5.4

Return to Figure 3 main document

A.4. Number of Colorado Evaluation Clients Referred by Referral Source (n = 478).

Referral Source	Number of Clients	Percent (%)
Probation	392	82.0%
Private Attorneys	39	8.2%
Parole/TASC	15	3.1%
Court	11	2.3%
DOC	11	2.3%
Other	8	1.7%
Community Corrections	1	0.2%
County DHS/DYS	1	0.2%

Return to Figure 4 main document

A.5. Offense Types for Evaluation Clients by Court (n = 477).

Adult Criminal Court (n = 401) Offense Type	Number of Clients	Percent (%)
Contact Offense	228	56.2%
Non-Sex Crime w/ a History of a Sex Crime	81	20.0%
Non-Contact Anonymous Online Victim	49	12.1%
Non-Contact In-Person Victim	37	9.1%
Other Crimes	19	4.7%

Juvenile Court (n = 76) Offense Type	Number of Clients	Percent (%)
Contact Offense	66	82.5%
Non-Contact In-Person Victim	4	5.0%
Non-Sex Crime w/ a History of a Sex Crime	4	5.0%
Non-Contact Anonymous Online Victim	1	1.2%
Other Crimes	1	1.2%

Return to Figure 5 main document

A.6. Percent of Evaluation Clients in Each Risk Level Category by Court (n = 476).

Adult Criminal Court (n = 400) Risk Level	Number of Clients	Percent (%)
High	77	19%
Moderate-high	60	15%
Moderate	122	30%
Moderate-low	57	14%
Low	84	21%

Juvenile Court (n = 76) Risk Level	Number of Clients	Percent (%)
High	3	4%
Moderate-high	5	7%
Moderate	20	26%
Moderate-low	17	22%
Low	31	41%

Return to Figure 6 main document

A.7. Number of Colorado Treatment Clients Referred by Referral Source (n = 644).

Referral Source	Number of Clients	Percent (%)
Probation	261	40.5%
Parole/TASC	199	30.9%
DOC	66	10.2%
Court	64	9.9%
Community Corrections	23	3.6%
Private Attorneys	13	2.0%
County DHS/DYS	11	1.7%
Other	5	0.8%
Diversion	2	0.3%

Return to Figure 7 main document

A.8. Number of Treatment Clients by Offense Type in the Adult and Juvenile Courts (n = 650).

Adult Criminal Court (n = 582) Offense Type	Number of Clients	Percent (%)
Contact Offense	415	71.3%
Non-Contact Anonymous Online Victim	104	17.9%
Non-Contact In-Person Victim	56	9.6%
Other Crimes	16	2.7%
Non-Sex Crime w/ a History of a Sex Crime	12	2.1%

Juvenile Court (n = 68) Offense Type	Number of Clients	Percent (%)
Contact Offense	60	88.2%
Non-Contact In-Person Victim	5	7.4%
Non-Contact Anonymous Online Victim	2	2.9%
Other Crimes	2	2.9%
Non-Sex Crime w/ a History of a Sex Crime	0	0.0%

Return to Figure 8 main document

A.9. Percent of Treatment Clients in Each Risk Level Category at the Beginning of Treatment by Court (n = 638).

Adult Criminal Court (n = 574) Beginning Risk Level	Number of Clients	Percent (%)
High	73	13%
Low	173	30%
Moderate	145	25%
Moderate-high	66	12%
Moderate-low	117	20%

Juvenile Court (n = 64) Beginning Risk Level	Number of Clients	Percent (%)
High	2	3%
Low	19	30%
Moderate	17	27%
Moderate-high	4	6%
Moderate-low	22	34%

Return to Figure 9 main document

A.10. Percent of Treatment Clients in Each Risk Level Category at the End of Treatment by Court (n = 638).

Adult Criminal Court (n = 574) Ending Risk Level	Number of Clients	Percent (%)
High	109	19%
Low	276	48%
Moderate	49	9%
Moderate-high	55	10%
Moderate-low	84	15%

Juvenile Court (n = 64) Ending Risk Level	Number of Clients	Percent (%)
High	1	2%
Low	47	73%
Moderate	3	5%
Moderate-high	4	6%
Moderate-low	9	14%

Return to Figure 10 main document

A.11. Percent of Treatment Clients (from both Adult and Juvenile Courts) in Each Beginning Risk Level that Decreased, Maintained, or Increased Risk Levels by the end of Treatment (n = 638).

Beginning Risk Level	Number of Clients Decreased Risk	% of Clients Decreased Risk	Number of Clients No Risk Change	% of Clients No Risk Change	Number of Clients Increased Risk	% of Clients Increased Risk
High (n = 75)	22	29%	53	71%	0	0%
Low (n = 191)	0	0%	159	83%	32	17%
Moderate (n = 161)	86	53%	29	18%	46	29%
Moderate-high (n = 70)	34	49%	21	30%	15	21%
Moderate-low (n = 139)	71	51%	47	34%	21	15%

Return to Figure 11 main document

A.12. Treatment Outcomes by Court Type (n = 637).

Adult Criminal Court (n = 572) Treatment Outcome	Discharge Category	Number of Clients	Percent (%)
Successful, Tx. Completed	Successful	234	41%
Unsuccessful/Non-Compliant	Unsuccessful	186	32%
Administrative Transfer	Administrative	90	16%
Successful, Continued Tx. Needed	Successful	50	9%
Medical	Administrative	8	1%
Incompetency	Administrative	2	0%
Therapeutic Transfer	Administrative	2	0%

Juvenile Court (n = 65) Treatment Outcome	Discharge Category	Number of Clients	Percent (%)
Successful, Tx. Completed	Successful	47	72%
Unsuccessful/Non-Compliant	Unsuccessful	9	14%
Administrative Transfer	Administrative	6	9%
Successful, Continued Tx. Needed	Successful	3	5%

Return to Figure 12 main document

A.13. Percent of Clients with Successful Discharges by Beginning Risk Level (n = 635).

Beginning Risk Level	Number of Clients Successful Discharges	% of Clients Successful Discharges	Overall % of Clients Successful Discharge (All Clients)
High (n = 74)	17	23%	52%
Low (n = 192)	131	68%	52%
Moderate (n = 161)	78	48%	52%
Moderate-high (n = 69)	31	45%	52%
Moderate-low (n = 139)	75	54%	52%

Return to Figure 13 main document

A.14. Median Treatment Lengths for Treatment Clients by Discharge Type, Beginning Risk Level, and Court Type (n = 637).

Discharge Type	Median Treatment Length (Months)	Overall Median Treatment Length for All Clients (Months)
Administrative (n = 108)	12.8	19.1
Successful (n = 333)	27.3	19.1
Unsuccessful (n = 195)	8.9	19.1

Beginning Risk Level	Median Treatment Length (Months)	Overall Median Treatment Length for All Clients (Months)
High (n = 75)	8.3	19.1
Low (n = 192)	21.0	19.1
Moderate (n = 161)	21.1	19.1
Moderate-high (n = 69)	17.5	19.1
Moderate-low (n = 138)	22.1	19.1

Court Type	Median Treatment Length (Months)	Overall Median Treatment Length for All Clients (Months)
Adult Criminal Court (n = 572)	19.4	19.1
Juvenile Court (n = 65)	15.9	19.1

Return to Figure 14 main document

A.15. Number of Polygraph Clients by Referral Source (n = 1,688).

Referral Source	Number of Clients	Percent (%)
Probation	1130	66.9%
Parole/TASC	449	26.6%
Community Corrections	65	3.9%
DOC	28	1.7%
Private Attorneys	7	0.4%
Other	4	0.2%
County DHS/DYS	2	0.1%
Court	2	0.1%
Diversion	1	0.1%

Return to Figure 15 main document

A.16. Types of Disclosures Made During Adult and Juvenile Polygraph Exams (N = 3,052).

Adult Criminal Court (n = 2,993) Disclosure Type	Number of Clients	Percent (%)
No Admissions	1674	55.9%
Other	528	17.6%
Sexual Behavior	384	12.8%
Change of Circumstance/Risky Behavior	307	10.3%
Historical Information	284	9.5%
Sexually Abusive Thoughts, Feelings, & Attitudes	183	6.1%

Juvenile Court (n = 59) Disclosure Type	Number of Clients	Percent (%)
No Admissions	23	39.0%
Other	16	27.1%
Sexual Behavior	12	20.3%
Historical Information	8	13.6%
Change of Circumstance/Risky Behavior	4	6.8%
Sexually Abusive Thoughts, Feelings, & Attitudes	3	5.1%

Return to Figure 16 main document

A.17. Polygraph Exam Outcomes by Court Type (n = 3,050).

Adult Criminal Court (n = 2,992) Exam Outcome	Exam Outcome Category	Number of Clients	Percent (%)
No Deception Indicated / No Significant Response	Non-Deceptive	1758	58.8%
Deception Indicated / Significant Response	Deception Indicated	656	21.9%
No Deception Indicated/ No Opinion	Non-Deceptive	430	14.4%
Inconclusive / No Opinion	Inconclusive	148	4.9%

Juvenile Court (n = 58) Exam Outcome	Exam Outcome Category	Number of Clients	Percent (%)
No Deception Indicated / No Significant Response	Non-Deceptive	27	46.6%
Deception Indicated / Significant Response	Deception Indicated	22	37.9%
Inconclusive / No Opinion	Inconclusive	5	8.6%
No Deception Indicated/ No Opinion	Non-Deceptive	4	6.9%

Return to Figure 17 main document

A.18. Polygraph Exam Outcomes by Exam Type (n = 3,050).

Exam Type	% Deceptive Exams	% Inconclusive Exams	% Non-Deceptive Exams
Maintenance/Monitoring Exams (n = 2185)	19%	5%	76%
Sex History Exam (n = 668)	24%	5%	71%
Specific Issue (n = 140)	39%	12%	49%
Instant/Index Offense Exams (n = 52)	79%	10%	12%
Child Contact Screening Exam (n = 9)	22%	0%	78%
Other (n = 1)	100%	0%	0%

Return to Figure 18 main document

A.19. Percent of all Treatment Clients with Successful and Unsuccessful Discharge Types Over Years 1 through 4 of Data Collection.

Data Collection Year	% Successful	% Unsuccessful
Year 1	36%	40%
Year 2	40%	43%
Year 3	48%	39%
Year 4	51%	30%

Return to Figure 19 main document

A.20. Range of Problematic Sexual Behaviors Exhibited by Referrals to Approved Juvenile Providers.

Problematic Sexual Behaviors	**Provider Count**
Coercion/force	12
Digital fondling	19
Digital penetration	11
Oral contact	14
Oral penetration	13
Anal contact	10
Anal penetration	8
Penile-vaginal contact	12
Penile-vaginal penetration	8

Return to Figure 20 main document

A.22-27. Number of Adult and Juvenile SOMB Providers by County

COUNTY NAME	ADULT Treatment Providers	JUVENILE Treatment Providers	ADULT Evaluators	JUVENILE Evaluators	ADULT Polygraph Examiners	JUVENILE Polygraph Examiners
Adams	106	79	68	37	13	8
Alamosa	10	4	8	3	9	8
Arapahoe	97	75	65	40	14	9
Archuleta	8	6	7	6	3	2
Baca	6	5	4	3	2	2
Bent	6	5	4	3	3	3
Boulder	52	46	43	25	12	8
Broomfield	32	22	21	10	6	5
Chaffee	12	6	9	4	4	4
Cheyenne	6	5	5	4	2	2
Clear Creek	14	11	10	7	2	2
Conejos	5	2	4	1	1	1
Costilla	5	2	4	1	1	1
Crowley	10	6	6	3	2	2
Custer	5	1	5	0	1	1
Delta	13	9	8	1	4	4
Denver	134	112	87	52	14	7
Dolores	3	2	3	2	4	3
Douglas	70	54	46	30	10	6
Eagle	16	10	12	7	5	4
El Paso	85	56	36	15	9	6
Elbert	9	4	6	3	2	2
Fremont	69	15	20	7	6	5
Garfield	21	6	15	4	4	4
Gilpin	7	6	5	3	2	2

COUNTY NAME	ADULT Treatment Providers	JUVENILE Treatment Providers	ADULT Evaluators	JUVENILE Evaluators	ADULT Polygraph Examiners	JUVENILE Polygraph Examiners
Grand	6	5	5	3	2	2
Gunnison	3	1	1	0	3	3
Hinsdale	3	2	3	2	2	2
Huerfano	5	2	5	2	1	1
Jackson	2	1	2	1	1	1
Jefferson	99	88	61	41	16	9
Kiowa	5	2	3	2	1	1
Kit Carson	4	3	3	2	2	2
La Plata	7	4	6	4	5	4
Lake	6	2	4	2	1	1
Larimer	44	42	38	23	7	6
Las Animas	3	0	3	0	1	1
Lincoln	3	2	3	2	2	2
Logan	10	11	10	10	2	2
Mesa	36	15	17	4	5	5
Mineral	2	1	1	0	1	1
Moffat	6	3	4	2	3	3
Montezuma	9	5	8	4	5	4
Montrose	14	6	8	1	5	5
Morgan	11	10	12	8	3	3
Otero	6	3	4	1	2	2
Ouray	1	0	1	0	4	4
Park	13	7	9	5	2	1
Phillips	2	1	2	1	1	1
Pitkin	4	2	4	1	3	3
Prowers	6	5	4	3	1	1

COUNTY NAME	ADULT Treatment Providers	JUVENILE Treatment Providers	ADULT Evaluators	JUVENILE Evaluators	ADULT Polygraph Examiners	JUVENILE Polygraph Examiners
Pueblo	46	19	29	9	6	4
Rio Blanco	8	4	7	3	2	2
Rio Grande	5	2	4	1	1	1
Routt	11	5	9	4	4	4
Saguache	7	4	6	3	1	1
San Juan	4	2	4	2	3	2
San Miguel	1	2	1	0	2	2
Sedgwick	3	2	3	2	2	2
Summit	10	5	7	3	4	3
Teller	7	3	6	3	2	1
Washington	3	2	3	2	2	2
Weld	58	60	47	29	7	5
Yuma	6	5	5	4	2	2

Return to Figures 22-27 main document

A.28. **ODVSOM Shared Services Model and Organizational Chart 2023.**

Position	Staff Member
ODVSOM Program Director	Chris Lobanov-Rostovsky
ODVSOM Training and Special Project Coordinator	Taylor Redding
SOMB Program Coordinator	Raechel Alderete
SOMB Adult Standards Implementation Specialist	Erin Austin
SOMB Juvenile Standards Implementation Specialist	Paige Brown
SOMB Application and Compliance Review Coordinator	Reggin Palmitesso-Martinez
ODVSOM Documentation Specialist	Kelly Lippitt
ODVSOM Staff Researcher	Dr. Rachael Collie
ODVSOM Staff Researcher	Dr. Yuanting Zhang
ODVSOM Staff Researcher (0.3)	Alyssa Dalen
ODVSOM Program Assistant	Jill Trowbridge
DVOMB Program Coordinator	Jesse Hansen
DVOMB Implementation Specialist	Caroleena Frane
DVOMB Application and Compliance Review Coordinator	Brittanie Sandoval

Note: ODVSOM (Office Domestic Violence and Sex Offender Management) are shared staff that support both the SOMB (Sex Offender Management Board) and DVOMB (Domestic Violence Management Board).

Return to Figure 28 main document

Appendix B: SOMB Reauthorization Bill SB 24-164.

The Department of Regulatory Agencies (DORA) completed a Sunset Review of the SOMB in 2022, as per §24-34-104, C.R.S., and published its Sunset Report on October 14, 2022. The SOMB Reauthorization Bill, SB23-164, adopted the recommendations made in the report and added several further mandates.

The recommendations adopted from the sunset report are summarized as follows:

- Continue the SOMB for 5 years until September 1, 2028.

- Clarify that Supervision Officers are required to follow the SOMB Adult and Juvenile Standards and Guidelines when working with individuals convicted of sexual offenses and directing agencies that employ Supervising Officers to collaborate with the SOMB to develop procedures to hold accountable Supervising Officers who fail to do so.

- Repeal the limitation on the number of treatment providers given to adults or juveniles when choosing a provider, and direct that the supervising agency provide a complete list of treatment providers who have the expertise to work with the specific risks and needs of that adult or juvenile. The Supervising Officer shall make specific recommendations that take into consideration individual risk and needs, the ability of the treatment provider to accept new clients, the geographic proximity of the treatment provider, the nature of the programs offered, and any other relevant factors to the client's treatment needs, capability of the provider, and safety of the community. If the adult or juvenile has an intellectual or developmental disability, the supervising agency shall make a recommendation for a treatment provider approved by the SOMB to work with clients with intellectual disability/developmental disability. The exception to these changes is the Division of Youth Services which can assign juveniles to a treatment provider based on the juveniles' risk and needs and will have procedures in place to allow for a juvenile or family to seek a change in treatment provider based on responsivity factors.

- Beginning September 1, 2024, and every two years thereafter, the Board shall conduct compliance reviews on at least 10% of Approved Treatment Providers.

- Update the language concerning fingerprint collection as part of the SOMB approved provider application process to reflect the current practice of having a third-party vendor take and forward these to the Colorado Bureau of Investigation.

- Repeal of the Department of Regulatory Agencies' responsibility to publish a list of approved treatment providers.

The additional mandates included in the reauthorization bill are summarized as follows:

- Updates to the definitions for "adult sex offender", "juvenile who committed a sexual offense", and "sex offender". The changes involve that a "juvenile who committed a sexual offense" means a juvenile who was less than 18 years of age at the time the sexual offense was committed and who has either been adjudicated as a juvenile, received a deferred adjudication, or *been sentenced in the district court before 21 years of age*. The latter italicized aspect of the definition was added. The changes also include that the definition of a

"sex offender" for persons who have a prior sex offense only applies if a *discretionary* request by the prosecuting attorney or court for an evaluation leads the court to determine the person should undergo sex offender treatment.

- Requires programs implemented under the Adult and Juvenile Standards and Guidelines must ensure, to the extent possible, that treatment is responsive to the developmental status of the client at the time of treatment as well as their linguistic, cultural, religious, and racial characteristics; and sexual orientation, gender identity, and gender expression (per §24-34-301, C.R.S).

- Requires the SOMB, in collaboration with the State Parole Board, to revise the specific sex offender release guideline instrument on or before December 1, 2023, for use with sex offenders with determinate sentences. The revised release guideline must incorporate the concepts of Risk-Need-Responsivity or another evidence-based correctional model and be as flexible as possible to ensure that offenders have timely access to the necessary programs to prevent the offender harming victims or potential victims. The release guideline must not include the inability to access treatment during incarceration (when determined to be eligible) as a basis for denying parole. Additional considerations required relate to risk, effective use of limited resources, availability of treatment resources, and the efficacy of treatment as a condition of community supervision or parole.

- Requires the Department of Corrections to identify all inmates who are classified to undergo sex offense-specific treatment, eligible to receive said treatment, and have not been provided the opportunity to receive such treatment while incarcerated. The Department of Corrections shall also identify aggregate risk assessment scores, total treatment capacity, SOMB approved providers employed or contracted to the Department, frequency of treatment groups and cancellations of treatment groups, number of open positions, and efforts in the past five years to increase treatment capacity. The data must be reported to the SOMB on or before July 31, 2023.

- The SOMB shall form a subcommittee with representative stakeholders to study and develop solutions to address treatment resources for sex offenders who are incarcerated or in the custody of the Department of Corrections. The subcommittee shall present written findings in a report and proposal to the House and Senate judiciary committees on or before February 1, 2024. The specific directives for the subcommittee were:

    - Analyze the data provided by the Department of Corrections and identify inmates eligible to receive treatment, with priority towards inmates who are past parole eligibility date, have not been provided a treatment opportunity, and require treatment to meet community corrections or parole eligibility requirements.

    - Identify all barriers faced by the Department in providing timely access to treatment to meet parole eligibility requirements with recommendations for workable solutions to increase treatment access.

    - Determine which, if any, SOMB Standards and Guidelines are barriers to providing timely access to treatment and make recommendations concerning changes or

exceptions to the standard for sex offenders incarcerated in the Department of Corrections.

- Review and consider revisions to the Department of Corrections policies and administrative regulations to prevent unnecessary backlog in making treatment accessible to inmates who require treatment to meet parole eligibility requirements.

- Review the criteria under §18-1.3-1009 and revise policies of the Department of Corrections and administrative regulations to prevent unnecessary backlog in making treatment accessible to inmates who require treatment to meet parole eligibility requirements.

- Review parole guidelines for those inmates with determinant sentences and make revisions as necessary to prevent unnecessary backlog in making treatment accessible when required for parole eligibility.

- Determine whether additional treatment providers will contract with the Department of Corrections to provide evaluation or treatment services and make workable recommendations concerning how to immediately increase inmate access to those providers.

- Determine whether increased funding or any other resources could make access to telehealth treatment viable for inmates and the amount of increased funding or resources necessary to accomplish this goal.

- In consideration of any existing treatment backlog and finite treatment resources, make recommendations for procuring or making available sufficient treatment resources without negatively impacting public safety and protection of victims.

- Allows for the Department of Corrections to employ or contract with an individual or entity to provide sex offense-specific evaluation, treatment, or polygraph services if the director of the program is an SOMB Approved Provider, the Department operates an offense-specific treatment program and monitoring that conforms with the SOMB Standards and Guidelines, and the employee or contractor is trained to comply. Any individual providing offense-specific evaluation or treatment must have a baccalaureate degree or above and be a licensed mental health professional. Any individual providing polygraph examiner must have graduated from an accredited program and have a baccalaureate degree or higher.

Return to Appendix B main document

Appendix C: SOMB Committee Updates

1. **Executive Committee**
   Active
   Committee Chair: Kim Kline
   Committee Vice-Chair: Katie Abeyta

   Purpose: The SOMB Executive Committee reviews and maintains the mission of the SOMB, including discussing and preparing the monthly Board agenda consisting of presentations, action items, and decision items. The Executive Committee typically meets once per month.

   Major Accomplishments: The Committee met on 11 of the 12 months in 2023. The Committee managed the SOMB agenda and had oversight of the work occurring in the other committees. In addition, the committee monitored progress in implementing the requirements of the SOMB reauthorization bill and coordinated a Board retreat in October 2023 to facilitate relationship-building and shared engagement in the mission of the Board.

   Future goals: The Committee will continue to maintain the mission of the SOMB and monitor progress implementing outcomes of the reauthorization bill.

2. **Best Practices Committee**
   Active
   Committee Chairs: Hannah Pilla and Jennifer Harris

   Purpose: As per statute 16-11.7-103 (4) (b) (II) C. R. S., the Best Practices Committee informs, initiates, and makes recommendations to the Board and other Committees about implementing current research and best practices in and through revisions to the *Adult and Juvenile Standards and Guidelines*. The Committee also attends to other policy work, as requested. Per statute, at least 80% of the members of the committee are treatment providers. The Committee typically meets once per month.

   Major Accomplishments: The Committee met on 10 of the 12 months in 2023. The Committee reviewed and actioned a range of proposed revisions to the Adult and Juvenile Standards and Guidelines and discussed issues arising in the field. Actions included advising the Adult and Juvenile Standards Revisions Committee of issues to consider, forwarding proposed revisions to the Board for consideration, reviewing and addressing public comment, and returning proposed revisions to the Board for ratification. Highlights include:

   - Review of substantial revisions to the Adult Standards and Guidelines Section 2.000 Offense-Specific Evaluations. Additional review of proposed revisions to Section 3.000 Offense-Specific Treatment concerning appeals, evaluation timeframes, written progress reports, and competency standards.

   - Review of Appendix P adult sex history packet, children with problematic sexual behavior resource document, and Appendix E guidelines for the evaluation of adults and juveniles with sex offending history and a new non-sex crime.

- Review of revisions to the Juvenile Standards and Guidelines EDI guiding principle, and parts of Sections 2.000, 3.000, 5.000, and 9.000. Discussion of updates to the guidelines for adolescents published by the Association for Treatment and Prevention of Sexual Abuse.

- Discussion and clarification of legal precedent and Standards and Guidelines concerning contact of juveniles with minor siblings and adults with stepchildren who are not the victim of the offense.

Future Goals: The Committee will continue to review and provide feedback to the Adult and Juvenile Standards Revision Committees regarding proposed revisions to the *Adult and Juvenile Standards and Guideline*. The Committee will continue to initiate requests to other SOMB committees or establish dedicated subcommittees to address contemporary issues. The Committee will continue to review relevant and contemporary research to ensure the *Standards and Guidelines* adhere to and reflect evidence-based and best practices.

3. **Application Review Committee**
Active
Committee Chair: Carl Blake
Committee Vice-Chair: Jesse Hansen

Purpose: The Application Review Committee (ARC) reviews all new and re-applications for treatment providers, evaluators, and polygraph examiners. The Committee reviews complaints made against listed providers and conducts randomized or for-cause Standards Compliance Reviews. The Committee typically meets twice per month.

Major Accomplishments: The Committee convened 21 times during 2023. The Committee diligently reviewed applications from providers and addressed complaints. The Committee continued to monitor variances and the application process to ensure proper oversight of listed providers. The Committee implemented a new online application process to replace the former hybrid online and paper-based system. Highlights include:

- The Committee received complaints against 13 providers and successfully resolved these for eight providers. As well, the Committee successfully resolved complaints against three providers that were carried over from the previous year.

- Complaints were resolved by a finding of either dismissed (as not founded or outside of the purview of the SOMB) or founded. The remaining complaints are still under investigation, either by the Committee or the Department of Regulatory Agencies (DORA).

- The Committee performed four standards compliance reviews to evaluate if standards were being met and to require corrective actions where necessary.

- No appeals of the complaint resolutions or compliance reviews were lodged by providers or complainants in 2023.

- The Committee reviewed a complaint in which the alleged behavior did not violate current standards, however, the Committee determined that the raised concern was significant enough to warrant a review and possible revision of current standards. As a result, both

the *Adult and Juvenile Standards and Guidelines* were revised to address the complainants' concerns and to ensure there is adequate guidance moving forward.

Future Goals: Continue reviewing applications, complaints, and variances. Begin implementation of the new mandate to review 10% of providers every two years.

4. **Adult Standards Revisions**
   Active
   Committee Chair: Taber Powers
   Vice-Chair: Lauren Rivas

   Purpose: The Adult Standards Revision (ASR) Committee was reconvened in 2020 to review and revise the *Adult Standards and Guidelines* as needed to meet the legislative requirement that they are evidence-based. Revisions are also made to clarify information based on any feedback received from stakeholders. The Committee typically meets once per month.

   Major Accomplishments: The Committee met on 9 of the 12 months in 2023. The Committee established three workgroups so did not convene for two months to allow workgroups that involved most members of the Committee to meet. Highlights include:

   - Completed substantial revisions to the Adult Standards and Guidelines Section 2.000 Offense-Specific Evaluations, as well as revisions to several standards in Section 3.000 Offense-Specific Treatment concerning appeals, evaluation timeframes, written progress reports, and competency standards.

   - The Sex History Packet workgroup revised Appendix P Sex History Packet with particular attention to improving clarity about how to administer the sex history packet and rewriting concepts and language regarding normative sexual behavior that was inclusive of people with LGBTQ+ identities. The revised Sex history Packet was approved by the SOMB in 2023.

   - The Treatment Providers workgroup revised the standards for discharge summaries and treatment plans following concerns being raised about these areas of practice through the Adult Standards Revision Committee and Application Review Committee. The proposed revisions will continue to be moved through the Adult Standards Revision Committee, the Best Practices Committee, and the SOMB in 2024.

   - The Denial workgroup revised the standards for managing clients in denial to ensure it reflected research evidence and best practices. The proposed revisions will continue to be moved through the Adult Standards Revision Committee, the Best Practices Committee, and SOMB in 2024.

   Future Goals: The ASR Committee will complete the proposed revisions to Section 3.000 Standard of Practice for Treatment Providers coming from the Treatment Provider and Denial workgroups. The ASR will continue to review and revise standards related to polygraph examiners and polygraph examinations. The ASR will continue to implement updates to the wording and clarification of standards arising from the reauthorization bill, as well as continue to respond to emerging issues and requests from the BPC and Board.

5. **Juvenile Standards Revision Committee**

Active

Committee Chair: Carl Blake

Purpose: The Juvenile Standards Revision (JSR) Committee is responsible for reviewing and updating the *Juvenile Standards and Guidelines* as needed, based on emerging research and best practices. The Committee also makes revisions to improve clarity based on feedback from stakeholders. Meetings are typically held monthly or bimonthly.

Major Accomplishments: The Committee met 5 times in 2022 due to some of the revision work occurring outside of meetings and holiday conflicts. Highlights include:

- The Committee has adopted a more structured approach to its work cycle to simplify the process of providers implementing updates to the standards and guidelines. The Committee plans to revise the *Standards and Guidelines* between July and December, present these to the Board in January and February, and consider public feedback during this time. Final updates will be ratified in March or April. Providers will be required to implement the changes by the start of July, which allows time to notify providers of the changes and schedule any necessary implementation training. This cycle is intended to make it easier for providers to track changes by having all regular updates implemented at the same time, while still allowing for statutorily mandated changes to occur as necessary.

- The Committee systematically reviewed the ATSA[33] Practice Guidelines for Assessment, Treatment, and Intervention with Adolescents Who Have Engaged in Sexually Abusive Behavior, to identify any areas for potential update in the Juvenile Standards and Guidelines.

- The Committee completed revisions to the EDI guiding principle and other standards within Sections 2.000, 3.000, 5.000, and 9.000. The revisions ensure that cultural factors are explicitly considered when relevant, clarify certain aspects of evaluations regarding juvenile registration, and provide further clarification on various treatment and victim impact issues.

- The Committee has been working on revising the definition of a juvenile who has been adjudicated of a sexual offense to bring it in line with the changes mandated in the SOMB reauthorization bill. Additionally, the Committee is proposing to clarify the wording that indicates when a standard is required rather than recommended. The Committee is also proposing revisions to clarify and enhance the evaluation standards.

Future Goals: The Committee will finalize and implement the recommended revisions and embed the new work cycle.

[33] Association for Treatment and Prevention of Sexual Abuse

6. **Victim Advocacy Committee**
Active
Committee Chair: Katie Abeyta
Vice-Chair: Allison Boyd

Purpose: The Victim Advocacy Committee ensures that the SOMB remains victim-centered and that the *Adult* and *Juvenile Standards and Guidelines* address victim needs and include a victim perspective. The Committee typically meets once per month.

Major Accomplishments: The Committee met 11 times in 2023. The Committee reviewed and provided feedback on the recommended revisions to the *Standards and Guidelines* made by the Adult and Juvenile Standards Revision Committees and the Best Practices Committee. Highlights of other accomplishments include:

- Completion of a resource guide for victims that provides information about sex-offending treatment and supervision in Colorado and answers common questions. The resource guide is free to access on the SOMB website, *Understanding Sex Offender Treatment and Supervision in Colorado: A Resource Guide for Victims of Sexual Assault*.

- Surveying providers to gather information about their use of victim clarification interventions and their perspective on the role of the Victim Representative in the treatment teams. The survey is informing training to support and enhance the effectiveness of clarification and the role of the Victim Representative. The key findings were shared with the Board and other stakeholders.

- The Committee conducted a series of trainings on victim issues through various channels. These included organizing a Victim Panel at an SOMB meeting, facilitating interactive training on using victim clarification interventions with internet-facilitated sex offending at an SOMB meeting, and presenting a conjoint update with the DVOMB[34] Victim Advocacy Committee at the annual OVDSOM conference. These trainings were open to providers and other stakeholders for free and were eligible for training credit. The Committee also provided a lunch and learn training for providers on Victim Representation on Community Supervision and Multidisciplinary Teams.

- Coordinated and hosted a meeting with DVOMB Victim Advocates to facilitate networking and identify opportunities for combined projects and efforts.

Future Goals: The Committee aims to promote and distribute the victim resource guide. It intends to review the standards related to Victim Representatives in both the Adult and Juvenile Standards and Guidelines. As well, the Committee will consider issues related to resources for Victim Representatives and transitioning clients between systems as cases proceed through the criminal justice system. The possibility of evaluating the benefits and impact of victims working with Victim Representatives will be explored. Additionally, the Committee will continue to support the SOMB in maintaining a victim-centered approach to sex offender management and work toward increasing victim services stakeholder presence at committee and Board meetings.

[34] Domestic Violence Offender Management Board

7. **DV/SO Training Committee**
Active
Committee Chairs: Jesse Hansen and Nicole Feltz

Purpose: The Training Committee identifies training topics and objectives that support understanding and implementation of the SOMB *Standards and Guidelines* and the DVOMB *Standards and Guidelines*. The Committee helps define and assess the training needs of its stakeholders and collaborates with other agencies to develop trainers in specialized, needed areas. The Committee supports the planning of training events. The Committee typically meets monthly.

Major Accomplishments: The Committee met 11 times in 2023. The Committee prepared for and debriefed the 2023 Domestic Violence and Sex Offender Management Conference, which had 586 attendees. The conference was held in person, with a virtual option available for three months following the conference. The Committee oversaw the SOMB's other training events and provided a joint advanced series training to SOMB and DVOMB providers to understand intergenerational trauma for BIPOC clients.

Future Goals: The Committee is continuing to plan for training events, including the 2024 Domestic Violence and Sex Offender Management Conference. The Committee will explore opportunities to provide additional conjoint SOMB and DVOMB training events,.

8. **Sex Offender Surcharge Allocation Committee**
Active
Committee Chair: Lisa Mayer

Purpose: The Sex Offender Surcharge Allocation Committee makes recommendations to the SOMB about the allocation of money in the Sex Offender Surcharge Fund, and the coordination of such allocations with any money expended by any of the Departments to identify, evaluate, and treat adult sex offenders and juveniles who have committed sexual offenses. The Committee meets as needed.

Major Accomplishments: The Committee met and discussed account balances, revenues, expenditures, projected adjustments in future years, and agency needs. The Committee presented its recommended allocations for FY 2024-25 to the SOMB in September 2023, which were approved, as follows:

- $305,387 to the Division of Criminal Justice (DCJ) for administration and implementation of the Standards. This includes $245,387 for personnel, contract, and operation dollars, and $60,000 for FTE appropriated positions. $3,500 of these funds will be used to provide cross-system training. These dollars may be matched by grants as available.
- $453,044 to the Judicial Department for direct services, beginning with the funding of sex offender evaluations, assessments, and polygraphs required by statute during the pre-sentence investigation.
- $45,062 to the Department of Corrections to be used to manage sex offender data collection, including entry of ViCAP, psychological and risk assessment test results, and demographics for use in treatment planning and research (personnel, operating and POTS dollars for FTE appropriated positions).

- $57,350 to the Department of Human Services to be used for training and technical assistance to county departments, the Division of Youth Services, and the Division of Child Welfare.
- The total expenditure from the funds will be $860,843.
- When the above needs have been satisfied, additional dollars for direct services for additional sex offender treatment, polygraphs, or related services should be considered.

Future Goals: The Committee will meet as needed to create recommended allocations in 2024 for the 2025-26 financial year.

Return to Appendix C main document