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.

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Executive Summary

Pursuant to Section 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.

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 in support of ongoing committee work and the development of this report.

Section 1: Research and Evidence-Based Practices

Within the field of sexual offender treatment and management, the interest in evidence-based practice is increasing. Establishing the degree to which provided services are effective is an essential part of improving public policies aimed at reducing the risk for future sexual re-offense by identified adult sex offenders and juveniles who have committed sexual offenses.

- *Treatment Responsivity in Sex Offense-Specific Services*

  Treatment responsivity is the third principle of the Risk-Need-Responsivity (RNR) model. The principle proposes the mode and style of treatment should match the learning styles and characteristics of clients to facilitate engagement and behavioral change. Applying the responsivity principle means using therapeutic modes and styles *generally* supported by research as the starting point in treatment planning. For sex offense-specific rehabilitation, the research evidence predominantly supports the use of cognitive-behavioral treatments and a therapeutic style that is collaborative, structured, reasonably directive, and uses motivational strategies. The treatment responsivity principle further involves *additional* tailoring of generally supported therapeutic modes and styles to individuals' unique characteristics and circumstances. In this way, the responsivity principle recognizes that specific characteristics and circumstances may make it more or less likely that an individual with a sex offense conviction will engage and progress in treatment. The treatment responsivity principle complements the Risk and Need principles, and they are intended to be implemented together.

  A systematic search of the research literature was undertaken to identify treatment responsivity factors for adults convicted of sex offending. The main area addressed by the research was the factors that predict treatment attrition. Attrition represents the antithesis of treatment engagement and progress and signals significant treatment responsivity issues. Treatment attrition typically involves discharge due to serious behavior problems, such as persistent non-compliance with program requirements despite remedial attempts, significantly disruptive or aggressive behavior within treatment sessions or settings, and reoffending. Treatment attrition is of significant concern as it is a lost opportunity to benefit from treatment and is shown to be associated with higher rates of recidivism.

One meta-analysis on the predictors of attrition from sex offender treatment programs was conducted a decade ago. That meta-analysis found that treatment readiness factors (e.g., greater denial, lower motivation, and negative attitudes toward treatment), general criminality-antisociality, personality disorder, and lower aptitude (e.g., lower educational achievement) were most consistently predictive of treatment attrition. Subsequent research has supported and elaborated on these findings. Of note, lower aptitude appears less associated with attrition when programs are specifically designed for participants with high needs in this area or where the program has a significant therapeutic community component. Also, a mental illness diagnosis or acute symptoms was associated with attrition and lower levels of participation in some studies. Of note, research has not shown a direct or substantial association between the degree of sexually deviant interests and attrition. Being a member of an ethnic minority has been examined as a potential predictor of attrition in several studies, with most finding no direct or strong association between ethnic minority status and attrition. A significant limitation to advancing understanding of the relationship between ethnic-racial identity and treatment responsiveness, however, is the lack of systematic study that has been undertaken in this area.

- *SOMB Treatment Attrition Data Analysis*

  A data analysis project was undertaken to identify factors associated with behavioral non-compliant discharge from sex offense-specific treatment for adult clients using data recorded in the SOMB Provider Data Management System (PDMS). The data was analyzed for the period from January 2020 to February 2022. The final analytic sample had 867 records: 362 (42%) in the behavioral non-compliant discharge group and 505 (58%) in the compliant discharge group. The sample was almost all male and predominantly White. The average client age was 43 years. The average duration of treatment for the compliant discharge group was three years, while for the non-compliant discharge group, it was one year.

  Independent t-tests showed that the non-compliant discharge group had significantly more clients of minority racial-ethnic identity, younger age, and from urban settings. The non-compliant discharge group had a higher risk and a higher denial level. Several small differences were consistent with recognition by treatment providers of the greater risk, needs, and responsivity barriers present for clients in the non-compliant discharge group and attempts to meet these with available RNR strategies. Logistic regression statistical models were used to control for the potential inter-relationships among the variables and to determine their unique association with discharge when the other variables were held constant. Factors uniquely associated with membership in the non-compliant discharge group were being Hispanic or Asian, being urban, having a higher beginning risk level and less change in risk by the end of treatment, and having a greater number of treatment responsivity modifications (i.e., higher treatment responsivity needs). Greater treatment plan modifications were associated with less likelihood of a non-compliant discharge which appears to reflect a positive effect of efforts to adapt treatment to individual client needs.

  Additional analyses focused on factors associated with non-compliant discharge among lower-risk clients, who are typically expected to present fewer issues, and factors associated with compliant discharge among higher-risk clients, who are typically expected to present greater issues. For lower-risk clients, substance use, client factors, lack of community engagement, and greater denial significantly increased the odds of a non-compliant discharge compared to a

compliant discharge. Having a contact offense and treatment modifications to address risk was also significantly associated, perhaps reflecting that additional risk indicators were not initially captured in the pre-treatment evaluation. For the higher-risk group, greater time in treatment, treatment plan modifications, and fewer client responsivity barriers (client factors, substance abuse, and lack of community engagement) were significantly associated with a compliant discharge.

Overall, the analyses were consistent with previous findings in the research literature. The analyses confirmed that specific characteristics of clients differentiated those who were more or less likely to be discharged from treatment for non-compliant behavior. The findings will inform the emphasis the SOMB takes when revising the *Standards and Guidelines* and when addressing implementation support. Future work may include continuing the project with subsequently collected data and revising the data management system to refine responsivity items in future updates. An important caveat regarding the findings is that these results do not indicate recidivism. The non-compliant group had an average of one year of treatment before discharge which is still a potentially meaningful treatment dose. It will require recidivism outcome analyses to determine the nature of the relationship between non-compliant discharge and reoffending in this sample.

- *SOMB Data Collection Analysis:*

  The SOMB data collection project provides information to the SOMB, other affiliated stakeholders who may benefit from having critical information, and those who advocate for the clients who receive services. The SOMB data collection system received a significant amount of data entry in Year 3, demonstrating the continued commitment by Approved Providers to meet the requirements and support evidence-based research for the *Standards and Guidelines*. In particular, the number of evaluation and treatment completion data entries was comparable to Year 2. The total number of polygraph examination entries was lower and appears to reflect a degree of fatigue with a higher data entry burden experienced by polygraph examiners, which is something being addressed by the SOMB. Year 3 contained records for 427 evaluations, 539 completed treatments, and 2,992 polygraph examinations (of which 2,737 contained valid entries). Among the data records, 85% of the evaluations, 87% of the completed treatments, and 98% of the polygraph examinations were for clients subject to the Adult *Standards and Guidelines*. The remaining were for clients subject to the Juvenile *Standards and Guidelines*.

  Evaluation

  Among the 427 evaluation records, 62% had a contact offense, 17% had a current non-sex crime with a history of conviction for a sex crime, 9.4% had a non-contact in-person victim, and 4.7% had “other” sex crimes. The implementation of the RNR Principles was evident via the range of options used to gather assessment data and individualize recommendations according to risk level, treatment needs, and treatment responsivity. Typically, 3-4 standardized risk assessment instruments were used in evaluations, with the SOTIPS and the VASOR/VASOR-2 the most common adult instruments and the J-SOAP-II the most common juvenile instrument. Most juvenile clients were assessed as having low, low-moderate, or moderate risk of sexual recidivism. Most adult clients were also assessed as having low, low-moderate, or moderate risk, although the risk levels were more evenly spread from low to high. Over one-third of adult clients were assessed as having moderate-high (15%) or high-risk (19%).

Treatment Completion

Among the 539 records for completed treatment, 471 (87.4%) were for clients 18 and over, and 68 were for clients under 18. The clients' ethnic identities were 56% White, 27% Hispanic, 11% African American, 2% Alaska Natives/American Indians, and 0.6% Asian or Pacific Islanders. Over three-quarters of the clients had an offense of conviction or adjudication that involved a contact sexual offense (421; 78%), with the remaining involving a non-contact online offense (68; 11.3%), another non-contact offense (38; 7.1%), or a non-sex crime with a history of a sex crime (13; 2.4%). Incorporation of the RNR Principles by Approved Treatment Providers was evident via the options used to individualize treatment according to risk level, treatment needs, and treatment responsivity. Of note, client treatment needs were identified by using self-report methods (87%), discussion with the CST/MDT (87%), discussion with the support systems (80%), and review of records or collateral data (62%).

Among the treatment clients, most were classified as at low, low-moderate, or moderate risk of sexual recidivism, with more being at low risk by the end of treatment (i.e., 43% vs. 28%). A small proportion had a higher risk at the end of treatment. A successful discharge showed a clear relationship with risk level, with lower-risk clients having a high rate and higher-risk clients having a low rate of successful discharges. The proportion of clients with no or low denial increased by the end of treatment, while the proportion with moderate or high denial decreased. By the end of treatment less than 15% continued to show moderate or high denial compared with 35% at the beginning of treatment. Approximately half (261; 48%) of the discharged clients successfully completed treatment, reflecting an increase from Years 1 and 2. A further 16% had administrative-type discharges, and 35.6% (192) had a non-compliance discharge, reflecting fewer non-compliance discharges than in Year 2. The reasons for the non-compliance discharge showed a small increase in the number of clients committing new non-sexual and sexual crimes, consistent with a general upward trend in crime rates in Colorado and the US in association with the Covid-19 pandemic. The rate of successful discharge was higher for juvenile clients, while the rate of non-compliant discharge was low.

Polygraph Examination

Most of the 2,737 valid polygraph examination records were initial exams (77%; 2,119), while 23% (618) were retest examinations. Only a small number were conducted on juveniles (1.6%), consistent with revisions to the Juvenile *Standards and Guidelines* for polygraph examinations to only be used when clinically indicated. Over half (1,439; 52.6%) of the examinations resulted in clinically relevant disclosures during the pre-test, test, or post-test phases, approaching a 10% increase from Year 2. Of the clinically relevant disclosures, 500 (18%) indicated sexual behavior, 358 (13%) admitted historical information, 371 (13.6%) admitted changes of circumstance/risky behavior, and 371 (13.6%) admitted other behaviors of concern. Among adult court clients, 78% of the polygraph examinations were classified as non-deceptive consistent with most clients demonstrating accountability in their treatment and supervision process. Among the small number of juvenile court clients, 63% were classified as non-deceptive, while about one-third were found to have deception indicated. The rates of non-deceptive findings were 76% for Maintenance/Monitoring exams, 74% for Sex History exams, 54% for Child Contact Screening exams, 52% for Specific Issue exams, 8% for Index Offense exams, and 7% for Instant Offense exams.

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 reflect the recommendations of the Department of Public Safety.

Family First Prevention Services Act (FFPSA) and the Juvenile Standards and Guidelines

The Family First Prevention Services Act (FFPSA) is federal legislation passed in 2018. It seeks to focus child welfare services toward keeping children safely with their families rather than using out-of-home placements. The Act directs that the funds previously used to help with costs associated with foster care now be used primarily for children to remain in supported care with their parents or relatives. The SOMB Juvenile Standards Revision Committee recognized the potential for changes in juvenile residential placement at the State and local level under the FFPSA Act to have implications for Approved Providers and the Juvenile *Standards and Guidelines*. As out-of-home placements have often been part of best practices where juveniles are adjudicated for sexually harmful behavior against family members, a change in the policy and funding legislation may impact future case management. The Juvenile Standards Review Committee proposed revisions to two sections of the Juvenile *Standards and Guidelines*, specifically Sections 2.200 Evaluation and 9.310 Family Reunification. The general tenet of the proposed changes is to include discussion points that acknowledge the potential issues and provide guidance on best practices. Going forward, the Juvenile Standards Revision Committee will monitor the impact of the FFPSA and continue to work with stakeholders on policies and processes to support best practices with juveniles who have committed sexual offenses.

Housing Barriers for Registered Sex Offenders

Housing instability for persons on the sex offender registry represents a public safety concern. Persons on the sex offender registry face additional challenges in finding suitable, affordable housing, and research shows that housing instability is associated with higher rates of recidivism and return to prison. A recent study, for example, found that veterans on the registry had about twice the odds of housing instability and three times the odds of homelessness compared to other veterans. Another study of parolees with a sex offense conviction found that frequent housing moves were associated with greater rearrest and approximately doubled the odds of a return to prison for technical violations. Yet another study found that the odds of *sexual* recidivism were six times higher amongst persons on the sex offender registry who were transient compared to those who were not. One barrier to suitable, affordable housing is formal and informal residential restrictions. Although Colorado has no state-wide restrictions, several local municipalities have their own, and many landlords likely have restrictions. Research shows that housing instability increases after the passage of residential restriction laws, despite the research not supporting residential restrictions as an effective mechanism to reduce sexual recidivism. Instead, research shows that risk varies among persons on the sex offender registry, with the lowest risk group having less likelihood of arrest for new sex crimes than offenders without a sex offense history. The research also shows that risk declines substantially over time the longer persons on the registry live in the community successfully.

Housing instability threatens the effectiveness of sex offense-specific treatment in several ways. One consequence of residential restrictions is that available housing tends to be in the least desirable areas, where social disorganization, poverty, lack of social capital, poor quality housing stock, and crime are most prevalent. Further, this downward social impact disproportionately affects persons

from ethnic-racial minority groups. Residing in more socially disorganized communities exacerbates limited employment opportunities, reduces access to treatment services, and challenges developing positive social support networks, all of which play a part in developing a prosocial lifestyle. Offender treatment readiness models recognize that treatment engagement and progress depend on *both* internal characteristics like motivation *and* living in an environment where changes are possible and supported. As a comparison, in the behavioral health field, housing issues are given greater recognition as a barrier to treatment engagement, and the current best practice is to address both housing and treatment needs concurrently. The extent of housing instability and homelessness for persons on the sex offense registry in Colorado does not appear to have been systematically documented or examined to date. Nonetheless, a recent query with the Colorado Bureau of Investigation found that the Colorado Sex Offense Registry recorded 5-6% of currently registered sex offenders as homeless or transient. That rate is consistent with recently published reports for California and Florida where housing instability for persons on the sex offender registry is considered a significant problem.

To help counter misunderstanding, stigma, and exaggerated fears, the SOMB produced a variant of a research-based white paper consisting of a research-based informational handout titled *Housing Barriers for Sex Offenders* that is suitable for use by SOMB Approved Providers, justice agencies, and persons with a sex offense conviction. The handout outlines basic facts and key research on individuals with a sex offense conviction, including information on risk, recidivism, reintegration, and housing that encourages a reasoned approach to decision-making. The SOMB also produced a short PowerPoint presentation to support the handout. In the future, the SOMB will consider adding questions about client housing instability in updates to the SOMB Provider Data Management System to enable future analyses to evaluate whether housing instability has a moderating effect on treatment attendance, progress, or recidivism. The SOMB is also examining whether it is possible to report on the rates of housing instability in the Annual Lifetime Supervision Report. More broadly, the SOMB would support annual or biannual data collection efforts by other government stakeholders, so the rates of housing instability among persons on the sex offender registry could be documented and tracked over time. Such data collection efforts would allow the potential impact of broad housing initiatives or social policies to be assessed and allow other agencies to have readily available information to consider when developing housing policies or programs.

SOMB 2022 Sunset Review

The Colorado Department of Regulatory Agencies published its Sunset Report of the SOMB on October 14th, 2022. The report contained six recommendations that will be reviewed by the Legislature:

1. Continue the Sex Offender Management Board for seven years, until 2030.

2. Clarify that supervising officers are required to follow the *Standards and Guidelines* when working with sex offenders and direct those agencies that employ supervising officers to collaborate with the SOMB in developing procedures to hold accountable those who fail to do so.

3. Repeal the limitation on the number of treatment providers given to offenders and provide every available listed treatment provider.

4. Require standards compliance reviews on at least 10% of approved providers every two years.

5. Modernize language related to criminal history record checks and fingerprinting requirements.

6. Repeal the requirement that the Department of Regulatory Agencies participates in the publication of the list of approved providers.

Section 3: Milestones and Achievements

A highlight of the many achievements of the SOMB in 2022 are:

- Appointed seven new Board members and reached full Board membership of 25 representatives.
- Updated SOMB policy on gathering formal public comment.
- Celebrated SOMB 30th Anniversary.
- Continued emphasizing and integrating Equity, Diversity, and Inclusivity (EDI) throughout SOMB processes.
- The SOMB Family Education, Engagement, and Support Working Group published a *Resource Guide for Families of Adults Accused, Charged, or Convicted of Sexual Offenses in Colorado.*
- Completed a provider recruitment and retention project.
- Continued to adapt the way the SOMB conducts business in response to the COVID-19 pandemic, moving to a hybrid model for meetings, training, and conference.
- Managed 14 SOMB committees and workgroups.
- Approved 185 applications for placement or continued placement on the SOMB Approved Provider List during 2022.
- As of November 2022, there are **246** adult treatment providers and **185** juvenile treatment providers approved by the SOMB in Colorado. There are **28** adult polygraph examiners and **15** juvenile polygraph examiners.
- Reorganized the ODVSOM office structure to utilize a shared services model and support the implementation of the *Standards and Guidelines*.
- Reviewed the extent that the criteria in the Adult and Juvenile *Standards and Guidelines* are supported by evidence-based and research-informed sources.
- Supported implementation through multiple communication strategies, training, and individualized technical assistance. Continued to support the work of the SOMB committees and workgroups, as well as the implementation of the *Standards and Guidelines* by the provider community, by providing research literature reviews on topics being addressed.
- Conducted 26 training events with over 1,650 attendees from across Colorado. The events covered a range of topics related to the evaluation, treatment, and supervision of

individuals convicted of or adjudicated for sexual offenses. In addition, the SOMB provided over 10 presentations at SOMB monthly meetings.

- Published the 2023 SOMB Annual Legislative Report and the 2022 Lifetime Supervision of Sex Offenders Annual Report.

Section 4: Future Goals and Direction

- Continue to focus on executing its statutory duties and supporting service providers to implement the *Standards and Guidelines* with fidelity.

- Begin Phase II of the data collection project and examine longer-term outcomes for individuals who received offense-specific treatment in Colorado, including recidivism.

- Implement the new online SOMB Approved Provider application and complaint processes through the Provider Data Management System.

- Fully operationalize the ODVSOM shared services office model to evolve implementation support, research-informed practice, and administrative functions.

- Continue revisions and changes to the SOMB *Standards and Guidelines* to keep pace with emerging research and literature.

- Continue supporting current projects led by the Victim Advocacy Committee to ensure victim clarification procedures and the Victim Advocate role are being optimized for the benefit of victims.

Introduction

Purpose

Pursuant to Section 16-11.7-109 (2), C.R.S.,[1] 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 regarding 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 2022 achievements and current efforts being undertaken by the SOMB.

Background of the Sex Offender Management Board

In 1992, the Colorado General Assembly passed legislation (Section 16-11.7-101 through Section 16-11.7-107, C.R.S.) that created 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*). The General Assembly changed the name to the Sex Offender Management Board (SOMB) in 1998 to more accurately reflect the duties assigned to the SOMB. The *Adult Standards and Guidelines* were originally drafted by the SOMB over a period of two years and were first published in January 1996. The *Adult Standards and Guidelines* applied to convicted adult sexual offenders under the jurisdiction of the criminal justice system. From the beginning, the *Adult Standards and Guidelines* were designed to establish a basis for systematic management and treatment of adult sex offenders. The legislative mandate to the SOMB and the primary goals of the *Adult Standards and Guidelines* are 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, and 2022.

In 2000, the Colorado General Assembly amended and passed legislation (16-11.7-103, C.R.S.) that required the SOMB to develop and prescribe a standardized set of procedures for the evaluation and identification of juveniles who committed sexual offenses. The *Standards and Guidelines for the*

[1] C.R.S.16-11.7-109 (2): 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.

Evaluation, Assessment, Treatment and Supervision of Juveniles Who Have Committed Sexual Offenses (henceforth referred to as the *Juvenile Standards and Guidelines*) was first published in 2003, and subsequently revised in 2008, 2011, 2014, and 2017. As with the *Adult Standards and Guidelines*, the *Juvenile Standards and Guidelines* continue to hold public safety as a priority, specifically the physical and psychological safety of victims and potential victims.

Both the *Adult* and *Juvenile Standards and Guidelines* are now continuously revised in real-time on the SOMB website, updating each section with new changes as they are approved. Between 2017 and 2022, a number of revisions were made to each document. These revisions addressed omissions in the prior versions and incorporated the growing literature on sex offender treatment and management.

The *Adult* and *Juvenile Standards and Guidelines* are both specifically designed to establish a framework for the systematic risk management, assessment, and clinical treatment of adults and juveniles who have committed sexual offenses. The *Adult* and *Juvenile Standards and Guidelines* support a comprehensive range of therapeutic modalities and interventions for identified treatment needs, along with behavioral monitoring strategies for improved supervision based on risk level. This systemic approach fulfills a two-fold purpose: (1) managing and reducing sexually abusive risk behavior, while also (2) promoting protective factors that enable an offender's success.

The *Adult* and *Juveniles Standards and Guidelines* support a coordinated approach in which a Community Supervision Team (CST) for adult sex offenders, or a Multi-Disciplinary Team (MDT) for juveniles who have committed sexual offenses, provide an individualized treatment and supervision plan that targets both psycho-social deficits and potential risk factors, while concurrently building upon the resiliency and positive traits inherent in the person. To be effective, this approach must include interagency and interdisciplinary teamwork. The CST and MDT commonly consist of a supervising officer, treatment provider, victim representative, polygraph examiner, and other adjunct professionals, where applicable. CST and MDT members, independent of each other, possess critical expertise and knowledge that once shared can enable improved decision-making among the team. This enhances not only public safety but the supervision and accountability of the individual under supervision.

The *Adult* and *Juvenile Standards and Guidelines* are based on research and best practices for managing and treating adult sex offenders and juveniles who have committed sexual offenses. To the extent possible, the SOMB has based the *Adult* and *Juveniles Standards and Guidelines* on evidence-based practices in the field. However, the specialized field of sex offender management and treatment is still developing and evolving. Professional training, literature reviews, and documents from relevant professional organizations have also been used to direct the *Adult* and *Juveniles Standards and Guidelines*. The SOMB will continue to modify the *Adult* and *Juveniles Standards and Guidelines* periodically on the basis of new empirical findings.

In part, the SOMB stays current on research through the work of its active committees. These committees meet on a regular basis and report back to the SOMB to inform potential modifications 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 Committee
9. Sex Offender Registration Legislative Work Group

Report Organization

This annual legislative report consists of four sections. The first section provides a summary of the current and relevant literature concerning research and evidence-based practices. The second section highlights relevant policy issues. The third section highlights the 2022 achievements of the SOMB. This section will include priorities identified by the SOMB, which will be addressed in 2023. The fourth and final section provides the future goals and directions of the SOMB.

Section 1: Research and Evidence-based Practices

Treatment Responsivity in Sex Offense-Specific Services

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. The SOMB is tasked with developing these *Standards and Guidelines* in an objective and research-informed manner. The current treatment philosophy mandated in the Act and embodied in the SOMB is the Risk-Need-Responsivity (RNR) model. The RNR model is consistent with an approach to policy that seeks standardization of treatment for those convicted or adjudicated of sexual offending whilst affording individualization to specific characteristics and circumstances. As part of developing and amending the *Standards and Guidelines* to ensure they reflect evidence-based best practices, it is important to conduct reviews of the relevant research literature. In 2022 a comprehensive research review on treatment responsivity factors was conducted.

Treatment responsivity is the third principle of the RNR model (Andrews & Bonta, 2010; Andrews, Bonta, & Hoge, 1990; Bonta & Andrews, 2017). The principle proposes that the mode and style of treatment should match the learning styles and characteristics of clients to facilitate engagement and behavioral change. An example of the responsivity principle is adapting the pace and complexity of treatment sessions to be suitable for individuals with cognitive or learning disabilities. In such instances, similar problems may be addressed through treatment, but how they are addressed may vary. The responsivity principle also allows for the development of programs designed to specifically address a responsivity factor shared by a subgroup, such as the development of a deniers' program for when individuals categorically deny their offending despite having a conviction for sex offending or the development of culturally adapted programs for individuals from specific racial-ethnic heritages.[2]

The responsivity principle recommends the use of therapeutic modes and styles that are *generally* supported by research as the starting point in treatment planning. For sex offense-specific rehabilitation, the research evidence predominantly supports the use of cognitive-behavioral treatments and a therapeutic style that is collaborative, structured, reasonably directive, and uses motivational strategies (Hanson, Bourgon, Helus & Hodgson, 2009; Marshall et al., 2003; Marshall & Serran, 2004). The treatment responsivity principle further recommends *additional* tailoring of generally supported therapeutic modes and styles to the unique characteristics and circumstances of individuals. In this way, the responsivity principle recognizes that certain characteristics and circumstances may make it more or less likely that an individual with a sex offense conviction will engage and progress in treatment. The treatment responsivity principle complements the risk and need principles, and they are intended to be implemented together. The risk principle recommends that

[2] The term culturally adapted refers to the use of language, symbols, examples, and rituals from the clients' cultural-racial heritage within treatment, so treatment is better matched with the client's cultural heritage and lived experience (Lau, Chang, Okazaki, & Bernal, 2016).

treatment intensity is matched to individuals' recidivism risk level such that as the risk level increases, so does the intensity and amount of treatment and management.[3] The need principle recommends that treatment targets the psychological and behavioral factors that are shown in research to be associated with higher rates of recidivism; these are commonly called dynamic risk factors or criminogenic needs.[4]

The SOMB Adults Standards Revision Committee requested a review of the treatment responsivity research literature to inform work on revisions to the Adult *Standards and Guidelines* Section 2.000 Standards for Sex Offense-Specific Evaluations. A review was presented on February 17, 2022. The literature review was also applicable to pending work on Section 3.000 Standards for Sex Offense-Specific Treatment and informed a preliminary analysis of SOMB data on client discharge status. The following section summarizes the main findings from the literature review and the implications for sex offense-specific evaluations and treatment. The section after that summarizes the SOMB preliminary research analysis on client treatment completion and attrition.

Summary of Literature and Research

For this review, a systematic search of the research literature was undertaken with a preference for research articles published in the last 10 years. A total of 20 empirical research studies were analyzed. As the review focused on treatment responsivity in adults convicted of sexual offending, it may not be generalizable to juveniles. Of note, research on the responsivity principle is also less well-developed than the research on either the risk or need principles of the RNR model (Higley, Lloyd, & Serin, 2019; Hubbard & Peeler, 2009). Nonetheless, a research base exists from which to inform evidence-based treatment responsivity standards.

The main area addressed in the research was the factors that predict treatment attrition. Treatment attrition refers to not completing a program and, in some instances, dropping out from a program before it starts. Attrition represents the antithesis of treatment engagement and progress and signals significant treatment responsivity issues. Treatment attrition can be due to voluntary withdrawal, although it typically involves discharge due to serious behavior problems. Such problems include persistent non-compliance with program requirements despite remedial attempts, significantly disruptive or aggressive behavior within treatment sessions or settings, and reoffending. Treatment attrition is of significant concern as it is a lost opportunity to benefit from treatment and is shown to be associated with higher rates of recidivism (Hanson et al., 2002; Lösel & Schmuker, 2005). To a lesser extent, the other area addressed in the research were factors that affected therapeutic alliance, participation, and progress toward goals. More variability existed within the design of that research, but the findings were consistent with those for attrition and lend support for broad overall conclusions.

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[3] Typically, a greater dose and intensity of treatment is achieved through more treatment-related contacts per week and over a longer period, whereas a lower dose and intensity is achieved with fewer treatment contacts over a shorter period. To help practitioners determine the appropriate dose and intensity of treatment, guidelines exist (e.g., Hanson et al., 2017) and practitioners can measure progress against treatment goals determined from the evaluation.

[4] The RNR model distinguishes between criminogenic needs and non-criminogenic needs. Criminogenic needs are the dynamic risk factors shown in research to be associated with recidivism (repeat sexual offending) by convicted sex offenders. Non-criminogenic needs are the other psychological and behavioral problems or treatment needs that may be present for the offender but that are not supported by research as having a strong association with recidivism. The RNR model contends that criminogenic needs should receive the most focus within a treatment program, as it is change in these factors that is expected to lead to reduced recidivism risk.

One meta-analysis on the predictors of attrition from sex offender treatment programs has been conducted. That meta-analysis found that the average attrition rate from sex offender programs was 29% (Olver, Stockdale, & Wormith, 2011). The rate was similar to that found for general correctional programs and less than that found for domestic violence treatment programs. Amongst the wide range of factors examined in this meta-analysis, treatment readiness factors, general criminality-antisociality, personality disorder, and lower aptitude were most consistently predictive of treatment attrition. Within the category known as *treatment readiness factors* were greater denial, earlier stages of change[5], lower motivation, negative attitudes toward treatment, poor treatment engagement, and indicators of lower self-efficacy.[6] Within the category of general criminality-antisociality was greater antisocial orientation, nonsexual violent offending, any offending, and greater antisocial-psychopathic personality traits. Within personality disorders was any personality disorder, particularly antisocial personality disorder and psychopathy. Within the category of lower aptitude was lower intelligence, lower educational level, and greater unemployment. Overall, treatment attrition was associated with greater recidivism rates than treatment completion.

Subsequent research has supported and elaborated these main meta-analytic findings. In particular, treatment readiness factors, criminality-antisociality, and personality disorder have continued to been shown to be associated with treatment attrition and indicators of poor program engagement (e.g., Bosma, Kunst, Dirkzwager, & Nieuwheerta, 2017; Carl, & Lösel, 2021; Hatcher & Roberts, 2019; Higley, Lloyd, & Serin, 2019; Howard, de Almeida Neto, & Galouzis, 2019; O'Brien & Daffern, 2017; Stinson, Becker, & McVay, 2017; Stück, Broken, & Brunner, 2021; Sturgess et al., 2016; Topp, Olver, & Jung, 2019). Lower aptitude (e.g., low educational achievement) has also been supported in some studies but not universally (e.g., Beyko & Wong, 2005; Carl, & Lösel, 2021; Howard, de Almeida Neto, & Galouzis, 2019; Stinson et al., 2017; Stück et al., 2021). It appears aptitude has less influence on engagement and attrition when programs are specifically designed for participants who present high need in this area, or where the program has a significant therapeutic community component. Although mental illness did not emerge as a significant predictor of attrition in the meta-analysis, more recent studies have shown that a mental illness diagnosis or acute symptoms is associated with attrition and lower levels of participation (Stinson et al., 2017; Sturgess et al., 2016; Topp et al., 2019).[7] Although younger age has been associated with attrition in some studies (Howard et al., 2019; Stück et al, 2021; Topps et al., 2019), the effect is small and probably reflects that younger age is also associated with general antisociality and psychological immaturity. Research has also not shown a direct or substantial association between the degree of sexually deviant interests and attrition (e.g., Howard et al., 2019; Olver et al., 2011; Olver & Wong, 2011; Stück et al, 2021).

Being a member of an ethnic minority has been examined as a potential predictor of attrition in several studies, with most finding no direct or strong association between ethnic minority status and attrition

[5] The Stages of Change Model (Prochaska, DiClemente, & Norcross, 1992) describes readiness to change behavior through various stages. It was developed in the substance addiction field but has been applied widely within behavioral health and offender rehabilitation. In the earliest stages of the model there is pre-contemplation (i.e., there is no intention to take actions to work on treatment needs or change) and contemplation ((i.e., there is some stated intention to take actions to work on treatment needs or change but there also ambivalence).

[6] Self-efficacy refers to the belief in one's own capacity to act in the ways necessary to achieve a specific goal such as addressing a specific problem or complete treatment.

[7] One recent study also found a small association between greater adverse childhood experiences and treatment non-completion (Willis & Levenson, 2021), that is potentially explained by an association between adverse childhood experiences and the presence of mental health problems.

(e.g., Beyko & Wong, 2005; DeSorcy, Olver, & Wormith, 2014; Howard et al., 2018; Olver et al. 2011; Olver & Wong, 2011). This contrasts with the small effect typically found in other violent or general offending treatment programs (e.g., Olver et al. 2011; Ternes, Richer, & Farrel, 2020). One study associated Indigenous ancestry with a lower therapeutic bond, but this did not translate into greater attrition or a direct impact on recidivism outcomes (DeSorcy et al, 2014). Notwithstanding this lack of positive findings, language and culture barriers are generally recognized as something that can impede participation and progress in evaluation and treatment (Barber-Rioja & Rosenfeld, 2018; Carl, & Lösel, 2021; Sue, Sue, Neville, & Smith, 2019; Weiss & Rosenthal, 2012). In keeping with this, a small meta-analysis of a broad range of offender programs found some preliminary support for culturally relevant programs being more effective for indigenous offenders than generic programs (Gutierrez, Chadwick, & Wanamaker, 2018). A significant limitation to advancing understanding of the relationship between ethnic-racial identity and treatment responsiveness is the lack of systematic study that has been undertaken in this area.

SOMB Treatment Attrition Data Analysis

The SOMB Provider Data Management System (PDMS) affords the opportunity to examine attrition outcomes for sex offense-specific treatment in Colorado. Approved Treatment Providers have entered client treatment completion data since January 1, 2020, which includes treatment discharge. The data analysis aimed to examine the factors recorded in the PDMS that were associated with discharge for serious behavioral non-compliance from adult sex offense-specific treatment.[8] A non-compliant discharge is the PDMS category most consistent with attrition studied in treatment responsivity and outcome research. The findings from these analyses may inform future revisions to the Adult *Standards and Guidelines* and implementation support strategies. The findings may also inform future revisions to data recorded in the PDMS. To provide a comparison group, adult clients who successfully completed treatment or were complying but had a type of administrative discharge were combined into a single compliant discharge comparison group.

The analyses sought to:

1. Identify factors from the SOMB PDMS associated with behavioral non-compliant discharge from sex offense-specific treatment for adult clients.

2. Among the lower-risk adult clients, identify factors from the SOMB PDMS that contributed to behavioral non-compliant discharge. The purpose was to identify responsivity factors that interfered with compliance in lower-risk clients who are typically expected to present fewer issues.

3. Among the higher-risk adult clients, identify factors from the SOMB PDMS that contributed to compliant discharge. The purpose was to identify protective factors and strengths that aided treatment responsivity and compliance in higher-risk clients who are typically expected to present greater issues.

[8] The decision to focus on adults and exclude juveniles at this stage was twofold: (i) separate analyses would be necessary to sufficiently consider developmental and service delivery issues for juveniles that are unique from adults, and (ii) a substantially higher proportion of adults have a non-compliant discharge than juveniles (for whom non-compliant discharge is extremely uncommon in the data available on the PDMS).

Method

The data was extracted from the SOMB PDMS for the period January 2020 to February 2022 and aligned closely with the first two years of SOMB client data described in the 2022 SOMB Annual Legislative Report. The data was entered at the time of discharge by Approved Treatment Providers and included demographic, offense, risk, treatment-related information, and discharge reason.[9] The initial dataset contained 1,191 client records, of which 867 had complete data and made up the final analytic sample.[10] The final sample contained 362 (42%) clients in the behavioral non-compliant discharge group and 505 (58%) clients in the compliant discharge group.[11] All data analysis was completed using SPSS Statistics (Version 28) and should be considered preliminary.

Results

Table 1. Descriptive Statistics for Demographic Characteristics with Between Group Statistical Comparisons.

Variable	Total (N=867) % or M (SD)	Compliant (n=505) % or M (SD)	Non-compliant (n=362) % or M (SD)	T-Test Statistic *p value*
Male	96%	87%	95%	<.001
Race				
White	63%	72%	57%	<.000
Black	9%	6%	12%	<.001
Hispanic	25%	19%	28%	<.001
Asian	3%	3%	3%	.63
Age (20-92 yrs.)	43.48 (13.78)	45.89 (14.20)	39.38 (12.13)	<.001
DD/ID	5%	4%	7%	.07
Urban	34%	30%	37%	.01
Rural	66%	70%	63%	.01

Source of Data: SOMB PDMS Year 1 and 2 data. M = Mean, SD = Standard Deviation
DD/ID = Developmental/Intellectual Disability

Table 1 shows the distribution of demographic characteristics for the total sample and the compliant and non-compliant discharge groups. As shown, the sample was almost all male and predominantly White. The average client age was 43 years, with two-thirds falling between 30-57 years. Independent t-tests indicated the non-compliant discharge group had significantly more minority racial-ethnic clients (Black and Hispanic), younger clients, and urban clients than the compliant discharge group.

[9] The main types of discharge were (i) successful completion of treatment, (ii) behavioral non-compliance including violating treatment contract or terms and conditions of supervision, new non-sexual crimes, and new sexual crimes, and (iii) administrative reasons namely administrative transfer, medical discharge, lack of progress or non-amenable to treatment, maximum benefits, administrative reasons, incompetency discharge, therapeutic transfer, DYS aged out of system, and unknown reasons.

[10] A review of the descriptive statistics for the initial versus final analytic sample indicated no significant differences between the two, consistent with missing data being random.

[11] The compliant discharge group had 368 with a successful treatment completion discharge and 141 with an administrative discharge.

The non-compliant discharge group also had more clients with developmental or intellectual disabilities, although the difference did not reach statistical significance. The results indicated significantly fewer females had a behavioral non-compliant discharge than males, although females were only a small proportion of the total clients.

Table 2 shows the distribution of treatment, risk, and responsivity data variables for the total sample and the complaint and non-compliant discharge groups.[12] As expected, the duration of treatment differed significantly with the compliant discharge group spending just under 3 years on average in treatment and the non-compliant discharge group spending 1 year on average in treatment. The non-compliant discharge group had a higher beginning risk level on average, that marginally increased by discharge. A greater proportion of the non-compliant discharge group had an unrelated victim, a contact offense, and had undertaken previous sex offense-specific treatment, all of which are consistent with a higher initial risk level. The non-compliant discharge group also had a higher denial level at the beginning of treatment, and this changed less by the end of treatment compared to the compliant discharge group. Several small differences between the non-compliant and compliant discharge groups were found related to modifications of treatment. These appear to show recognition by Approved Treatment Providers of the greater risk, needs, and responsivity (RNR) issues present for the non-compliant discharge group and attempts to meet these with available RNR strategies.

The analyses shown in Tables 1 and 2 involve independent comparisons only and do not consider the potential interactions and inter-relationships among the variables studied. Logistic regression statistical models provide a method of examining the extent that each of the variables *uniquely* predicted membership of the non-compliant discharge group when the other variables were held constant. Table 3 shows the results of logistic regression analyses with demographic, treatment, risk, and responsivity variables entered as potential predictors. Logistic regression produces an Odds Ratio statistic that indicates the probability that an event will occur when a variable is present compared to the probability it will occur when the variable is absent. In these analyses, an Odds Ratio > 1 shows that a non-compliant discharge was more probable when that variable was present, while an Odds Ratio < 1 shows that a non-compliant discharge was less probable when that variable was present.

Table 3 shows that demographic variables, treatment duration, risk, and treatment responsivity modifications significantly added to the prediction of non-compliant discharge. Being Hispanic or Asian significantly increased the likelihood of non-compliant discharge, although the relatively small number of Asian clients in the sample may have influenced the magnitude of the effect found. Being urban also increased the likelihood of non-compliant attrition, as did having a higher beginning risk level and less change in risk by the end of treatment. Denial at the beginning of treatment failed to have a unique effect when the other variables were controlled, although less change in denial potentially had a small effect. Having a greater number of treatment responsivity modifications was associated with non-compliant discharge and reflects that these clients presented more treatment responsivity needs. Having a modified individualized treatment plan was associated with less likelihood of a non-complaint discharge and appears to indicate that efforts to adapt treatment to be more responsive to client needs had a positive effect. Overall, the logistic regression model accounted for 67% of the variance in discharge outcomes.

[12] The variables are single items entered by Providers as binary data, either present or absent. For some variables change scores were calculated. The variables are organized in the tables into subcategories based on conceptual alignment with the RNR model for ease of interpretation of the findings.

Table 2. Descriptive Statistics for Treatment Variables with Between Group Statistical Comparisons

Variables	Total (N=867) M (SD) or %	Compliant (n=505) M (SD) or %	Non-compliant (n=362) M (SD) or %	T-Test p value
Duration Treatment (range 0 to 23.5 years)	2.15 (2.09)	2.87 (2.36)	1.07 (1.18)	<.001
Previous Sex Offense-Specific Treatment	46%	37%	51%	<.001
Current Adjunct Substance Use Treatment	.21	14	29	<.001
Risk-Offense Characteristics				
Beginning Risk (Range 1 Low to 5 High)	2.67 (1.39)	2.45 (1.30)	3.07 (1.37)	<.001
Risk Change (range -4 to 4)	.16 (1.42)	.78 (1.19)	-.71 (1.23)	<.001
Unrelated Victim	.64	53%	68%	<.001
Contact Offense	.71	62%	73%	<.001
Victim less than 15	.59	55%	58%	.30
Denial Level				
Beginning Denial (Range 0 None to 3 High)	1.33 (.93)	1.24 (.92)	1.45 (.97)	<.001
Change Denial pre-post (range -2 to 3)	.52 (.77)	.63 (.79)	.32 (.67)	<.001
Treatment Risk-Related Modifications				
Adjust frequency of treatment services	58%	52%	52%	.81
Modification to supervision conditions	10%	8%	12%	.02
Recommended modify supervision conditions	9%	8%	9%	.26
Treatment Need/Responsivity-Related Modifications				
Individualized treatment plan	94%	86%	88%	.20
Increased resources	34%	28%	37%	<.001
Recommended modify supervision conditions	15%	13%	16%	.14
Modified treatment expectations	21%	17%	25%	<.001
Modified supervision conditions	7%	7%	5%	.22
Other adjustments	6%	3%	8%	<.001
Total strategies (range 0-9)	3.24 (1.69)	2.76 (1.87)	3.33 (1.74)	<.001
Client Responsivity Barriers				
Standards	2%	2%	2%	.37
Lacks supports	31%	24%	34%	<.001
Client Factors	72%	56%	81%	<.001
Substance Use	28%	16%	41%	<.001
Lack community engagement	24%	17%	30%	<.001
Terms of Supervision	5%	4%	6%	.13

Source of Data: SOMB PDMS Year 1 and 2 data. M = Mean, SD = Standard Deviation

Table 3. Adjusted Odds Ratios [a] Predicting Non-Compliant Discharge in the Full Sample (N = 867)

Variables	Model 1	Variables	Model 1
Male	.50	Treatment Risk Modifications	
Race		Adjust frequency of treatment	0.87
Black	1.41	Implemented mod. to supervision	1.96
Hispanic	2.07**	Recommended modify supervision	0.53
Asian	4.12*	Treatment Responsivity Modifications	
Age (20-92 yrs.)	0.99†	Individualized treatment plan	0.33*
DDID	.89	Increased resources	0.65
Urban	2.30***	Recommended modify supervision	0.94
Treatment Duration	0.34**	Modified treatment expectations	0.78
Treatment Duration Sq (DT*DT)	1.18	Modified supervision conditions	0.67
Treatment Duration Cubic (DT*DT*DT)	0.99	Other adjustments	0.75
Previous Offense-Specific Treatment	0.99	Total sum	1.27*
Concurrent Substance Use Treatment	1.05	Client Responsivity Barriers	
Risk-Offense Characteristics		Standards	0.79
Beginning Risk	2.14***	Lacks supports	1.13
Risk Change	.28***	Client Factors	1.36
Unrelated Victim	1.57†	Substance Use	1.45
Contact Offense	1.49	Lack community engagement	1.45
Victim less than 15	1.16	Terms of Supervision	1.88
Denial Level			
Beginning Denial	1.12		
Change Denial pre-post	0.72†		
Model □ ^{2}	601.69***		
df	35		
Nagelkerke R Square	0.67		

Source of Data: SOMB PDMS Year 1 and 2 data. †p<.10; *p<.05; **p<.01; ***p<.001.

a. Adjusted Odds Ratios is an Odds Ratio that has been adjusted to account for other predictor variables in a model. OR > 1 (Probability of Event Occurring); OR: < 1 (Probability of Event Occurring Decreases)

To address the second and third aims of the study, separate logistic regression models were calculated to predict non-compliant discharge in lower-risk clients and compliant discharge in higher-risk clients. The lower-risk subgroup was made by combining clients with moderate-low and low-risk levels (n=439) and the higher-risk subgroup was made by combining clients with moderate-high and high-risk levels (n=274). For each logistic regression analysis, all the same demographic, treatment, risk, and responsivity variables were entered as potential predictors, excluding beginning risk as this defined the two groups. Table 4 highlights the statistically significant results of the two logistic regression models only. The full results showing all variables entered in the logistic models are provided in **Appendix A**.

Table 4. Statistically Significant Adjusted Odds Ratios[a] Predicting Non-Compliant Discharge Amongst the Lower-Risk Subgroup and Compliant Discharge Amongst the Higher-Risk Subgroup[b]

Lower-Risk Subgroup Predicting Non-Compliant Discharge Statistically Significant Variables Only	Model 2 (n=439)	**Higher-Risk Subgroup Predicting Compliant Discharge Statistically Significant Variables Only**	Model 3 (n=274)
Age	.98*	Hispanic	.36*
Urban	2.67**	Urban	.40*
Duration Treatment	.13*	Duration Treatment	7.77***
Risk-Offense Characteristics		Duration Treatment Sq (DT*DT)	.76***
Contact Offense	3.03**	Duration Treatment Cubic (DT*DT*DT)	1.01*
Denial Level		Denial Level	
Beginning Denial	1.63*	Change Denial pre-post	1.70†
Change Denial pre-post	.43***	Treatment Risk Modifications	
Treatment Risk Modifications		Implemented mod. to supervision	.16*
Implemented mod. to supervision	3.61*	Treatment Responsivity Modifications	
Treatment Responsivity Modifications		Individualized treatment plan	7.59*
Individualized treatment plan	0.25†	Client Responsivity Barriers	
Recommend modified supervision	0.19*	Client Factors	.26**
Client Responsivity Barriers		Substance Use	.39*
Client Factors	2.77**	Lack community engagement	.28**
Substance Use	2.65**		
Lack community engagement	2.07*		
Model X^2	207.12***	Model $\square^2$	163.32***
df	33	df	33
Nagelkerke R Square	.52	Nagelkerke R Square	.60

Source of Data: SOMB PDMS Year 1 and 2 data. †p<.10; *p<.05; **p<.01; ***p<.001.

a. Adjusted Odds Ratios is an Odds Ratio that has been adjusted to account for other predictor variables in a model. OR > 1 (Probability of Event Occurring); OR: < 1 (Probability of Event Occurring Decreases)

b. The full results showing all variables entered in the logistic regression models are provided in Appendix A.

For the lower-risk subgroup, having a contact offense, a higher level of denial at the beginning of treatment, and less change in denial by the end of treatment were associated with a higher likelihood of non-compliant discharge. Implementing modifications to supervision was associated with a higher likelihood of non-compliant discharge, likely reflecting that these clients presented poor treatment engagement and risk issues that were being responded to via this strategy. Having modifications to the individualized treatment plan or recommendations for modified supervision was associated with a lower likelihood of a non-compliant discharge. Several client treatment responsivity barriers increased the likelihood of non-compliant discharge amongst lower-risk clients. Being young and in an urban setting continued to influence non-compliant attrition. Overall, the logistic regression model accounted for 52% of the variance in discharge outcomes in this subgroup analysis.

For the higher-risk subgroup, the length of time in treatment was a strong predictor of compliant discharge, showing that the longer a client was retained in treatment increased the odds of a compliant discharge. However, the analyses also showed the duration of treatment showed curvilinear effect with longer duration associated with compliant discharge up to a point (about six years) after which the impact diminished. Having a modified individualized treatment plan was strongly associated

with compliant discharge, as was showing a greater change in denial between the beginning and end of treatment. The latter indicates engagement with treatment. Being Hispanic, urban, having changes to supervision implemented, and having several client responsivity barriers were associated with a lower likelihood of a compliant discharge. Overall, the logistic regression model accounted for 60% of the variance in discharge outcomes in this subgroup.

Discussion

The SOMB PDMS was used to examine the factors associated with behavioral non-compliant discharge (attrition) in sex offender treatment in Colorado. The aim of this first preliminary set of analyses was to identify factors in the client treatment completion data record associated with behavioral non-compliant discharge from sex offense-specific treatment for adult clients. One set of analyses focused on predictors of non-compliant discharge within the full sample. Another subset of analyses focused on lower-risk and higher-risk subgroups to identify factors that signal greater treatment responsivity needs in lower-risk clients than is expected based on their risk level and greater protective factors or strengths in higher-risk clients that aid compliant discharge.

The analyses found that having a Hispanic or Asian racial-ethnic identity significantly increased the likelihood of non-compliant discharge in the full sample but being Hispanic only emerged as significant in the subgroup analyses with the higher-risk subgroup. Being in an urban location was consistently associated with an increased risk of non-compliant discharge, potentially reflecting greater barriers to treatment attendance in urban areas. As expected, a higher recidivism risk level at the beginning of treatment was associated with non-compliant discharge. The compliant discharge group had an average risk level of low-moderate, while the non-compliant discharge group had an average risk level of moderate. Although the average level of denial differed between the non-compliant and compliant discharge groups, the difference was relatively small and was not significant in the logistic models indicating that the level of denial varies systematically with other factors such as risk. Several modifications to treatment and supervision were associated with non-compliant discharge, potentially reflecting recognition of greater risk and need by treatment providers and the use of these strategies to increase engagement and risk management.

Several client responsivity barriers significantly differed between the compliant and non-compliant discharge groups but were only significant in the subgroup analyses. Again, this reflects systematic variation between these client responsivity barriers and other variables included in the full analyses. In the subgroup analyses that focused on the lower-risk group, client factors, substance use, lack of community engagement, and greater denial all significantly increased the odds of a non-compliant discharge compared to a compliant discharge. Having a contact offense and treatment modifications to address risk were also significantly associated with a non-compliant discharge in the lower-risk group, perhaps reflecting that there were additional indicators of risk not initially captured in the pre-treatment evaluation. For the higher-risk group, greater time in treatment (up to six years) and having modifications to the individualized treatment plan were significantly associated with a compliant discharge. In keeping with the findings for the lower-risk group, having fewer client responsivity barriers (client factors, substance abuse, and lack of community engagement) was significantly associated with compliant discharge, although to a lesser degree than it was in the lower-risk group.

Overall, the analyses are largely consistent with previous findings in the research literature. The analyses confirm that certain characteristics of individuals differentiate those who are more or less likely to be discharged from treatment for non-compliant behavior. The findings can inform the

emphasis the SOMB takes in revisions to the *Standards and Guidelines* and in addressing implementation support. Going forward, further analyses of factors influencing progress in treatment may be possible, including replication of these analyses with the 2022 client data. As the implementation of the SOMB PDMS continues to evolve, future updates may also incorporate refinement of the responsivity-related items. An important caveat is that these results do not indicate recidivism. While non-compliant discharge is an undesirable event shown in research to increase risk, it does not necessarily foretell reoffending. Notably, the non-compliant group had an average of one year of treatment before discharge. It will require recidivism outcome analyses to determine the nature of the relationship between non-compliant discharge and reoffending in this sample.

Several limitations to the analyses are present that need to be borne in mind when drawing conclusions from the results. Approved Treatment Provider data entry occurs at the end of treatment after discharge has occurred. For this reason, it is possible that the discharge status and the nature of the therapeutic interactions leading to it may influence the judgments made by Providers. Another consequence of this data entry timeline is that some of the variables may reflect the process of non-compliant discharge rather than be true predictors of discharge. For example, supervision modifications may have occurred because of non-compliant behavior discharge rather than in any anticipatory manner or to manage these problems. As data is entered by many different Approved Treatment Providers, it is also difficult to control and evaluate the consistency and accuracy of data entry.

SOMB Data Collection Analysis

The 2016 Sex Offender Management Board (SOMB) Sunset review led to a consensus among the SOMB, General Assembly, and other stakeholders on 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, which required the SOMB to develop 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 begin this data collection once funding was available. The data collection plan was included in the 2017 SOMB Annual Legislative Report. The plan requires each Approved Provider 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 requires a review of national research along with conducting original research using Colorado data collected or reviewed by the SOMB [see 16-11.7-103 (4) (e), C.R.S.]. The Legislature funded the SOMB Provider Data Management System in 2018, and official implementation commenced on January 1, 2020.[13] The third year of data collection was in 2022.

Ongoing Implementation of the Data Collection Project

The SOMB data collection project provides information to the SOMB, other affiliated stakeholders who may benefit from having critical information, and those who advocate for the clients who receive services. The SOMB uses several strategies to maintain and improve the data collection system and processes. The SOMB continues to adjust data questions based on Approved Providers' feedback and, as well, recently introduced an online process for interested stakeholders to make suggestions or request

[13] Of note, a few Approved Providers began entering data after training in late 2019.

specific data analysis. The SOMB continues to provide training and technical assistance through regular group training sessions and individual consultations. Compliance with data entry is monitored through a process that identifies Approved Providers who have not entered any data at all, although it is important to note that the data collection system does not link specific data entry to Approved Providers per se. A recent review identified 63 Approved Providers who had not entered any data; however, follow-up by the Application Review Committee found many were legitimate instances due to the Approved Provider being relatively new and not having discharged any clients yet, or the Approved Provider not having an active caseload. The follow-up has since resulted in compliance with data entry by the small group who were not complying.

The completion date for the third year of data collection was set as November 1, 2022. Together with the first two years of data collection, a substantial amount of client service tracking data has been obtained, as shown in Table 5. The number of evaluation and treatment completion data entries in Year 3 was consistent with the amount entered in Year 2, considering the slight variances in the data timeframe used. The total number of polygraph examination entries was lower (i.e., 2,737 vs. 3,743) and appears to reflect, at least in part, Approved Provider fatigue with data entry. Approved Polygraph Examiners see a significantly greater volume of clients than Approved Evaluators and Treatment Providers, translating into a relatively high volume of data entry. For example, polygraph examiners can conduct up to four examinations per day. The SOMB addressed the burden of data entry for Approved Polygraph Examiners in February 2022 by simplifying their data entry requirements. It is also possible that fewer polygraph examinations were conducted in Year 3. The SOMB continues to support all Approved Providers to streamline the data process and ensure a clear understanding of the requirements. In keeping with the goal of 100% Approved Provider compliance with data entry requirements, the SOMB introduced a timeframe for year-end data entry in the *Standards and Guidelines* to encourage all required data to be entered by a consistent year-end date.

Table 5. Number of Client Service Records Entered in SOMB Data Collection System Years 1 to 3

Type of Service	Year 1: 2020	Year 2: 2021	Year 3: 2022	**Total**
Evaluations	386	670	427	1,483
Treatments	411	836	539	1,786
Polygraph Examinations	4,950	3,743	2,992	11,685

Source of Data: SOMB Annual Legislative Reports 2021-2023. Data is entered at the time of service completion for each client.

Note: Some variances exist in the total period used for data collection in each legislative report: Year 1 was 10.18.19 to 11.25.20, Year 2 was 11.30.20 to 11.30.21, Year 3 was 12.1.21 to 11.1.22.

An important part of the data collection project is the clients' consent to participate in the SOMB data collection. When clients consent to participate, an identifier in the form of a court case ID is included along with the otherwise non-identifiable service data. When clients decline to participate in the SOMB data collection, the client identifier is not included in the data record. The other non-identifiable service data can still be entered and is preferred as part of the SOMB's mandate to collect data to evaluate the efficacy of the SOMB policies. The major consequence of clients declining consent to participate in the SOMB data collection is that a client identifier is not included in the data record, preventing the SOMB from matching these records with recidivism data in future analyses. The SOMB works with Approved Providers and advocacy groups to encourage clients to participate fully in the data collection processes.

Research Questions

The analysis of SOMB data involves two phases. Phase I focuses on using the data to assess whether the *Standards and Guidelines* related to the Risk, Need, and Responsivity Principles (RNR) are being implemented as required. Phase I provides a general evaluation of the implementation of the *Standards and Guidelines* akin to a treatment process evaluation.[14] Phase II will focus on collecting longitudinal data on clients who agreed to participate in the data collection project to assess the effectiveness of treatment in reducing recidivism over time, protecting victims, and protecting the Coloradan public. Phase II will provide a general evaluation of treatment effectiveness akin to a treatment outcome evaluation.[15] The SOMB is currently in Phase I of its data analysis, and that is what is reported in the following summary. Phase II will begin in the upcoming year now that sufficient time has passed for longer-term and recidivism outcome analyses to be conducted.

The goal of Phase I analyses is to provide an annual snapshot of the services provided by Approved Providers and determine whether the services accomplish the following:

1. Adhere to the *Standards and Guidelines*
2. Are being implemented as required by the *Standards and Guidelines*
3. Reflect the RNR Principles including individualization of treatment to client risk level and treatment need

Summary of the Prior Year One & Year Two Data Analyses

Year 1 data was entered between October 18, 2019, and November 25, 2020, and contained records for 383 evaluations, 411 treatments, and 4,950 polygraph examinations. Year 2 data was collected between November 26, 2020, and November 30, 2021, and contained records for 670 evaluations, 836 treatments, and 3,743 polygraph examinations. During the first two years of data collection, Approved Providers appeared to follow the *Standards and Guidelines* and utilize the RNR principles to individualize treatment to client risk level and treatment needs. Regarding polygraph examinations, the majority in the first two years of data collection were for initial exams and produced no significant responses (NSR)/non-deceptive findings.

Summary of the Current Year Three Data Analyses

The following sections provide an initial summary of the services provided in Colorado in 2022 to clients convicted or adjudicated for sexual offenses. The data were drawn from three separate sets of questionnaires in the data collection system, one for each service type: evaluation, treatment, and polygraph examination. In addition, different versions of the questionnaires are used to match whether the Adult or Juvenile *Standards and Guidelines* applied to client services. It is important to note that in

[14] A process evaluation assesses the degree a treatment is delivered and received as intended, which in this instance means as defined in the *Standards and Guidelines*.

[15] A treatment outcome evaluation assesses the degree a treatment is effective at achieving its intended objectives, which in this instance means recidivism over time. Treatment outcome evaluations are ideally preceded by treatment process evaluations as part of ensuring treatment is as intended and to inform treatment outcome findings.

some instances, termed crossover cases, juvenile clients may be subject to Adult *Standards and Guidelines*, and adult clients may be subject to Juvenile *Standards and Guidelines*. Crossover cases arise due to the dates of the sexual offense and adjudication/conviction, and/or result from the court that processes the case.

Data included in the current, Year 3, analyses were entered between December 1, 2021, and November 1, 2022. The data contained records for 427 evaluations, 539 completed treatments, and 2,992 polygraph examinations, entered following service completion. It is important to note that the data do not include records for evaluations, treatments, or polygraph examinations that were in process but not completed during the Year 3 data collection period. Table 6 shows the Year 3 service records by service type and the applicable Adult or Juvenile *Standards and Guidelines*. Among the 427 evaluation records, 362 (85%) were subject to the Adult *Standards and Guidelines*, while 65 (15%) were subject to the Juvenile *Standards and Guidelines*. Among the 539 record of completed treatment, 471 (87.4%) were subject to the Adult Standards and Guidelines, while 68 (12.6%) were subject to the Juvenile *Standards and Guidelines*. Among the 2,992 polygraph examination records, 2,945 (98.4%) were subject to the Adult *Standards and Guidelines*, while 47 (1.6%) were subject to the Juvenile *Standards and Guidelines*. Of the 2,992 polygraph examination records, 255 involved no data entry, as the clients declined to participate in data collection allowing data entry to be skipped by Approved Providers. Thus, the total number of valid polygraph examination records included in the Year 3 data analysis was 2,737. Of note, the number of valid entries in Year 3 was comparable to that in Year 2.

Table 6. Year 3 Client Service Records Entered By Service Type and Subject to Adult or Juvenile Standards

	Evaluations	Treatments	Polygraph Examinations	**Total**
Type of Service	Count (%)	Count (%)	Count (%)	
Adult	362 (85%)	471 (87%)	2,945 (98%)[a]	3,778
Juvenile	65 (15%)	68 (13%)	47 (2%)	180
Total	427	539	2,992	3,958

Source of Data: SOMB Provider Data Management System

a. 255 records had no data entry as clients declined consent, resulting in 2,737 valid polygraph examination records in the final analytic sample.

Approved Treatment Providers reported that approximately 6% of clients declined to participate in data collection in Year 3, which was substantially lower than the 40% in Year 2 and 50% in Year 1. Nonetheless, in Year 3, the option to choose "unknown" court case ID was introduced and was selected by 30% of Approved Treatment Providers. Approved Polygraph Examiners reported that 66% of clients declined to consent to participate in the SOMB data collection in Year 3, compared to 60% in Year 2 and 33% in Year 1. Overall, a higher proportion of juvenile clients declined to participate in SOMB data collection than adult clients. For polygraph examinations, 77% of juveniles declined compared with 60% of adults, while for evaluations, 66% of juveniles declined compared with 43% of adults.[16]

[16] As described in the research question section, the major consequence of clients declining consent to participate in the SOMB data collection is that a client identifier is not included in the data record which prevents the SOMB's matching these records with recidivism data in future Phase II analyses.

Evaluation Results

Among the 427 evaluation records with valid data, 362 (85%) were subject to the Adult *Standards and Guidelines*, and 65 (15%) were subject to the Juvenile *Standards and Guidelines*. The ages of the clients was 12 to 79 years. Gender was female for 14 (3.3%), male for 396 (92.7%), "Other" for 1, and not answered for 16 clients. Prior sex offense-specific treatment had occurred for 140 (39%) clients subject to the Adult *Standards and Guidelines* and 9 (14%) clients subject to the Juvenile *Standards and Guidelines*. Developmental or intellectual disability (DD/ID) was present for 18 (4.2%) clients (17 adults, 1 juvenile). Regarding offense type, 62% of evaluation clients had a contact offense, 17% had a current non-sex crime with a history of conviction for a sex crime, 9.4% had a non-contact in-person victim (e.g., exposing, voyeurism, or image/video capturing), and 4.7% had "other" sex crimes.

The incorporation of the RNR Principles by Approved Evaluators was evident via the range of options used to individualize recommendations according to risk level, treatment needs, and treatment responsivity. In addition, a large majority of the Approved Evaluators (95%) reported specifically addressing the individual client's self-reported needs, reviewing past records and collateral data (91%), having discussions with Community Supervision Team and Multidisciplinary Team members (CST/MDT) (26%), and having discussions with the client's support systems about the client's needs (22%).

Among the options available to match treatment to the client's level of risk, Approved Evaluators reported using the following recommendations:

- Adjunct non-sex offense-specific treatment (49%)
- Adjustments to community access (e.g., levels of restrictions) (27%)
- Adjustments in the frequency of treatment services (22%)
- Changes to supervision (15%)
- Type of placement, length of stay, or step-down (14%)
- Adjustments to types of groups (13%)
- Other adjustments (6.3%)
- Implementing changes to supervision (2.3%)

Among the options available to match treatment to the client's needs, Approved Evaluators reported using the following recommendations:

- An individualized treatment plan (77%)
- Increased support (44%, as compared to 35% in Year 2)
- Increased resources (43%, as compared to 35% in Year 2)
- Modified programming (13%)

- Modifications to treatment expectations (9%)
- Implemented modification to treatment modality (9%)
- Used the sex history evaluation matrix (8.2%)
- Adjustments in the frequency of treatment services (8%)
- Used the young adult modification protocol (7%)
- Flexible scheduling options (3.3%)
- Modified the *Standards and Guidelines* by the MDT/CST (12 cases, or 2.8%)
- Modified supervision conditions (1.2%, as compared to 16% in Year 2)

Among the options available to match treatment to the client's treatment responsivity needs, Approved Evaluators reported using the following recommendations:

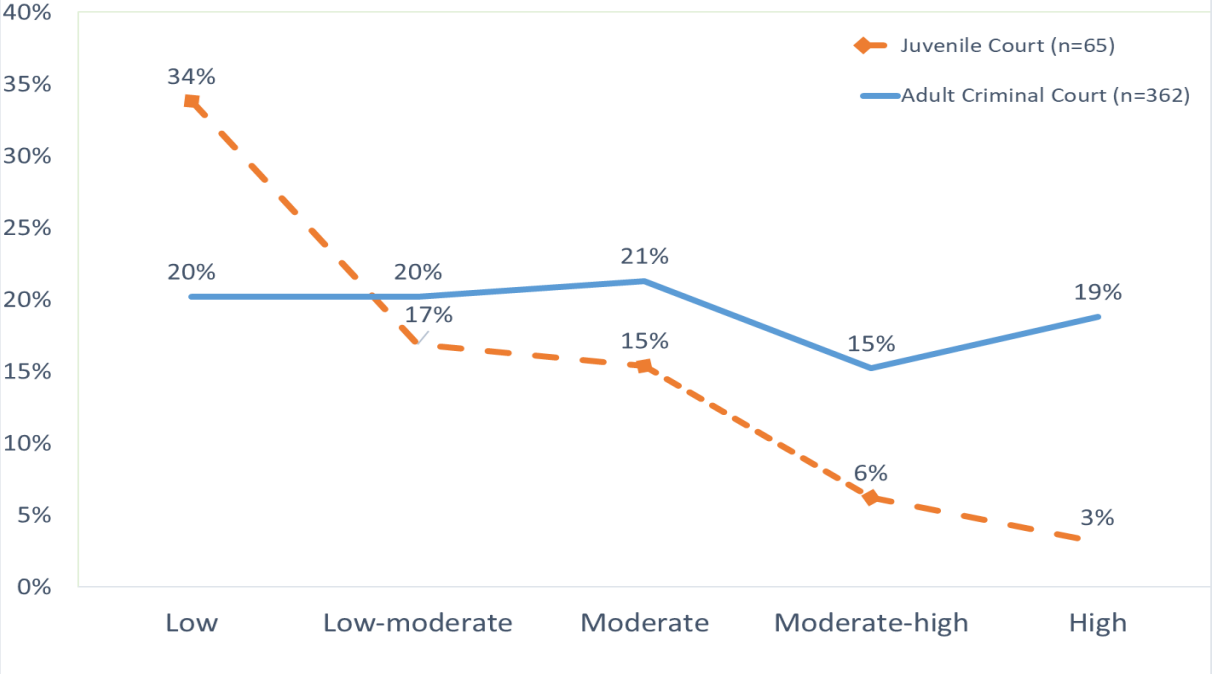
- Use of mental health-related adjunct therapy (68%)
- Feedback from the client (42%, as compared to 38% in Year 2)
- Assessment of intellectual/cognitive functioning (21%, as compared to 16% from Year 2)
- Assessment of cultural/language/sexual orientation/gender identity and family needs (15%)
- Recommendation to modify supervision conditions (13%)
- Modifications to increase progress (10%)
- Frequency of treatment services (8%)
- Implemented modification to supervision conditions (7%)
- Feedback from the support system (6%, as compared to 24% in Year 2)

Finally, the top three recommended treatment settings for adult clients were:

- Community Provider (59%; representing a 9% decrease from Year 2 number)
- Community Corrections (22%; representing a 9% increase from Year 2 number)
- Department of Corrections (11%)

Approved Evaluators reported typically using between 3-4 standardized and validated risk assessment instruments as part of the evaluation process, which is consistent with best practices and the *Standards and Guidelines*. The most used adult risk assessment instruments were the SOTIPS and the VASOR/VASOR-2[17], while the most used juvenile risk assessment instrument was the J-SOAP-II.[18] Figure 1 shows the assessed risk level for the adult and juvenile clients resulting from the evaluations. For juvenile clients, the majority (66%) were assessed as having low, low-moderate, or moderate risk of sexual recidivism at the time of the evaluation. That proportion was 11% greater compared to Year 2. For juvenile clients, a small proportion were assessed as having a moderate-high (6%) or high risk (3%) of sexual recidivism at the time of the evaluation.[19] For adult clients, assessed risk levels were more evenly spread from low to high risk. Nonetheless, the majority (61%) of adult clients were also assessed as having a low, low-moderate, or moderate risk of sexual recidivism at the time of the evaluation, although that proportion was 11% less compared to Year 2. For adult clients, just over one-third were assessed as having moderate-high (15%) or high-risk (19%) of sexual recidivism at the time of the evaluation.

Figure 1. Final Evaluation Risk Level by Court in 2022 (N=427)



[17] Sex Offender Treatment Intervention and Progress Scale (McGrath & Lasher, 2013); Vermont Assessment of Sex Offender Risk (McGrath & Hoke, 1994/2001); Vermont Assessment of Sex Offender Risk-2 (McGrath & Lasher, 2013).

[18] Juvenile Sex offender Assessment Protocol-II (Prentky & Righthand, 2003).

[19] For 5/65 the overall risk assessment rating was not available, while an additional 11 clients had missing data on this question.

Treatment Completion Results

Among the 539 valid records of treatment completion, 471 (87.4%) were for clients ages 18 and over and 68 were for clients under 18 (as compared to 55 from Year 2). The ages ranged from 14 to 83 years. Gender was female for 14 (2.6%), male for 509 (94.4%), "Other" for 7 (1.3%, as compared to 4% in Year 2), and skipped in 9 records. Treatment started as early as 2014 in one case. Developmental or intellectual disability (DD/ID) was present for 29 (5.4%) clients. The clients were 56% White, 27% Hispanic, 11% African American, 2% Alaska Natives/American Indians, 0.6% Asian or Pacific Islanders, and 2% "Other" or "Unknown". A small number of crossover cases were present. A total of 18 clients under 18 at adjudication were processed in the adult criminal court and thus subject to the Adult *Standards and Guidelines*. A total of 11 clients 18 or older at adjudication were processed in the juvenile court and thus subject to the Juvenile *Standards and Guidelines*. Regarding offense of conviction or adjudication, 421 (78%) clients had a contact sexual offense, 68 (11.3%) a non-contact online offense (e.g., child sexual abuse images, sexting), 38 (7.1%) a non-contact offense (e.g., exposing, voyeurism, image/video capturing), and 13 (2.4%) a non-sex crime with history of sex crime.

The Approved Treatment Providers reported that client treatment needs were identified by using self-report methods (87%), discussion with the CST/MDT (87%), discussion with the support systems (80%) (as compared to 40% from Year 2), and review of past records or collateral data (62%). The incorporation of the RNR Principles by Approved Treatment Providers was evident via the options used to individualize treatment according to risk level, treatment needs, and treatment responsivity.

Among the options available to match treatment to clients' needs, the Approved Treatment Providers entered using the following:

- An individualized treatment plan (87%)
- Modified assignments (56%, as compared to 45% from Year 2)
- Increased support (54%, as compared to 41% in Year 2),
- Flexible scheduling (46%, representing a 12% increase over Year 2)
- Increased resources (40%)
- Modified supervision conditions (29.4%, as compared to 15% from Year 2)
- Modified treatment expectations (28%)
- Modified programming (12%)
- Young adult protocol (12%, representing a 6% increase over Year 2)
- Modifications to *Standards and Guidelines* by the MDT/CST (7.4%)
- Implemented modification to supervision conditions (7%)
- Modifications to *Standards and Guidelines* through a variance (7.4%, representing a 6.5% increase from Year 2)

Figure 2 shows the overall risk level distribution for adult and juvenile clients combined at the beginning and end of treatment. The distribution was comparable to that found in Years 1 and 2, with most clients classified as at low, low-moderate, or moderate risk of sexual recidivism at both the beginning and end of treatment (i.e., 77% and 68%). At the end of treatment, however, a far greater proportion were classified as low risk compared to low-moderate or moderate risk (i.e., 43% vs. 28%), consistent with clients' risk being lowered through treatment participation. At the other end of the risk continuum, the proportion of clients classified as high-risk at the end of treatment also became more pronounced (i.e., 17% vs. 10%). A similar pattern was found in Year 2 and may be explained by some clients' exhibiting greater risk-related behaviors across the course of treatment and treatment providers developing a more accurate understanding of client risk by the end of the treatment.

Figure 2. Overall Risk Level at the Beginning and End of Treatment (N=539)

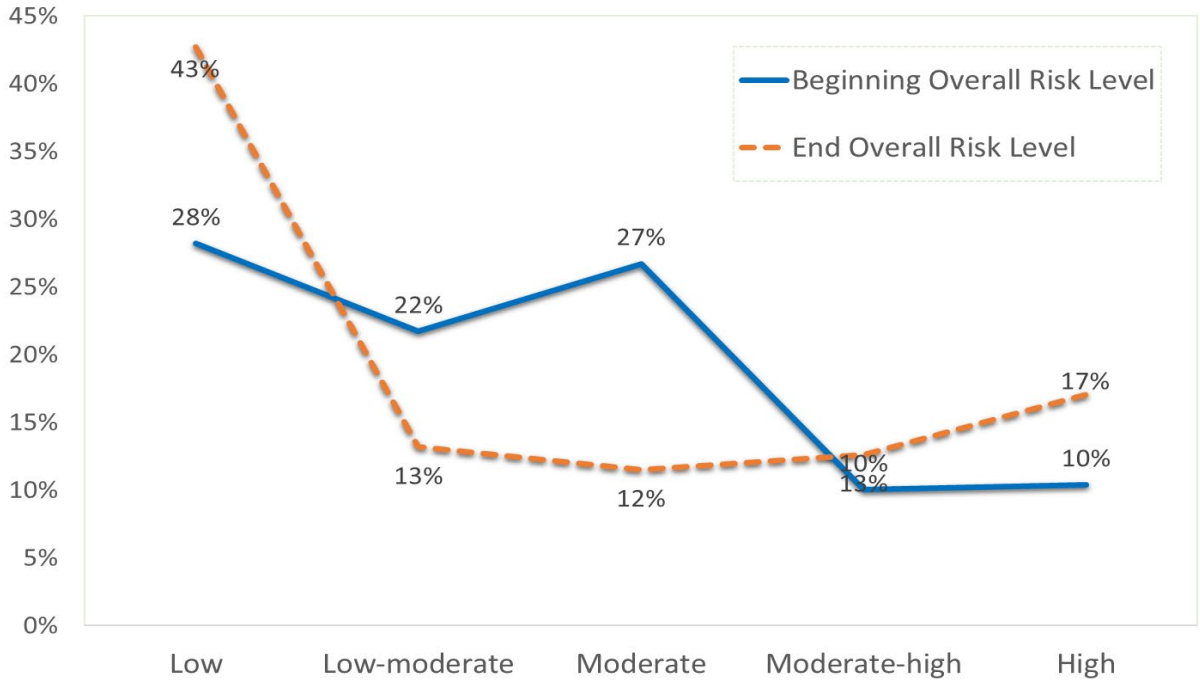


Figure 3 shows the end-of-treatment success discharge rates by the overall end-of-treatment risk level. A successful discharge showed a clear relationship with risk level, with higher-risk clients having a low rate of successful discharges compared to lower-risk clients who had a high rate of successful discharges.

Figure 4 shows the overall risk level of clients at the beginning and end of treatment by adult and juvenile court status. For clients processed in the juvenile court (and subject to the Juvenile *Standards and Guidelines*), the proportion classified as having a low-risk level substantially increased by the end of treatment. In tandem, the proportion classified as having a high-risk level decreased to a very small proportion by the end of treatment. For clients processed in the adult court (and subject to the Adult *Standards and Guidelines*), the pattern was similar, but with a less pronounced increase in the proportion classified as having a low-risk level by the end of treatment. In contrast to juveniles, there was an increase in the proportion of adult court clients classified as high-risk by the end of treatment.

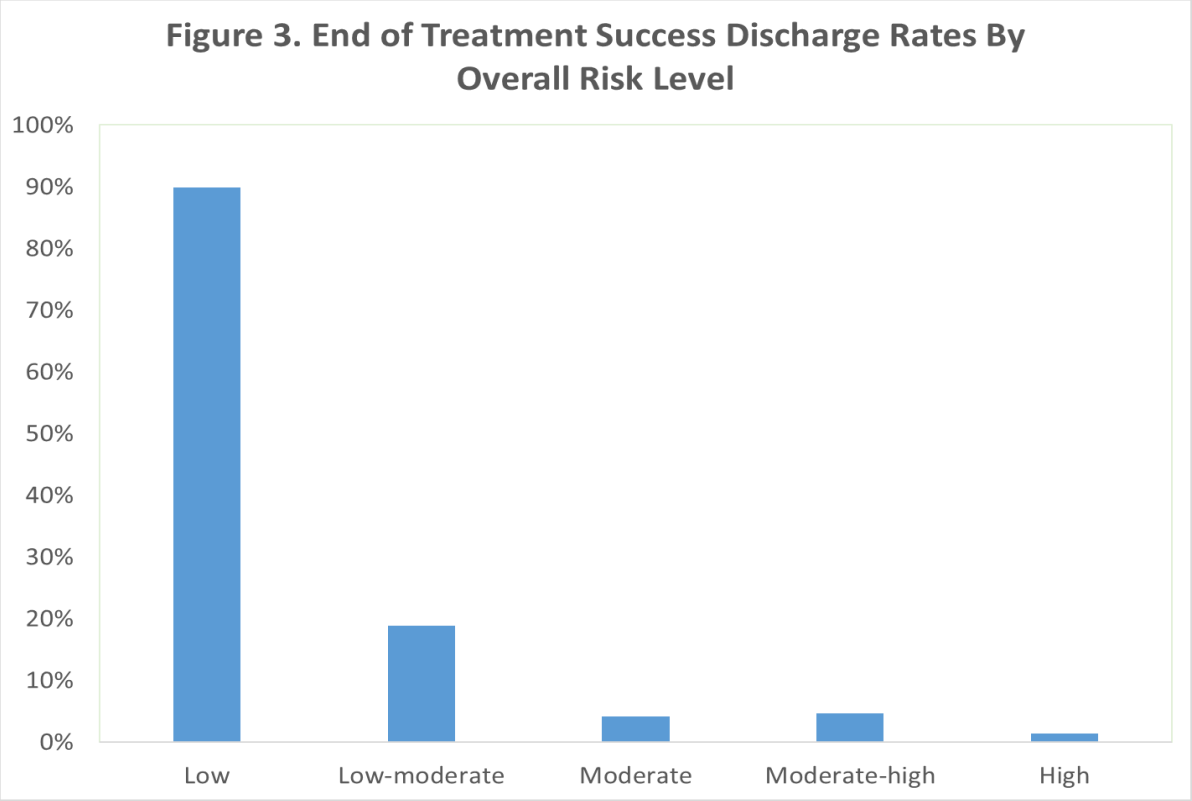


Figure 3. End of Treatment Success Discharge Rates By Overall Risk Level
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
Low
Low-moderate
Moderate
Moderate-high
High

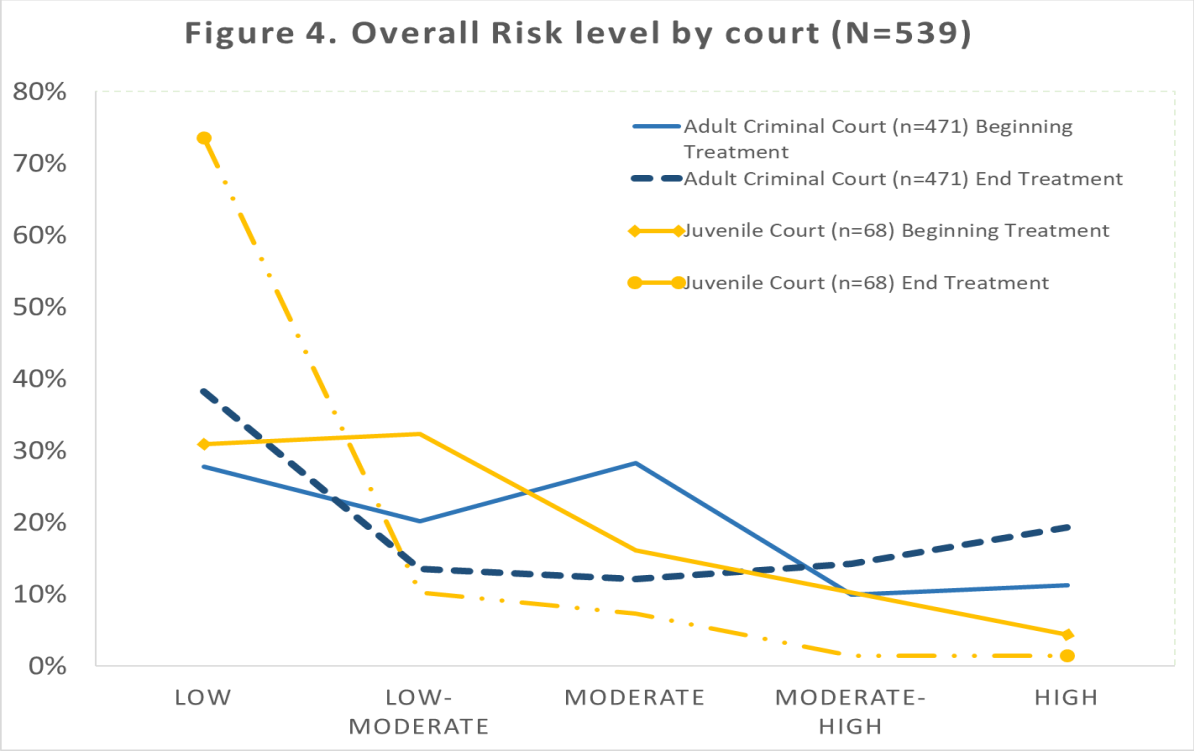


Figure 4. Overall Risk level by court (N=539)
80%
70%
60%
50%
40%
30%
20%
10%
0%
Adult Criminal Court (n=471) Beginning Treatment
Adult Criminal Court (n=471) End Treatment
Juvenile Court (n=68) Beginning Treatment
Juvenile Court (n=68) End Treatment
LOW
LOW-MODERATE
MODERATE
MODERATE-HIGH
HIGH

Figure 5 shows the level of denial at the beginning and end of treatment. The proportion of clients with no denial increased by the end of treatment in tandem with the proportion of clients with moderate and high denial decreasing by the end of treatment. By the end of treatment 80% of clients had low or no denial, while only 5% had high denial. That pattern was consistent with that found in Years 1 and 2.

Figure 6 shows the treatment discharge outcomes or types for both adult and juvenile clients. Approximately half (261; 48%) of the discharged clients had successfully completed treatment, compared to 40% in Year 2 and 36% in Year 1. The increase between Years 2 and 3 shows that 20% more clients in Year 3 had a successful treatment discharge compared to Year 2, and 33% more clients in Year 3 had a successful discharge compared to Year 1. A further 16% of clients had a range of administrative-type discharges, including administrative transfer (55 clients), medical discharge (5 clients), lack of progress (17 clients), maximum benefits (6 clients), administrative reasons (7 clients), incompetency reasons (7 clients), and therapeutic transfer (8 clients). The final 35.6% (192) treatment clients had a non-compliance discharge, which was lower than Year 2 (42%).[20]

The reasons for the non-compliance discharge included 28 (5.2%) clients violating treatment contracts or the terms and conditions of supervision, 20 (3.7%) clients committing new non-sexual crimes (as compared to 1.7% in Year 2), and 15 (2.7%) clients committing new sexual crimes (as compared to 1.4% in Year 2). Another 75 clients (71 adults, 4 juveniles; 13.9%) were unsuccessful because of readmittance to treatment/lack of investment in treatment goals, a discharge category added to the data collection system in February 2022. "Other" reasons was selected for the remaining 54 clients. Among the 68 clients subject to the Juvenile *Standards and Guidelines*, 76.6% had a successful discharge, while 7.4% had a non-compliant discharge. The remaining discharges were related to administrative transfer (7.5%), aging out of the system (DYS only) (1.5%), maximum benefit (1.5%), and administrative discharge (1.5%).

[20] The remaining 3% had missing data.

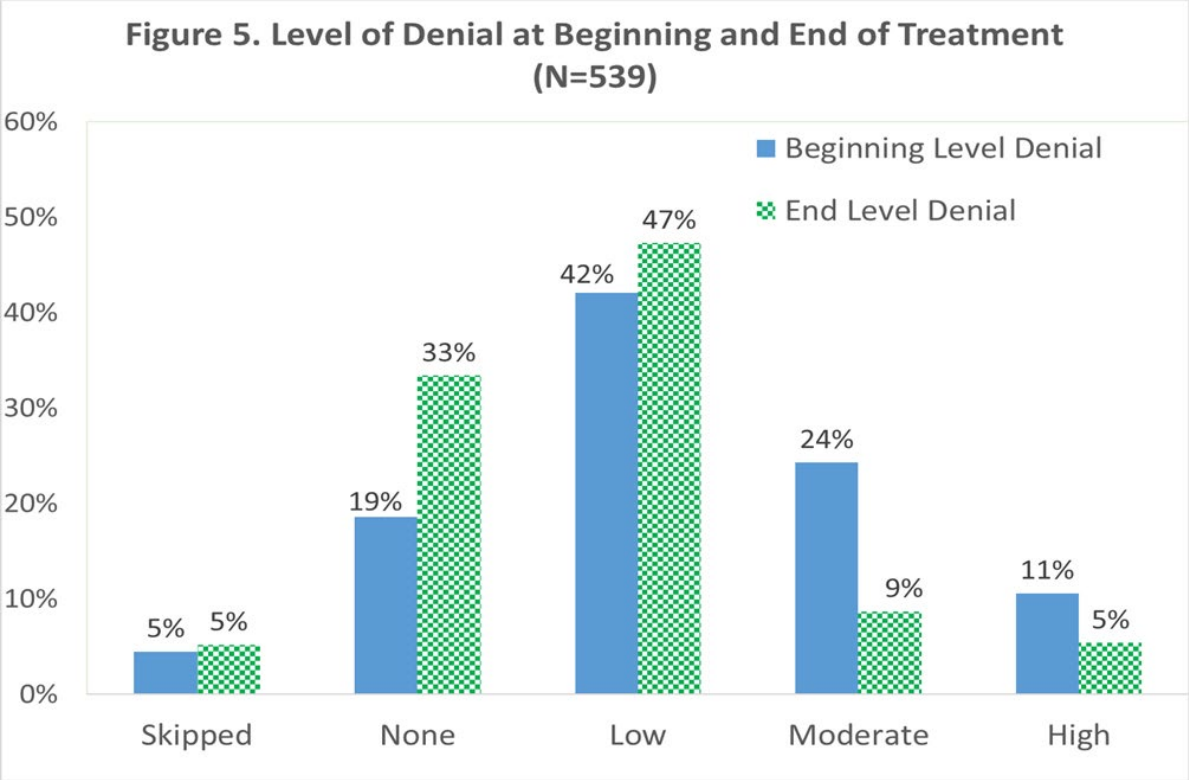


Figure 5. Level of Denial at Beginning and End of Treatment (N=539)
60%
50%
40%
30%
20%
10%
0%
Beginning Level Denial
End Level Denial
5%
5%
19%
33%
42%
47%
24%
9%
11%
5%
Skipped
None
Low
Moderate
High

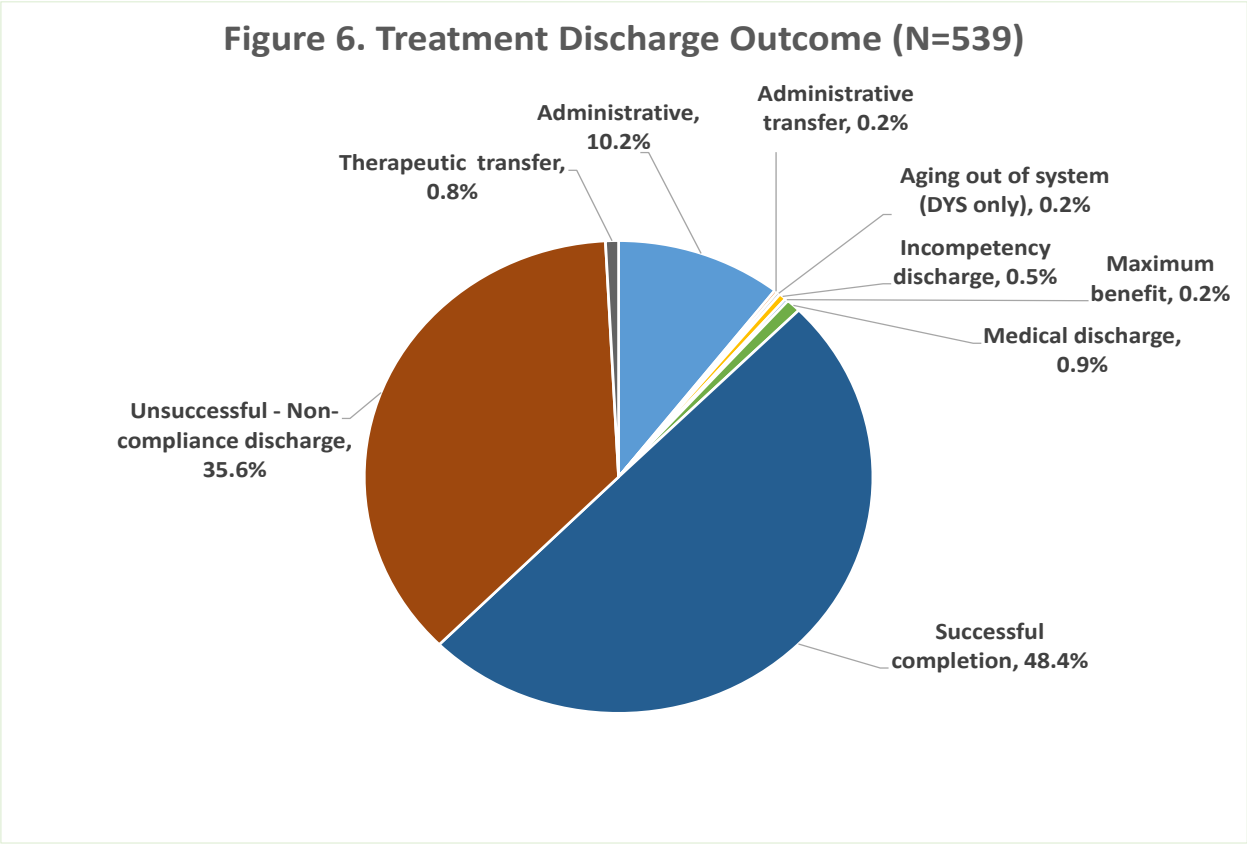


Figure 6. Treatment Discharge Outcome (N=539)
Administrative, 10.2%
Administrative transfer, 0.2%
Therapeutic transfer, 0.8%
Aging out of system (DYS only), 0.2%
Incompetency discharge, 0.5%
Maximum benefit, 0.2%
Medical discharge, 0.9%
Unsuccessful - Non-compliance discharge, 35.6%
Successful completion, 48.4%

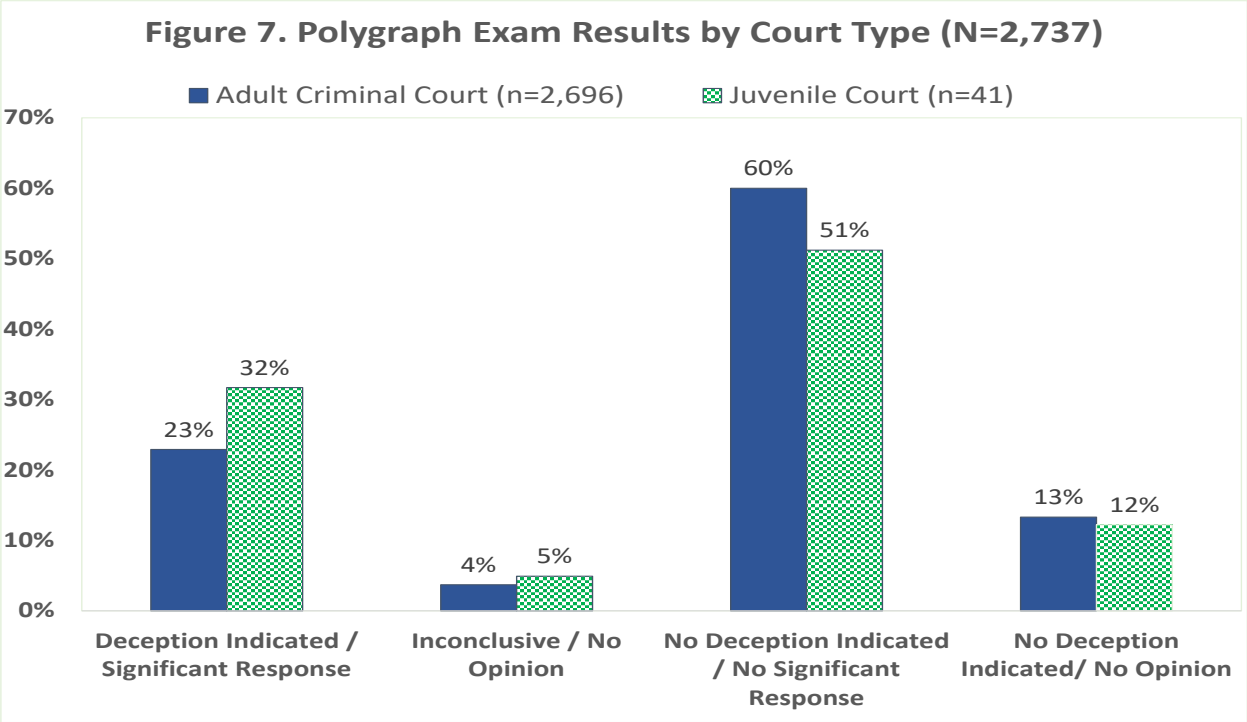
Polygraph Examination Results

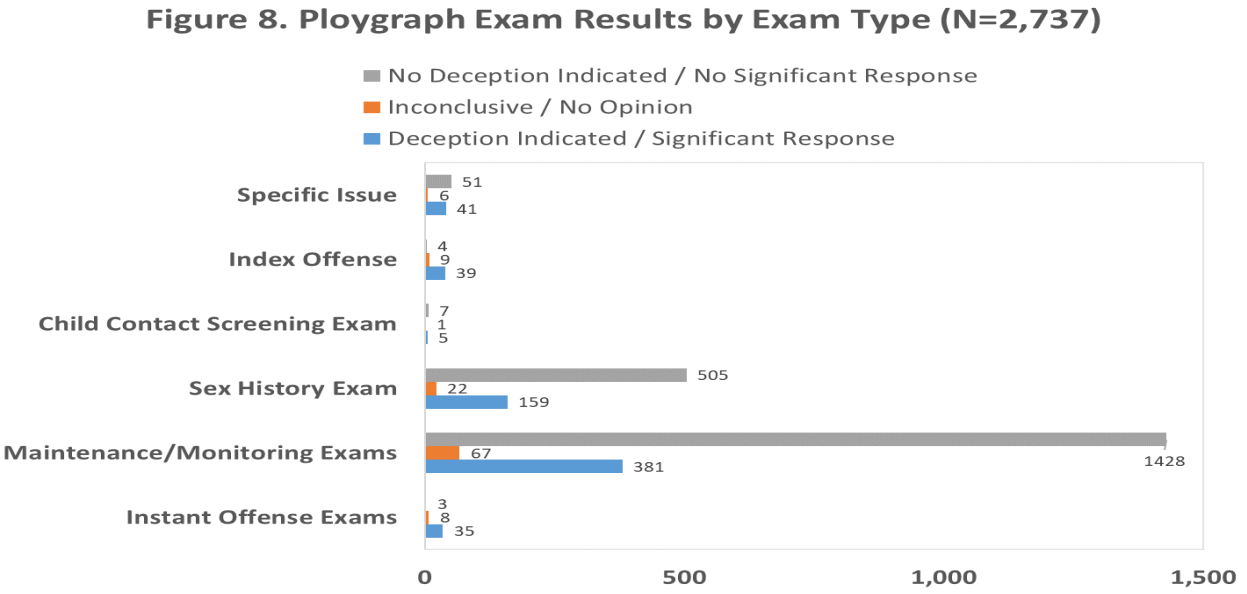
Among the 2,737 valid polygraph examination records, 77% (2,119) were initial exams (a slight increase from Year 2), while 23% (618) were retest examinations (a slight decrease from Year 2). Retest examinations are used to clarify initial examination results that are indicative of deception (SR/Deception), inconclusive findings (NO/Inconclusive), or that show an attempt to manipulate the test results. The specific types of examinations conducted were 1,877 (69%) Maintenance/Monitoring exams, 687 (25%) Sex History exams, 982 (3.6%) Specific Issue exams, 97 (3.6%) Instant Offense exams (as compared to 2.2% in Year 2), 52 (1.9%) Index Offense exams, and 13 (.5%) Child Contact Screening exams. Only a very small proportion of polygraph examinations were on juveniles (1.6%) in keeping with the Juvenile *Standards and Guidelines* being revised in previous years so that polygraph examinations are only used with juveniles when clinically indicated. The age range of the clients examined was 15 to 86 years. Approximately 3% (78 adults) were identified as having a developmental or intellectual disability (DD/ID). A very small number of referred clients (6 adults; 0.2%) were found to be unsuitable for polygraph examination (compared to 21 or 0.7% in Year 2).

The number of clients using countermeasures during the polygraph examination was relatively low (21 clients; 0.8%), consistent with that found in Year 2 (0.9%) and Year 1 (1.2%). The number suspected of using countermeasures was marginally higher (41 clients; 1.5%), although less than that found in Year 2 (1.9%) or Year 1 (2.6%). Over half (1,439; 52.6%) of the examinations resulted in clinically relevant disclosures during the pre-test, test, or post-test phases, representing an almost 10% increase from Year 2. Of the clinically relevant disclosures, 500 (18%) clients indicated sexual behavior (e.g., use of pornography), 358 (13%) clients admitted historical information (e.g., admitting an unknown offense), 371 (13.6%) clients admitted changes of circumstance/risky behavior (e.g., increased access to children), and 371 (13.6%) clients admitted other behaviors. The remaining 1,336 (49%) exams did not contain clinically relevant admissions.

Figure 7 shows polygraph examination findings by court type. Among adult court clients, 78% were classified as non-deceptive (i.e., non-deception indicated with NSR/Non-deceptive or NSR/NO), while about one-quarter were found to have deception indicated (i.e., SR/Deception). Among the smaller number of juvenile court clients, 63% were classified as non-deceptive (i.e., no deception indicated with NSR/Non-deceptive or NSR/NO), while about one-third were found to have deception indicated (i.e., SR/Deception). The findings for adults and juveniles were comparable to Year 2. When the findings are taken together, the proportion of adult and juvenile court clients with no significant response (i.e., NSR/Non-Deceptive or No Opinion and NO/Inconclusive) is 73%.

Figure 8 shows the polygraph examination findings by exam type. The rates of non-deceptive findings (i.e., NSR/Non-deceptive and NRS/NO) were 76% for Maintenance/Monitoring exams, 74% for Sex History exams, 54% for Child Contact Screening exams, and 52% for Specific Issue exams. The rates of non-deceptive findings were substantially lower at 8% for Index Offense exams and 7% for Instant Offense exams, not surprisingly, as these exams tend to be utilized when clients are denying the offense of conviction during treatment. The SR/deception responses were higher among repeat exams (35% vs. 20%), comparable to Year 2 (38% vs. 18%).





Limitations

Several issues potentially affect the completeness of the data set and, in turn, the representativeness and generalizability of the findings. A small group of Approved Providers was identified who had not entered any data in the system during the year, although compliance was remedied through subsequent follow-up by the Application Review Committee. A lower number of polygraph examinations compared

to Year 2 potentially signaled provider fatigue with data entry requirements and may have contributed to some missing polygraph examination data. The data collection system allows certain questions to be skipped as required or all questions to be skipped when clients decline to consent to participate in the data collection project. As previously noted, the major consequence is that a client identifier is not included in the data record, although the SOMB prefers that the remaining unidentified data be entered in keeping with its statutory mandate to measure the efficacy of its policies. Quite a few Approved Polygraph Examiners took advantage of the option to skip data entry, while most Approved Treatment Providers continued to enter data minus the client identifier as required.

Summary and Conclusions

The SOMB data collection system received a significant amount of data entry in Year 3, demonstrating the continued commitment by Approved Providers to implementing the *Standards and Guidelines* and supporting the SOMB goal of evaluating the *Standards and Guidelines*.

Overall, a high degree of consistency was apparent in the pattern and trends in the data across the three years of the data collection project. Encouraging findings included an increase in the successful discharge rate, translating to a fifth more successful discharge outcomes in Year 3 compared to Year 2 and a third more compared to Year 1. An increase in the proportion of juvenile treatment and evaluation records from Year 2 to Year 3 was also evident, alongside greater reporting of the different types of discharge that can be used with juvenile clients. As shown in Figure 9, the race-ethnicity composition of the clients continues to reflect small increases in the diversity of clients. Treatment providers had substantially more success obtaining client consent to participate in the data collection project compared to earlier years. However, as the court case ID was unknown for a substantial proportion of clients, the proportion of records in the data collection system that can be included in future Phase II analyses of recidivism continues to be between 40-60% depending on service type.

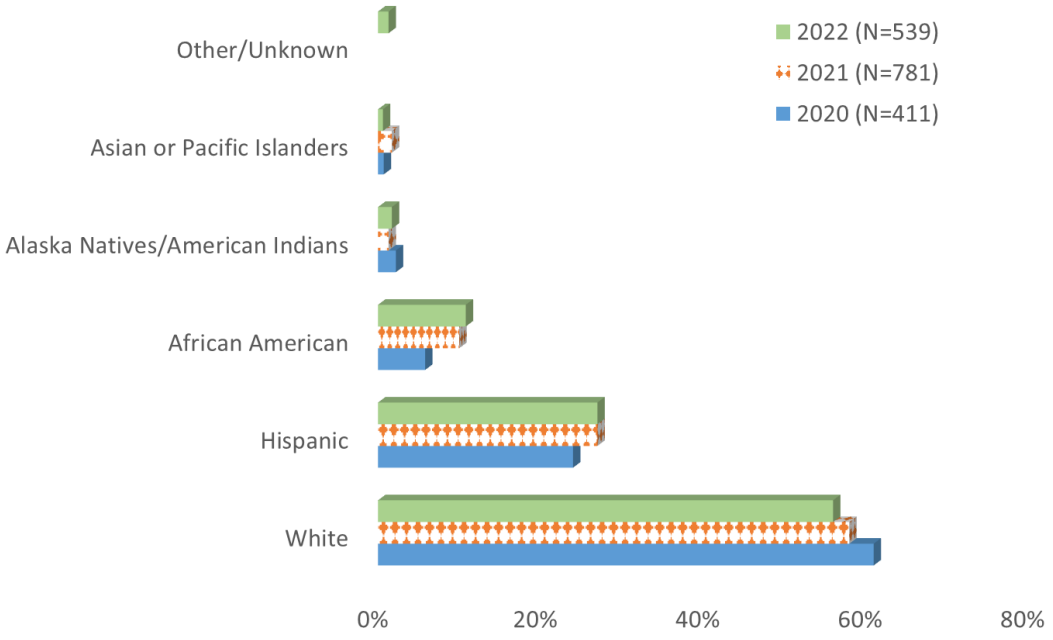
The Year 3 data indicated that the Approved Evaluator and Treatment Providers incorporated a range of RNR-informed treatment options and adjustments in their work alongside consultation within the MDT/CST and discussions with clients' support systems. Highlights of Year 3 compared to Years 1 and 2 included more recommendations for modified supervision and increased support. The findings for polygraph examinations were highly consistent as well, although there was a slightly greater proportion of initial examinations and fewer referrals were unsuitable for examinations. About three-quarters of polygraph exams were non-deceptive, consistent with most clients demonstrating accountability in their treatment and supervision process. Very few juvenile polygraph examinations were conducted, indicating implementation of previous *Standards and Guidelines* changes that restricted use with juveniles unless clinically indicated. Finally, unsuccessful non-compliance discharge accounted for a lower proportion of discharges in Year 3 compared to Year 2, although the rate of clients being processed for a new non-sex crime and sex crime increased to 3.7% and 2.7%, respectively. These increased rates are consistent with a general upward trend in crime rates in Colorado and the US in association with the Covid-19 pandemic.

In addition to data collection, the SOMB data collection system provides an avenue for Approved Providers to track service provision and communicate issues and concerns directly to the SOMB. Comment boxes are available throughout the data entry screens for Approved Providers to use to enter additional qualitative data. Ultimately, the comments help inform SOMB committee work on amendments to the *Standards and Guidelines*, implementation support, and training and technical assistance support. For example, several Approved Evaluators have added qualitative data indicating a

lack of appropriate assessment tools for sex history cases, female offenders, crossover cases, and transgender clients. Many Approved Polygraph Examiners have used the comment boxes to explain exam specifics, client countermeasures, or disclosures. Similarly, Approved Treatment Providers often include comments describing the denial intervention and other treatment modes used. The comments included by Approve Providers are valuable, and the SOMB is working on periodically summarizing these qualitative findings to inform research and revisions to the *Standards and Guidelines*.

Based on the Year 3 preliminary review of client service data, the major finding from earlier years that Approved Providers appeared to follow the *Standards and Guidelines* and utilize the RNR principles to individualize treatment to client risk and needs are supported. The SOMB data collection system supports the SOMB's evidence-based, data-driven perspective for ongoing improvements to the *Standards and Guidelines*. As part of the effective implementation of the data collection project, the SOMB is committed to balancing the needs of the project and the requirements of Approved Providers. The SOMB continues to seek feedback from Approved Providers and other stakeholders with the aim of improving data entry and the relevance of the data collection. For example, as of February 2022, polygraph examination data entry questions were streamlined to reduce the burden for Approved Polygraph Examiners. The treatment discharge questions were also updated to reflect current practices and allow the reasons behind successful and unsuccessful discharges to be understood better. The SOMB has also introduced a process for Approved Providers to suggest refinements and research questions. Finally, in the upcoming year, the SOMB will begin Phase II of the data collection project and work on studying the long-term outcomes of treatment services, including recidivism rates.

Figure 9. Race/Ethnicity of Clients Who Completed Treatment in 2020-2022



Section 2: Relevant Policy Issues and Recommendations

Background

Beginning in 2011 with the SOMB Sunset renewal, policies were established that required the SOMB 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 based on research and discusses research trends on pertinent or emerging topics in the field that may be of interest to the Legislature. The recommendations of the SOMB do not reflect the recommendations of the Department of Public Safety.

Family First Prevention Services Act (FFPSA) and the Juvenile Standards and Guidelines

The Family First Prevention Services Act (FFPSA) is federal legislation passed in 2018. It seeks to focus child welfare services toward keeping children safely with their families rather than using out-of-home placements. As per SEC. 50702, "*The purpose of this subtitle is to enable States to use Federal funds available under parts B and E of title IV of the Social Security Act to provide enhanced support to children and families and prevent foster care placements through the provision of mental health and substance abuse prevention and treatment services, in-home parent skill-based programs, and kinship navigator services.*"

Previously, Title IV-E funds were used to help with costs associated with foster care. Now the funds are used primarily for children who are *candidates for foster care* to remain in supported care with their parents or relatives. Reimbursement for prevention services is time-limited and available for up to 12 months. To be accessed, States must have a trauma-informed prevention plan, and the prevention services must be rated by the Title IV-E Prevention Services Clearinghouse as promising, supported, or well-supported. As part of the new emphasis on supported in-home placement and family-foster homes, the Act seeks to decrease the use of congregate or group care for children. With few exceptions, reimbursement for children placed in group care settings is limited to two weeks. Placement in a qualified residential treatment program remains possible under the FFPSA but is subject to a series of repeat reviews.

The SOMB Juvenile Standards Revision Committee recognized the potential for changes in juvenile residential placement at the State and local level under the FFPSA Act to have implications for Approved Providers and the Juvenile *Standards and Guidelines*. As out-of-home placements have often been part of best practice in cases where juveniles are adjudicated for sexually harmful behavior against family members, a change in the policy and funding legislation on out-of-home care may impact future case management. The Committee could foresee the potential for a misalignment between the best practice recommendations made by an Approved Provider or the multi-disciplinary team and the placement recommendation and practices made under the FFPSA. To address these potential

implications, the Juvenile Standards Review Committee proposed revisions to two sections of the Juvenile *Standards and Guidelines*, specifically Sections 2.200 Evaluation and 9.310 Family Reunification. The general tenet of the proposed changes is to include discussion points in the relevant sections that acknowledge the potential issues and provide guidance on best practices.

In the Evaluation Section 2.000 of the Juvenile *Standards and Guidelines*, Approved Providers are required to make recommendations based on the risk and needs of the juvenile rather than on the resources currently or locally available. In the amended discussion point, it is recognized that where these recommendations do not match the juvenile's placement or residence, providers should document the circumstances. In the Family Reunification Section 9.310 of the Juvenile *Standards and Guidelines*, it is recognized that there may be circumstances outside the control of the multi-disciplinary team (MDT), when the juvenile and victim have contact due to the juvenile remaining in the home when the juvenile is not eligible for a qualified residential treatment program. The Approved Provider and MDT are guided to document any concerns, establish treatment and safety plans that ensure the psychological and physical safety of the victim, and bring concerns and any new information to the referral source or court as needed for reconsideration of placement or assessment.

The proposed revisions to the Juvenile *Standards and Guidelines* are currently approved by the SOMB to be shared for public comment. Pending a review of those comments by the Juvenile Standards Committee, the final proposed revisions will be recommended to the Board in January 2023. Going forward, the Juvenile Standards Revision Committee will monitor the impact of the FFPSA and continue to work with stakeholders on policies and processes to support best practices with juveniles who have committed sexual offenses.

Housing Barriers for Registered Sex Offenders

Housing instability is a known public health issue and represents a public safety concern with justice-involved populations. Housing instability encompasses a range of challenges, including access to affordable and suitable housing, frequently moving, spending the bulk of income on housing, transience, and homelessness. Housing stability is recognized as important for employment, social services, and individual and family functioning, while housing instability is linked to a range of negative physical, mental, and behavioral health outcomes (Colorado Health Institute, 2020; Geller & Curtis, 2011). Housing shortages and affordability is a known state-wide problem that is not unique to individuals with a history of sexual offending.[21] [22] However, research highlights that justice-involved populations have additional challenges finding suitable and affordable housing (Geller & Curtis, 2011; Herbert, Morenoff, & Harding, 2015), and this is especially pronounced when there is a sex offense conviction history (e.g., Bryne et al., 2022; Evans & Porter, 2015; Levenson, Ackerman, Socia, & Harris, 2015; Tewksbury, Mustain, & Rolfe, 2016). A recent large study involving veterans, for example, found

[21] According to the National Low Income Housing Coalition, the shortage of affordable rental homes in Colorado for extremely low-income renters is 114,378. In Colorado, 22% of renter households meet the definition of "extremely low income" as their income is at or below the poverty guidelines or 30% of their area median income. https://nlihc.org/housing-needs-by-state/colorado.

[22] According to the Colorado Department of Local Affairs (DOLA; 2020), 150,000 Coloradan households were severely cost burdened (i.e., paid more than 50% of their gross household income in housing costs). The impact of housing insecurity was disproportionately experienced by people of color.

https://leg.colorado.gov/sites/default/files/images/dola_2021_housing_taskforce_docs_8-19-21.pdf.

that those on the sex offender registry had almost twice the odds of housing instability and three times the odds of experiencing homelessness than other veterans (Byrne et al., 2022).[23]

From a public safety perspective, housing instability is associated with higher rates of recidivism and return to prison among offenders (Bowman & Ely, 2020; Jacobs & Gottlieb, 2020; Rydberg, Huebner, Grommon, & Miller, 2022). One recent study found that frequent housing moves were associated with a higher rate of *any* rearrest in parolees with a sexual offense conviction (Rydberg et al., 2022). Specifically, greater housing instability was associated with a 38% increase in any rearrest for when there was a sex offense conviction against an adult and a 49% increase when there was a sex offense conviction against a child.[24] Housing instability was an even stronger predictor of return to prison for technical violations, with the rate approximately doubling for individuals with a sex offense conviction.[25] In another study, the odds of *sexual* recidivism amongst persons on the sex offender registry who were transient was six times higher compared to others on the registry who were not transient (Lee, Restrepo, Satariano, & Hanson, 2016).

One barrier to suitable and affordable housing for persons on the sex offender registry is formal and informal residential restrictions. Residence restrictions are laws that prohibit registered persons from living within a specific distance of schools, parks, and other areas where children congregate with the intent to limit the accessibility of potential victims. An additional type of law limits the number of persons on the registry that can reside in family dwellings and group homes. Although Colorado has no state-wide residential restrictions, several local municipalities have adopted their own.[26] These tend to prohibit persons on the sex offender registry from residing within 300-1000 feet of schools, daycare centers, and parks,[27] or restrict the number on the registry who can live in a residence from zero to three.[28] A potential ripple effect of residential restriction ordinances is that neighboring municipalities may feel pressure to adopt similar prohibitions to respond to heightened community fear that persons on the sex offender registry will move into their neighborhoods. Research shows that residential instability and homelessness increase after the passage of residential restriction laws due to them zoning out significant geographical areas as housing options (Byrne et al., 2022; Cann & Scott, 2020; Levenson, 2018; Rydberg et al., 2014; Suiter & Anderson, 2022; Tewksbury, Mustain, & Rolfe, 2016).

[23] Another recent study found the rate of homelessness was five times greater amongst veterans on sex offender registries compared to veterans not on registries (VA National Center on Homelessness among Veterans, 2020).

[24] Rearrests rates for sexual and nonsexual offenses were not separated in the data as the rate of rearrest for sexual recidivism was low over the two-year follow-up period both in the parolees with a sexual offense conviction (1.3%) and parolees with a non-sexual offense conviction (0.1%).

[25] For individuals with a sex offense conviction against an adult or child the likelihood approximately doubled. In comparison, the effect size was approximately half for individuals with a non-sex offense conviction.

[26] A review of city residence restrictions provided by Colorado Legal Defense Group indicated 13 cities had prohibitions against registered sex offenders residing within a set distance of child spaces while another 16 cities restricted the number of registered sex offenders who could reside in a household or group home. See https://www.shouselaw.com/co/blog/criminal-defense/are-there-residency-restrictions-for-sex-offenders/#2

[27] Some municipalities focus exclusively on individuals registered as sexually violent predators, while others more broadly specify registered sex offenders. Cities with these types of residential restrictions include Alamosa, Black Hawk, Castle Rock, Commerce City, Dacona County, Englewood, Greeley, Greenwood Village, Johnstown, Kiowa, Mancos, Mead, and Westminster (Colorado Legal Defense Group, https://www.shouselaw.com/co/defense/).

[28] Most municipalities limit the number of registered sex offenders living in a household or group residence to one. Cities with these types of restrictions include Alma, Arvada, Bennet, Brighton, Broomfield, Brush, Buena Vista, Federal Heights, Fort Morgan, Frasier, Hot Sulphur Springs, Lafayette, Lochbuie, Louisville, Sheridan, and Thornton (Colorado Legal Defense Group, https://www.shouselaw.com/co/defense/).

Many landlords are also likely to implement their own formal or informal residential restrictions further compounding a lack of access to housing options (Evans & Porter, 2015).

Despite the intention to protect children and promote public safety, research does not support residential restrictions as an effective mechanism to reduce sexual recidivism (Colombino, Levenson, & Jelic, 2011; Colorado Department of Public Safety, 2004; Levenson, 2018; Zandbergen, Levenson, & Hart, 2010; Levenson, Zgoba, & Tewksbury, 2007; Minnesota Department of Corrections, 2007; Socia, Levenson, Ackerman, & Harris, 2015; Socia & Stamatel, 2010; Socia, 2013). Research has failed to demonstrate that the introduction of residential restrictions has reduced repeat sex crimes, nor that distance living from places children congregate is an important factor in repeat sex offending (Columbino, Mercado, Levenson, & Jeflic, 2011; Levenson, 2018). Residential restrictions also do not fit with the known factors related to sexual recidivism (e.g., Babchishin & Hanson, 2020; Hanson & Morton-Bourgon, 2005). Instead, research has shown that risk varies considerably among individuals convicted of sex offending, with the lowest risk group having less likelihood of arrest for new sex crimes than offenders without a sex offense history (Hanson, Harris, Letourneau, Helmus, & Thornton, 2018). The research also shows that sexual recidivism risk declines substantially over time the longer individuals live in the community offense-free. Even for individuals assessed as high-risk when convicted or released, risk can decline to low levels with successful reintegration.

Another consequence of formal and informal residential restrictions is that available housing tends to be in the least desirable urban areas.[29] It tends to be in these areas that social disorganization and its components are most prevalent, including poverty, lack of social capital, poor quality housing stock, and crime. A recent 15-year longitudinal study of residential locations of persons on the sex offender registry found that a third of those followed moved into more socially disorganized neighborhoods (Tewksbury et al., 2016). The remainder stayed stable; none improved. The social decline was most pronounced for persons from racial minority groups, in keeping with the findings of other studies (Bryne et al., 2022; Cann & Scott, 2020; Mustaine & Rolfe, 2016; Suiter & Anderson, 2022). Residing in more socially disorganized communities exacerbates limited employment opportunities, reduced access to treatment services, and challenges developing positive social support networks, all of which have an important role in preventing future crime and improving overall outcomes (Hackett, Darling, Balfe, Masson, & Phillips, 2022; Nolan, Willis, Thornton, Kelley, & Beggs-Christofferson, 2022). The need to use temporary housing solutions like motels in undesirable locations to prevent housing instability is further driven by formal or informal restrictions imposed by some emergency shelters (Levenson et al., 2015; Rolfe, Tewksbury, & Schroeder, 2017) and the reduced access to housing aid programs experienced by persons who are registered sex offenders.[30]

In addition to being a risk factor for recidivism, there are reasons to believe that housing instability and its consequences compromise the effectiveness of sex offense-specific treatment. Housing is a basic human need and stable housing serves as an anchor for treatment attendance and engagement. Offender treatment readiness models recognize that engagement and progress depend on having *both* certain internal conditions or characteristics (e.g., motivation) *and* living in an environment where

[29] A research study undertaken by the Minnesota Department of Corrections (2015) found that concentrated disadvantage relative to affluence was the most consistent predictor of where registered sex offenders resided at greater rates.

[30] For example, the US Department of Housing and Urban Development (HUD) excludes any household with a member who has a lifetime sex offender registration accessing federally assisted housing (Sreenivasan, McGuire, Azizian, & Holliday, 2022); also see https://www.hud.gov/sites/dfiles/PIH/documents/HCV_Guidebook_Eligibility_Determination_and_Denial_of_Assistance.pdf.

changes are possible and supported (Ward, Day, Howells, & Birgden, 2004). In the behavioral health field, housing issues are given greater recognition as a barrier to treatment engagement, as it is generally recognized that meeting these basic needs takes precedence over attending treatment (SAMHSA, 2015, 2021). Similarly, in the behavioral health field housing interventions have been found to improve client access to mental health treatment (Leff et al., 2009). Addressing housing and treatment needs concurrently is now viewed as best practice in that sector (SAMHSA, 2021).

The extent of housing instability and homelessness for persons on the Colorado sex offender registry does not appear to have been systematically documented or examined to date. A research report conducted by the Department of Public Safety in 2004 for the Colorado Senate Judiciary Committee addressed safety issues raised by shared living arrangements and locations of persons on the sex offender registry.[31] The research found that shared living arrangements were a successful mode of containment for those classified as higher risk.[32] Placing restrictions on the residential location of correctionally supervised persons with a sex offense conviction was not supported as an effective method of reducing sexual recidivism. As that research predates the last decade when housing accessibility and affordability significantly worsened in Colorado, however, it may no longer accurately reflect the current housing affordability and accessibility challenges. More recent anecdotal accounts in the media and by various stakeholders present housing instability as a significant issue.[33] A recent query with the Colorado Bureau of Investigation found that the Colorado Sex Offender Registry recorded 5-6% of current registrants as homeless or transient.[34] That rate is consistent with recently published reports for California and Florida (Lee et al., 2016; OPPAG, 2021), where housing instability for persons on the sex offender registry is considered a significant issue.[35] An informal query with Community Corrections indicated that about half of all community corrections programs do not typically accept registered sex offenders, further confirming reduced access to treatment services locally.

In an effort to counter misunderstanding, stigma, and exaggerated fears regarding the dangerousness of all persons with a sex offense conviction, the SOMB produced a variant of a research-based white paper addressing housing barriers for persons on the sex offender registry. The paper consists of a research-based informational handout titled *Housing Barriers for Sex Offenders* that is suitable for use by SOMB Approved Providers, justice agencies, and persons with a sex offense conviction. The handout outlines basic facts and key research on individuals with a sex offense conviction, including information on risk, recidivism, reintegration, and housing that encourages a reasoned approach to decision-making

[31] Shared Living Arrangements (SLAs) was a variation of a therapeutic community treatment modality that was used by three sex offender treatment programs at the time of the study. SLAs typically involved 2-3 individuals living together in a house (rented or owned) under the approval of the treatment provider and supervising officer. As part of the SLA, individuals were required to implement a therapeutic community model that involved supporting treatment objectives and holding each other accountable (including notifying the appropriate authorities of breaches of contract or concerns). Residence checks were a component of the SLA.

[32] Of note, shared living arrangements are the type of housing solution prevented by local ordinances that restrict the number of registered sex offenders who can live within a group home or dwelling.

[33] A local newspaper article includes data showing disproportionate rates of Coloradoan registered sex offenders living in impoverished neighborhoods and suffering homelessness. See, https://coloradosun.com/2019/07/24/registered-sex-offenders-low-income-neighborhoods/.

[34] The number of current registered sex offenders entered in the sex offender registration database as transient was 639 and homeless was 458 (data as of 10/6/22). The total number of registered sex offenders in Colorado was 19,172 (as of 11/3/2022) (CDPS CBI, personal communication, 11/3/2022). The demographic breakdown of those figures was not known.

[35] Several research and media reports have highlighted large homeless encampments of registered sex offenders (see Levenson, 2018).

(Rich, 2020). The SOMB also produced a short PowerPoint presentation to support the information in the handout that can be used by Approved Providers or other stakeholders.

In addition, in future updates to the SOMB Provider Data Management System, questions about housing instability may be added to enable future analyses to evaluate whether housing instability has a moderating effect on treatment attendance, progress, or recidivism. The SOMB is also examining whether it is possible to report on the rates of housing instability in the Annual Lifetime Supervision Report. More broadly, the SOMB would also support annual or biannual data collection efforts by other government stakeholders, so the rates of housing instability among persons on the sex offender registry could be documented and tracked over time. Having this data on a regular basis would enable the extent of the problem to be monitored and the potential impact of any broad housing initiatives or social policies to be assessed. It may also assist other state and community agencies involved in developing housing policies or programs to understand and consider the needs and circumstances of this subpopulation.

Additional approaches to addressing housing instability for persons with a sex offense conviction discussed in the literature include promoting "rule of reason" policies rather than blanket exclusions, limiting the use of criminal background checks, and considering allowing certificate of relief mechanisms for individuals with a conviction to apply to persons on the sex offender registry in specific instances. As an alternative to residential restriction laws, loitering laws or child safety zones have been suggested as a better mechanism for prohibiting persons on the registry from loitering in places where children tend to be present without a legitimate reason or prior permission (Levenson, 2018).[36] The benefit of loitering laws is that they allow policing of risk-related behaviors and enforcement of consequences while not reducing the geographic areas of potential housing.

SOMB 2022 Sunset Review

The Colorado Department of Regulatory Agencies published its Sunset Report of the SOMB on October 14th, 2022. According to DORA, "a sunset provision repeals all or part of a law after a specific date unless the Legislature affirmatively acts to extend it." The sunset review process involves a thorough evaluation of programs according to specific statutory criteria (§ 24-34-104, C.R.S.) and is based upon input from a broad spectrum of stakeholders, including consumers, government agencies, public advocacy groups, and professional organizations. The SOMB has been subject to several Sunset Reviews since its inception in 1992, with the most recent prior review occurring in 2019. The first three recommendations in the current review reiterated recommendations made in 2019. Sunset reviews serve a meaningful role in improving the services offered to offenders without compromising community or victim safety.

After a comprehensive review of the SOMB, the 2022 Sunset Report recommended the following changes to Statute:

1. Continue the Sex Offender Management Board for seven years, until 2030.

[36] Two municipalities, Evans and Garden City, have local loitering laws that prohibit registered sex offenders being in places where children congregate without legitimate purpose or permission (Colorado Legal Defense Group, https://www.shouselaw.com/co/defense/).

Despite continuing to note some inefficiency in the SOMB processes, DORA reasoned that the standardization of services was largely accomplished and that the SOMB offered a forum for important discussions to occur at various stages of the policy-making process. DORA echoed the concerns regarding the number of appointed members on the SOMB made by an independent parliamentary examiner hired to examine SOMB processes in 2019. These issues notwithstanding, DORA concluded that the SOMB and its duties are necessary to protect the public health, safety, and welfare which warrant reauthorization.

2. Clarify that supervising officers are required to follow *Standards and Guidelines* when working with sex offenders and direct those agencies that employ supervising officers to collaborate with the SOMB in developing procedures to hold accountable those who fail to do so.

   DORA noted concerns were identified during its prior review that some supervising officers are not following the *Standards and Guidelines*. Both the Adult and Juvenile *Standards and Guidelines* are premised upon a coordinated and team-based approach for the professionals involved with supervision and treatment, which include supervising officers. Since supervising officers are not listed or otherwise approved by the SOMB (unlike evaluators, treatment providers, and polygraph examiners), it is unclear whether the SOMB has any ability to enforce compliance with the *Standards and Guidelines* with supervising officers.

3. Repeal the limitation on the number of treatment providers given to offenders and provide every available listed treatment provider

   Pursuant to § 16-11.7-105(1), C.R.S., the supervising agency of any person convicted of a sexual offense living in the community must provide a choice of two appropriate treatment provider agencies approved by the SOMB. The analysis by DORA concludes that this statutory requirement unnecessarily limits competition and the availability of listed providers. The report further requests that § 16-11.7-105(2), C.R.S. remain without modification, which states that once selected, the treatment provider agency may not be changed by the offender without the approval of the CST, the MDT, or the court.

4. Require standards compliance reviews on at least 10 percent of approved providers every two years.

   DORA noted that standards compliance represents an important component of meeting the statutory mandate to promote the consistent provision of services for sex offenders throughout the state to lower the incidence of reoffense. Although the SOMB conducts provider-for-cause compliance reviews, and these produce a high proportion of Compliance Action Plans, the SOMB lacks the staff resources to conduct random compliance reviews. DORA reasoned that several aspects of sex offender treatment are uniquely different from other types of mental health treatment and further raise the stakes of ensuring providers comply with the *Standards and Guidelines*. Importantly, the SOMB was created to protect victims and potential victims, receiving inadequate treatment presents an increased risk of harm to victims and the community, offenders have limited agency within the treatment context, and the consequence of poor outcomes can be severe for offenders. On these grounds, DORA recommended random provider compliance reviews.

5. Modernize the language related to criminal history record checks and fingerprinting requirements.

   DORA requested that the General Assembly update the language in § 16-11.7-106(2))a)(I), C.R.S., relating to criminal history checks and fingerprinting to align it with the use of a third-party vendor collecting and forwarding this information to the Colorado Bureau of Investigation and the Federal Bureau of Investigation.

6. Repeal the requirement that the Department of Regulatory Agencies participate in the publication of the list of approved providers.

   Dora requested that § 16-11.7-106(2)(b), C.R.S., is repealed as DORA is not involved in the compilation or publication of this list, and the SOMB maintains a publicly accessible website with a searchable database of approved providers.

Section 3: Milestones and Achievements

Overview of 2022 Accomplishments

Over the last year, the SOMB has continued to adapt to the challenges of the (post) COVID-19 pandemic and respond to business-as-usual requirements. The SOMB has moved from an online format to a hybrid model for meetings and training. As part of this, the SOMB was able to host its annual conference in person while extending an online option for those who preferred. Over 500 stakeholders participated, with access to sessions remaining online for three months. Continued efforts were made to support stakeholders, including updating the policy about using teletherapy as a treatment modality to allow for its continued use in line with best practices. Multiple avenues for learning about and clarifying the application of the *Standards and Guidelines* continued to be available, from lunch-and-learn seminars to regular emails and newsletters and individualized consultation with the SOMB Standards Coordinators. Motivational and self-care sessions were also provided at the conference. The SOMB also focused on issues of Equity, Diversity, and Inclusion (EDI). A regular series of presentations on EDI topics were included in monthly SOMB board meetings, and EDI considerations were featured in much of the training provided. Work on EDI issues occurred in several committees focused on revisions to the *Standards and Guidelines*.

SOMB Board Membership and Decision-Making Process

The SOMB welcomed seven new Board members in 2022 resulting in a fully staffed board of 25 members. The Board consists of representatives from the Department of Corrections, the Judicial Department, law enforcement, the Public Defender's Office, private criminal defense attorneys, rural and urban County Commissioners, clinical polygraph examiners, the Division of Youth Services, Department of Public Safety, District Attorneys, the Department of Human Services, licensed mental health professionals with expertise in treating sex offenders, the victim services community, the Department of Education, and community corrections. The Board voted to reappoint Kim Kline MA, LPC, ACS, to the Chair position for another two-year term.

The SOMB updated its policy regarding gathering Public Comments about proposed amendments to the *Standards and Guidelines* as part of the Board's decision-making process. In the prior version, a Public Comments period followed proposals being presented to the Board as a decision item for approval and before the final step of ratification. Essentially, after a series of phases of proposal, work, revision, and stakeholder/public input at the committee level, proposed amendments to the *Standards and Guidelines* went before the full Board for approval. If approved by the Board, the proposed amendments then went to a formal Public Comment period. The Board then reviewed the public comments at the next meeting and considered ratification of the proposal or, alternatively, returning the proposal to the committee level for further work or abandoning the item.

In the updated version of the policy, a formal Public Comments period occurs at an earlier stage of the decision-making process. The public comments then go back in the first instance to the original committee or workgroup responsible for the proposal for review and consideration. All proposed amendments to the *Standards and Guidelines* will continue to go through the same phases of proposal, work, revision, and stakeholder/public input phases at the committee and workgroup level, but once ready, the proposal is then presented to the full Board for approval to seek a formal Public Comment period. The originating committee or workgroup then considers the public comments and whether additional revisions are needed before following the standard process to have the proposal returned to the full Board for approval and ratification. The Board will be provided the public comments for review along with the final proposal. Other aspects of the decision-making policies and processes remain unchanged.

By adopting this revised Public Comments policy, the SOMB is giving the public an earlier formal opportunity to comment on and influence revisions to the *Standards and Guidelines*. The SOMB committees and workgroups developing the proposal are also given the opportunity to consider the public's perspective on policy initiatives before finalizing their work for Board approval and ratification. The Board will continue to consider public comments before any ratification of a proposal but as well can consider how any concerns expressed by the public are addressed in the proposal by the committees and workgroups.

SOMB 30TH Anniversary

The SOMB celebrated its 30th anniversary in 2022. The Colorado General Assembly passed legislation establishing the Sex Offender Treatment Board in 1992 and subsequently changed the name to the SOMB in 1998. In 2000, legislation created a requirement for a standardized set of procedures for the evaluation and identification of juveniles who have committed sexual offenses also. In recognition of the past 30 years, the SOMB celebrated in some modest and more formal ways. A series of "fun facts" about the SOMB were posed at SOMB meetings in the first part of the year. An anniversary event was hosted at the SOMB annual conference in July that was attended by the Director of the Division of Criminal Justice, CDPS, and many current and former members of the SOMB.

Efforts toward Equity, Diversity, and Inclusion

The SOMB continued to build upon prior efforts to strengthen equity, diversity, and inclusion (EDI) within the SOMB and the provider community. The SOMB prioritized discussion on EDI through its range of training options. A regular series of presentations were included in the monthly SOMB Board Meetings that addressed EDI issues and gave providers an opportunity to earn training credits. Topics included the intersection of violence-race-gender-sexuality, sex offense-specific treatment with clients of diverse ethnic backgrounds, victimization within the LGBTQ community, and presentations in honor of African American, Asian America, Hispanic American, and Native American heritage months. Workshops for providers on EDI issues were provided during the year as part of the SOMB advanced training series and within multiple sessions at the SOMB annual conference. The SOMB continued to incorporate inclusive questions in training and conference abstracts and the requirement that presenters describe how EDI would be addressed during their training or presentation.

The SOMB continued to address EDI in amendments to the Adult and Juvenile *Standards and Guidelines*. In the Adult *Standards and Guidelines*, the section on language, culture, and ethnic considerations was

expanded substantially to include standards and guidance on the use of interpreters during evaluations based on research and recommended best practices. Additional committee work on Section 2.000 Evaluations also explicitly highlighted cultural considerations and limitations when using risk and other psychological assessment instruments. A comprehensive research literature review on treatment responsivity also focused on the extent that race-ethnicity is a potential responsivity factor that influences engagement and progress in treatment.

Improving EDI representation in the provider community was a central objective of a research project to develop strategies to retain current providers and attract new providers. The project included a racial-ethnically diverse group of participants in line with national demographic population rates to ensure the representation of diverse views. The results were separated by race-ethnicity, gender, and other demographic categories so the findings could be considered through an EDI lens. Other analyses and research conducted by the SOMB on client tracking data included a focus on the race-ethnicity of the clients and how this influenced the findings.

Family Resource Guide

The SOMB Family Education, Engagement, and Support Working Group completed and released to the public a *Resource Guide for Families of Adults Accused, Charged, or Convicted of Sexual Offenses in Colorado*. The working group was established in June 2015 in response to family members' concerns about what happens to relatives who are accused or convicted of a sex offense. The group met monthly for six years and had input from family members, concerned citizens, advocates for people with sexual offenses, advocates for people who have been sexually victimized, community and prison-based therapists, probation and parole representatives, legal representatives, Board members, and SOMB staff. The resource provides information to family members from arrest to post-sentence that recognizes the impact on families and gives advice for coping and obtaining helpful information. The resource is organized into three parts: Supporting Your Loved One from Arrest to Sentencing, Serving the Sentence (with post-sentence considerations), and Agency Specific Information. The resource is freely available for download to the public. https://www.advocates4change.org/family-resource-guide/.

Provider Retention and Recruitment Project: Orange Circle Consulting

The Office of Domestic Violence and Sex Offender Management (ODVSOM) recognized a need to address the future recruitment and retention of Approved Providers participating in domestic violence and sex offense-specific treatment to enhance provider diversity and to ensure a sufficient and healthy workforce. Factors including a competitive labor market in the mental health professions, the additional stress of practicing in a forensic-legal context, and the nature of the therapeutic work can dis-incentivize becoming an Approved Provider. Orange Circle Consulting was recruited to complete an analysis of these recruitment and retention challenges and provide recommendations to attract additional Providers. More specifically, Orange Circle Consulting was to conduct formative research to develop effective strategies to attract new providers to the field and retain existing providers. The resulting strategies could be implemented or supported by the ODVSOM and shared with stakeholders to enhance similar efforts for their agencies and professions. The project involved collecting survey data on individuals currently pursuing or working as a therapist to identify core values that may align with and motivate becoming an Approved Provider. The survey also sought to determine existing knowledge and perceptions about the Colorado SOMB and DVOMB approaches. Attention was paid to participant recruitment to ensure the sample sufficiently represented people of Hispanic and African

American identities. A second arm of the project involved interviews and focus groups with current Colorado SOMB and DVOMB stakeholders to develop an understanding of how existing Approved Providers entered these fields of practice and identify any potential barriers or disincentives to becoming or remaining in this field.

A full summary of the project findings is provided in **Appendix B**. Survey respondents indicated that key influences in choosing a mental health profession were the desire to help people and an understanding of the benefits of therapy. Respondents willing to consider becoming an Approved Provider were more likely to show interest in helping achieve victim safety through offender rehabilitation, helping to make positive changes at a community level, and learning about the intersection between psychology, law, and forensic practice. Respondents of Hispanic and African American identities indicated a high willingness to consider becoming an Approved Provider. Stakeholder participants indicated that many came into this field of work by accident rather than with intention. Most identified the desire to make a positive impact on individuals and communities as a key motivator, alongside a curiosity to learn and work in a forensic context. Practicing in a field with a strong emphasis on evidence-based practices was seen as positive. Almost all stakeholders described working with this client group as mentally and emotionally challenging and highlighted that an additional element of professional liability and risk exists that is not perceived in general mental health settings.

For marketing and recruitment purposes, the project identified a range of potential audiences that could be targeted and noted that investments in internships and developing mentorship programs may help raise awareness within student training settings. Developing materials to showcase the positive aspects and outcomes of working with the client populations was also suggested as a strategy that could be effective in recruitment. Messaging that highlights the emphasis in the Colorado *Standards and Guidelines* on victim and community safety, evidence-based practices, EDI (equity, diversity, and inclusion), and being responsive to people's cultural identities would appear to align with the motivating values and interests expressed by survey respondents and stakeholders. Identifying opportunities to reach out to trainees or current mental health professionals of Hispanic and African American identities seems pertinent. A public relations outreach effort with existing Approved Providers was also suggested.

A full summary of the project findings is provided in **Appendix B**.

Move to Hybrid Platforms for Board Operations

The SOMB continued to adapt to the (post) COVID-19 pandemic environment by using and embedding hybrid platforms into all its operations. All Board meetings, most training, and many committee meetings can now be attended either in person or online. The use of a hybrid model will continue for the foreseeable future as it provides greater access and flexibility to stakeholders and supports SOMB's efforts to optimize stakeholder engagement and transparency. The success of these efforts is visible at monthly SOMB meetings where a rotating mix of Board members attend virtually (in lieu of not being able to attend at all), and a broad range of speakers have presented online that would not otherwise have been accessible. The SOMB's hallmark training event, the joint annual conference with the Domestic Violence Offender Management Board (DVOMB), successfully utilized hybrid in-person and online registration to meet the needs of stakeholders. Over 500 people attended in person, and all conference sessions were available online for three months following the conference.

Adult and Juvenile Standards and Guidelines Citation Reviews

Following implementation of the SOMB Audit recommendations related to documenting the presence or absence of research support for the *Standards and Guidelines*, the SOMB conducted an internal review to determine the extent the *Standards and Guidelines* are supported by evidence-based and research-informed sources. The Adult *Standards and Guidelines* is a 353-page document, while the Juvenile *Standards and Guidelines* is a 282-page document. Both are organized into sections reflecting specific services or issues (e.g., Section 2.000 Standards for Sex Offense-Specific Evaluation, Section 5.700 Contact with Victims, Children, and Vulnerable persons). Within each section are a series of criteria that mandate or guide the objectives, activities, and processes of Approved Providers and members of the community supervision or multidisciplinary teams. Some criteria are evidence-based and research-informed directives or guidance, some are requirements due to statutory regulations, and others are procedural instructions reflecting best or generally accepted practices. The objective of the review was to determine the proportion of criteria that reflected these three types of *Standards and Guidelines*.

The methodology involved reviewing the criteria and whether they were explicitly linked via citations or referencing to research sources, statutory regulations, or procedural best practice documents. Where criteria included multiple types of supporting sources (e.g., research and statutory), both were recorded. As a result, the percentages identified exceed 100%. For the Adult *Standards and Guidelines*, the review found that 77% were supported by research either directly in the document in footnote citations or via a research citation document attached at the end of each section. The review found that 25% reflected statutory regulations and 20% reflected procedural best practices. For the Juvenile *Standards and Guidelines*, the review found that 53% were supported by research sources, 41% reflected statutory regulations, and 8% reflected procedural best practices. The findings indicated that the Adult and Juvenile *Standards and Guidelines* are predominantly supported by evidence-based and research-informed sources. The SOMB anticipates refining the methodology to enable similar reviews to be incorporated into the ongoing section-by-section revision work undertaken by the Adult and Juvenile Standard Revision Committees.

Policy and Regulatory Work

Committees

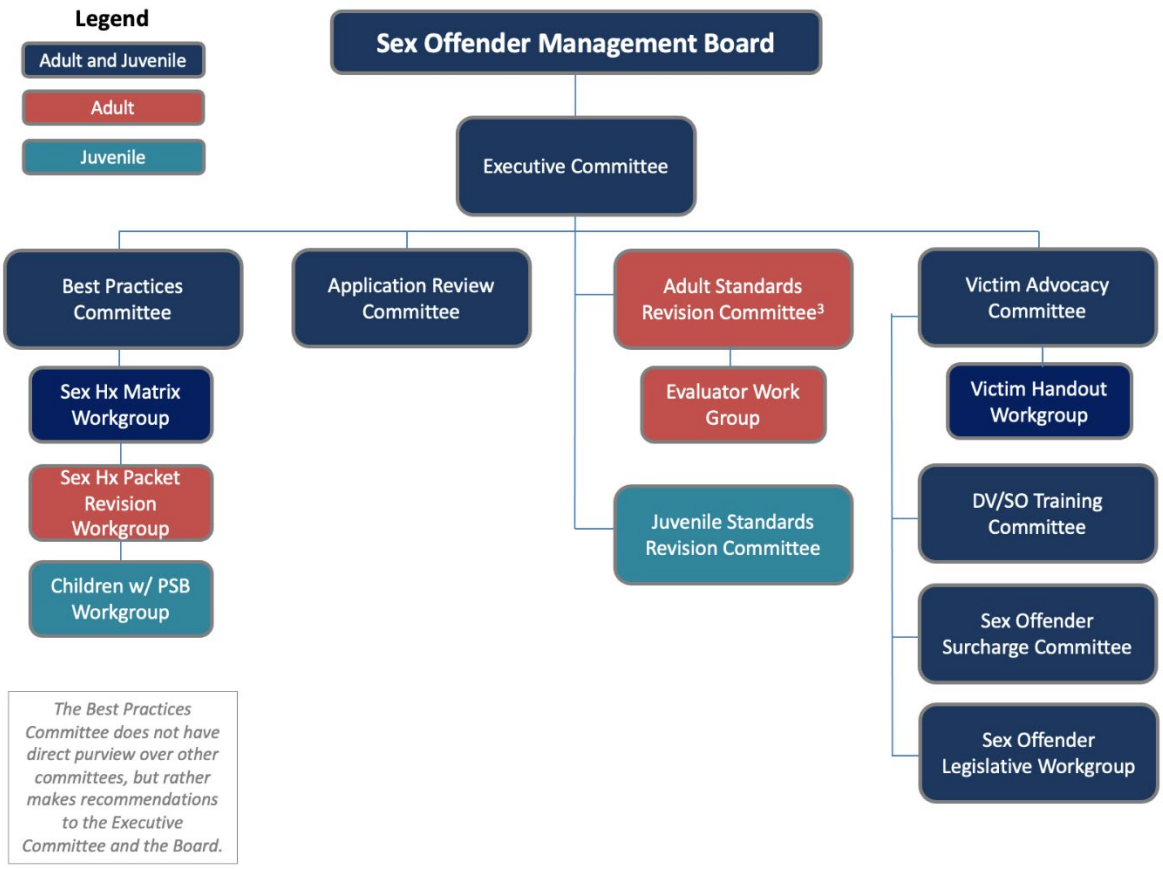
Most of the work conducted by the SOMB occurs at the committee level. Within these committees, a variety of policy and implementation-related work is proposed, discussed, and reviewed by relevant stakeholders. The committees then make proposals for the SOMB to consider. As needed, workgroups are formed to address specific topics that then report back to the governing committee. The SOMB staffed 14 active committees and workgroups during 2022 to work on statutorily mandated duties. All committees were open to all stakeholders. The committees and workgroups are shown visually in Figure 10 and were as follows:

1. Executive Committee
2. Best Practices Committee
    a. Sex History with New Non-sex Crime Workgroup
    b. Sex History Packet Revision Workgroup
    c. Children with Problematic Sexual Behavior Workgroup

3. Application Review Committee
4. Adult Standards Revisions Committee
    a. Evaluator Workgroup
5. Juvenile Standards Revision Committee
6. Victim Advocacy Committee
    a. Victim Handout Workgroup
7. DV/SO Training Committee
8. Sex Offender Surcharge Committee
9. Sex Offender Registration Legislative Work Group

All these committees have been and continue to be engaged in studying advancements in the field of sex offender management, recommending changes to the Adult and Juvenile *Standards and Guidelines* as supported by research, and suggesting methods for educating practitioners and the public to implement effective offender management strategies. For a comprehensive summary of the work of the SOMB committees, please refer to **Appendix C**.

Figure 10. Organizational Chart of SOMB Committees and Workgroups.



Applications for Listings on the SOMB Approved Provider List

As of the start of November 2022, During the calendar year of 2022[37], the Application Review Committee of the SOMB received 157 new applications for new listings, move up in status, and renewals on the Approved Provider list. The Application Review Committee approved 185 applications, which included applications that were outstanding (pending) from the previous 12-month period as well as applications that were submitted and processed within this 12-month period. A total of 38 applications were outstanding (pending) at the completion of the 12-month period. The SOMB count of approved applications report for 2022 is shown in Table 7.

Table 7. SOMB Count of Approved Applications Report for 2022

Application Type	Number Submitted	Number Approved	Number Pending
Application 1 (Initial)	50	48	4
Application 2 (Advancement)	53	51	14
Application 3 (Renewal)	54	86	34
Total	157	185	52

Current Availability of Providers

As of November 2022, the SOMB has 365 approved providers in total. Within that total of 365, **246** are adult treatment providers and **185** are juvenile treatment providers.[38] Within that overall total, the SOMB has 25 polygraph examiners, of whom **25** are adult polygraph examiners and **15** are juvenile polygraph examiners. Providers may choose 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 as well, such as approval to work with individuals with developmental-intellectual disabilities or approval to offer clinical supervision services. As a result, an approved provider may have up to eight listings some of which may have additional Developmental Disability/Intellectual Disability (DDID) specialization. Table 8 shows the current numbers of approved providers in Colorado by service listing.

In addition, each approved provider has specific counties in which they provide services. Figure 11 through 16 show the distribution of approved adult and juvenile evaluation, treatment, and polygraph providers across Coloradan counties. On average, each provider operated in three different counties. In

[37] The 12-month period used was 11/1/2021 to 10/31/22.

[38] 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.

total, the SOMB has approved providers located in all 22 judicial districts in the state.

Table 8. Number of approved sex offender service providers in Colorado, 2022[39]

		Service Level		
Population	**Service Listing**	**Associate**	**Full Operating**	**Total**
Adult	**Treatment Provider**	**84**	**162**	**246**
	Treatment Provider DD/ID[40]	*18*	*35*	*53*
	Clinical Treatment Supervisor	*N/A*	*92*	*92*
	Evaluator	**33**	**67**	**100**
	Evaluator DD/ID	*5*	*12*	*17*
	Clinical Evaluator Supervisor	*N/A*	*42*	*42*
	Polygraph Examiner	**5**	**20**	**25**
	Polygraph Examiner DD/ID	*2*	*11*	*13*
Juvenile	**Treatment Provider**	**75**	**110**	**185**
	Treatment Provider DD/ID	*6*	*21*	*27*
	Clinical Treatment Supervisor	*N/A*	*58*	*58*
	Evaluator	**21**	**39**	**60**
	Evaluator DD/ID	*3*	*11*	*14*
	Clinical Evaluator Supervisor	*N/A*	*21*	*21*
	Polygraph Examiner	**4**	**11**	**15**
	Polygraph Examiner DD/ID	1	5	6

Note: Italicized categories contain providers who may be approved to provide additional services and are not used to calculate the sum.

[39] The numbers come from the new SOMB Provider Database and show a date-in-time snapshot of Provider data on 11/1/2022. Any major discrepancies between these numbers and those from previous year's report may reflect the change in data management system and refinement of reporting processes.

[40] DD/ID indicates the provider has met the standards to be approved to provide services specifically to individuals with Development Disability/Intellectual Disability.

Figure 11. Number of SOMB Adult Treatment Providers by County

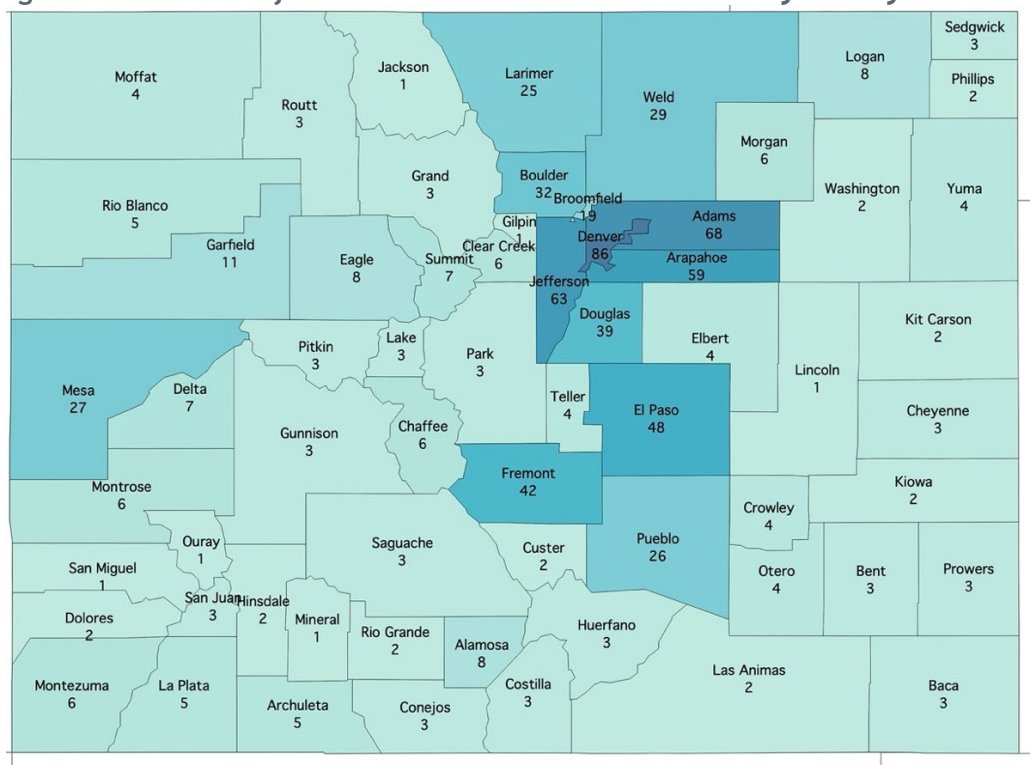


Figure 12. Number of SOMB Juvenile Treatment Providers by County

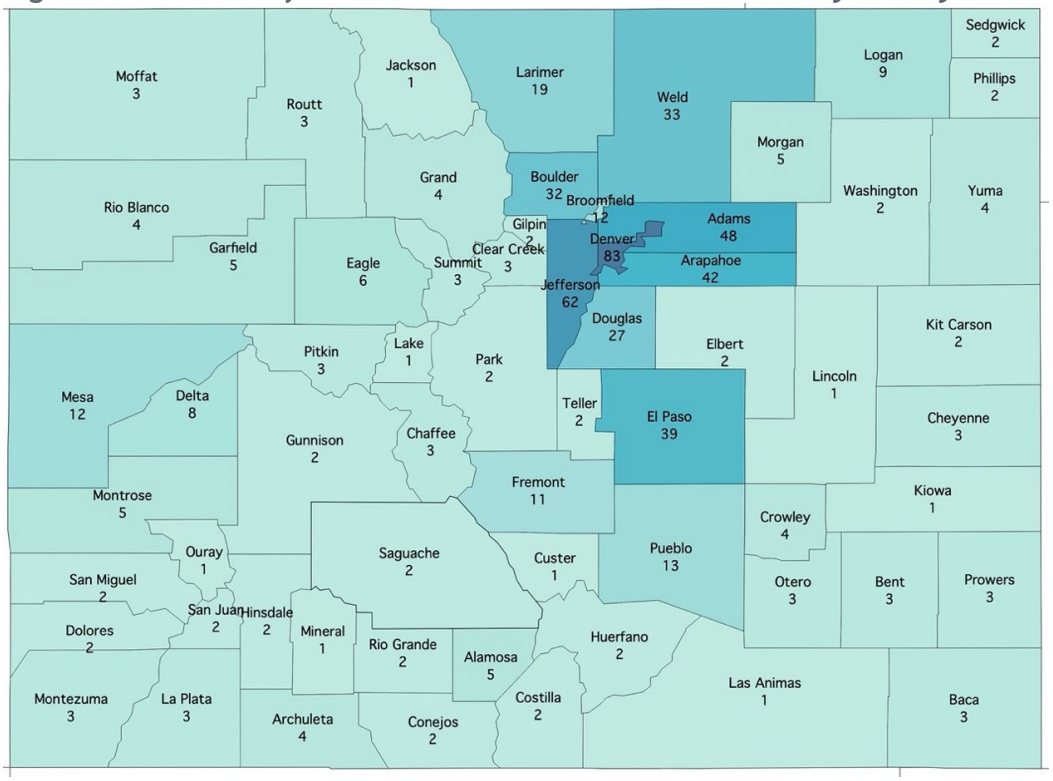


Figure 13. Number of SOMB Adult Evaluators Providers by County

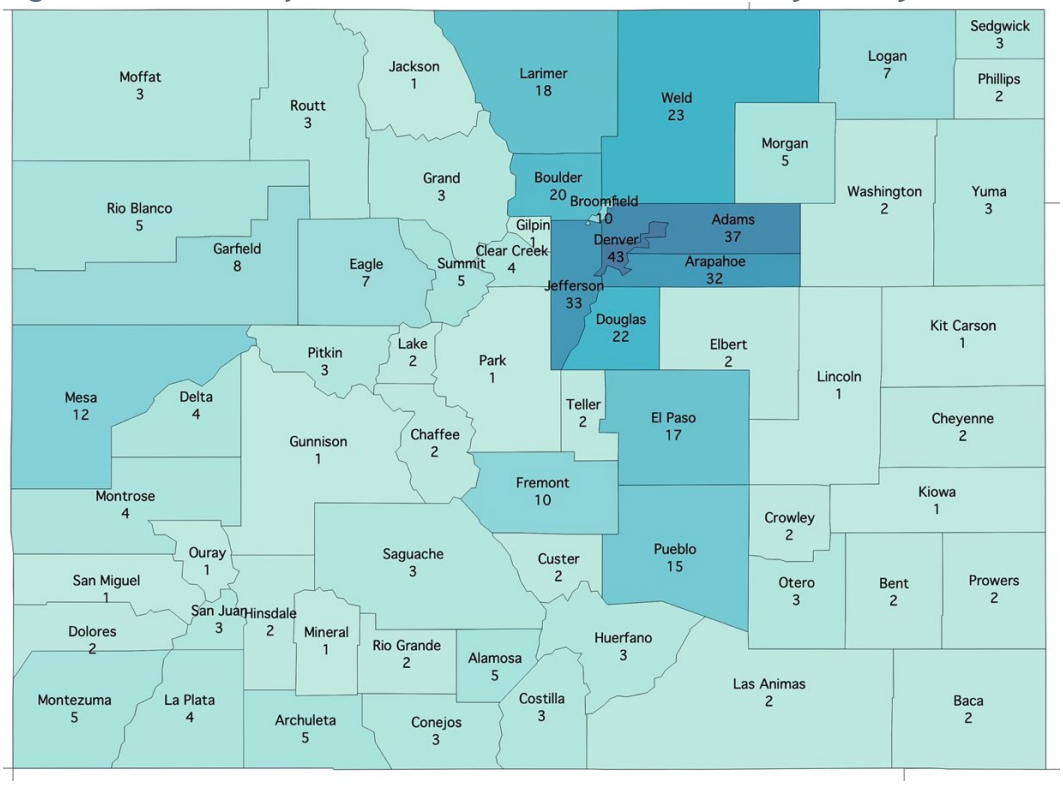


Figure 14. Number of SOMB Juvenile Evaluators by County

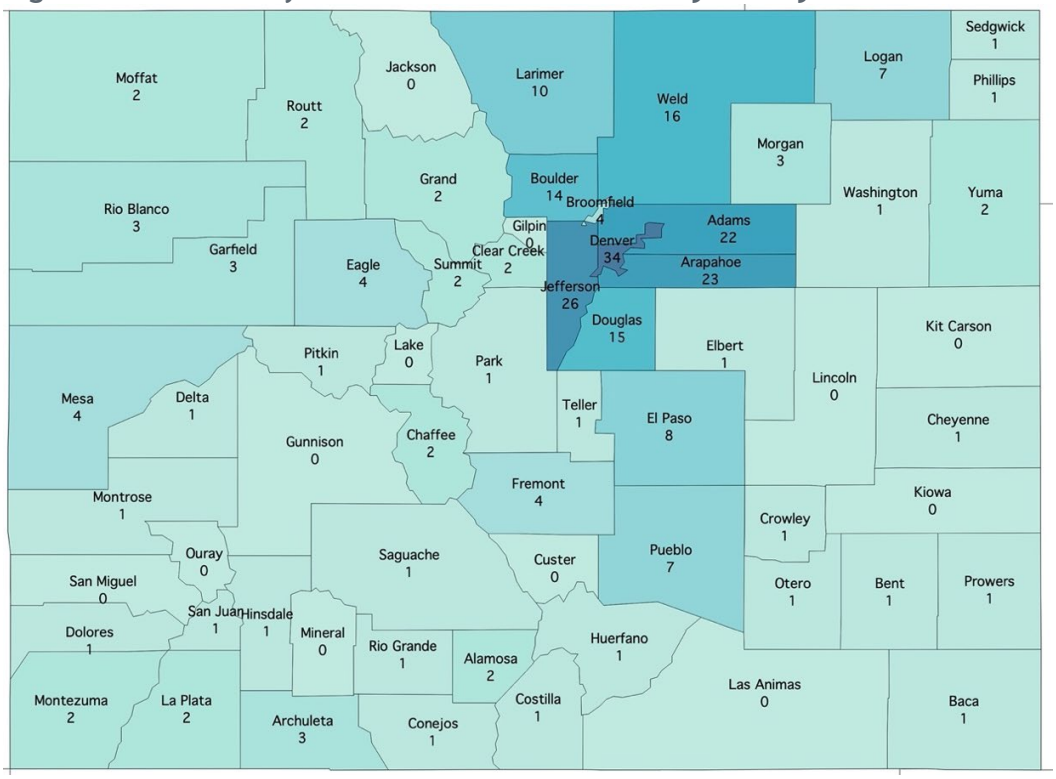


Figure 15. Number of SOMB Adult Polygraphers by County

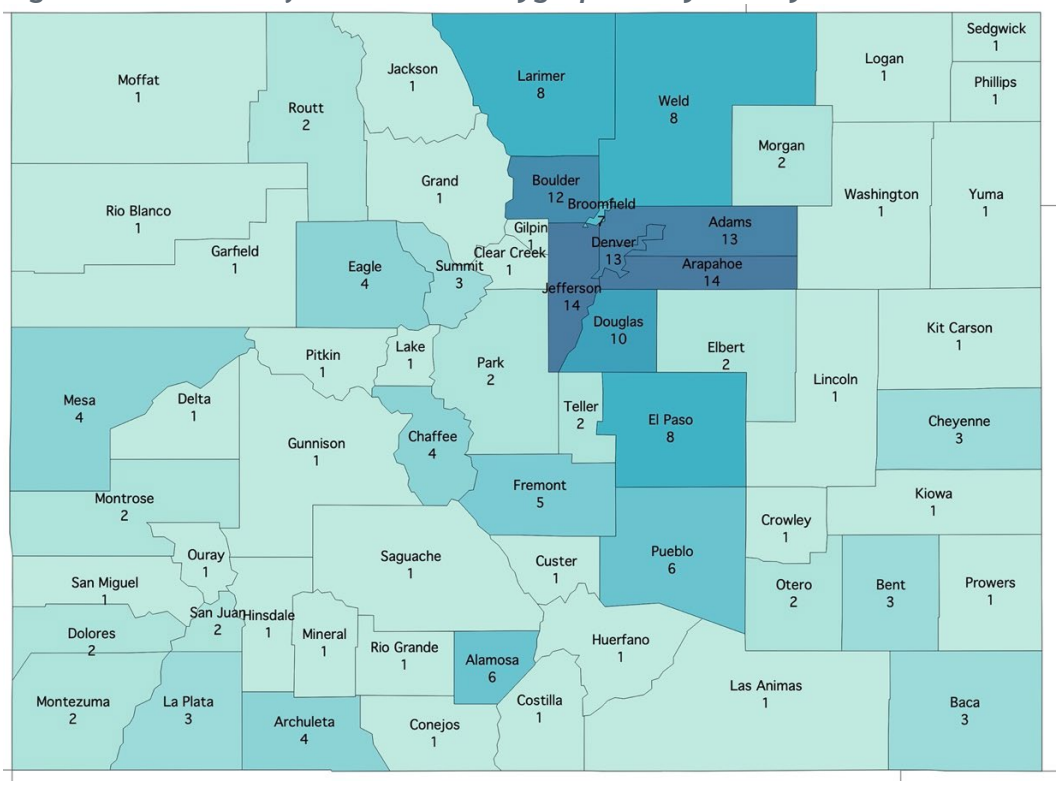
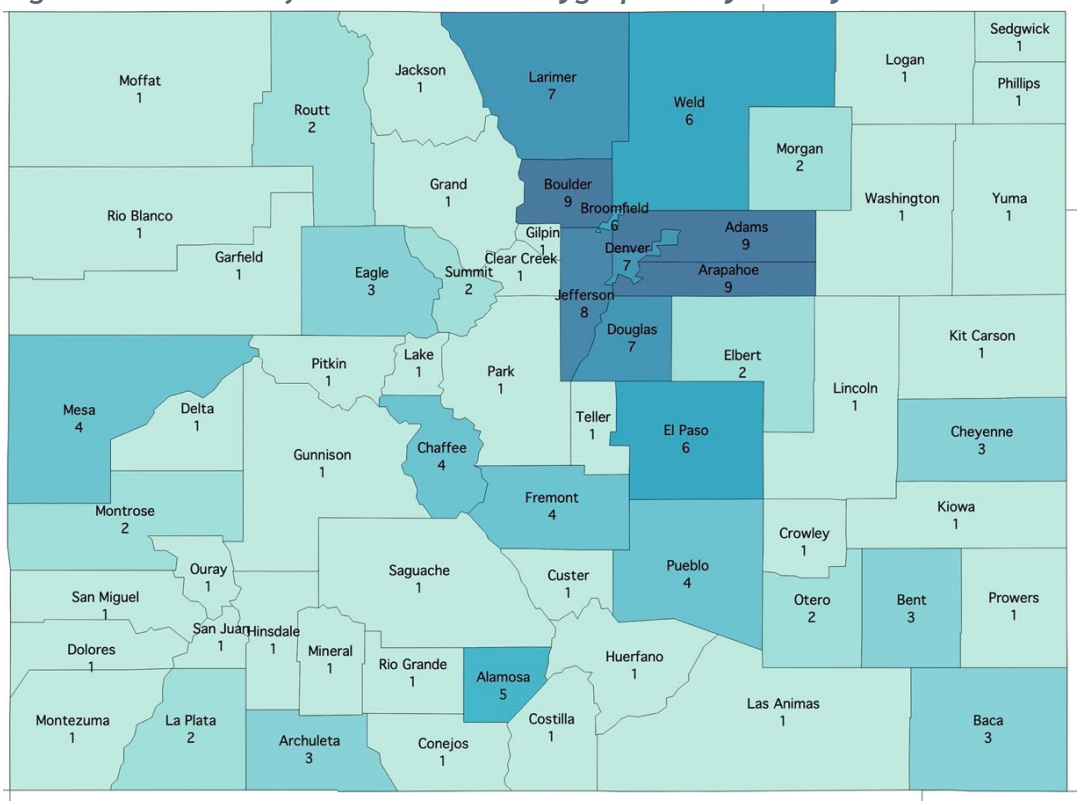


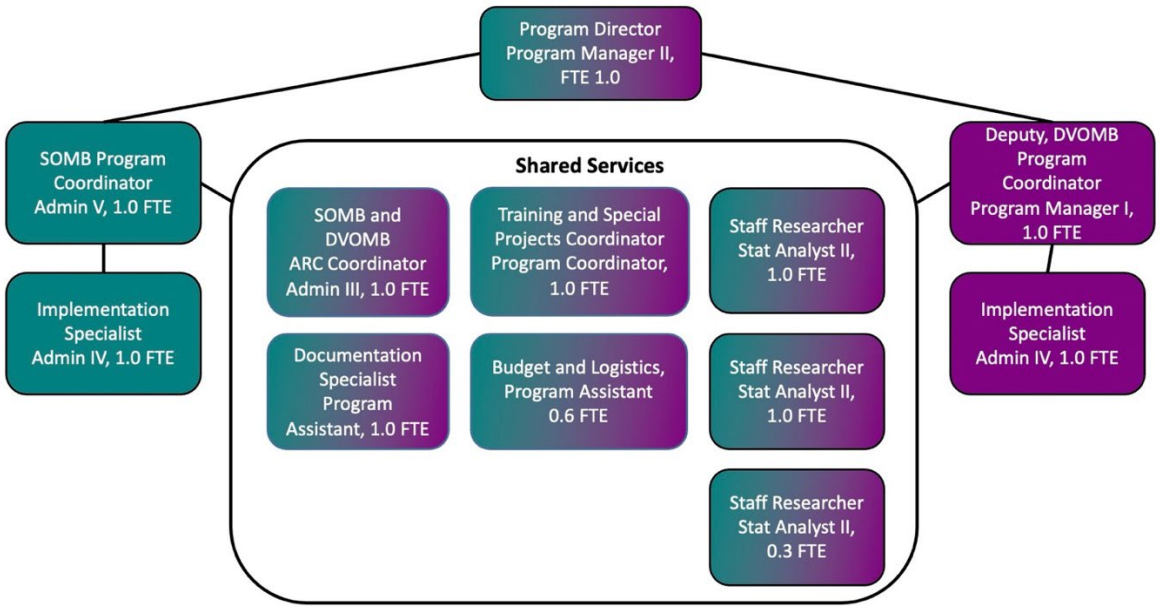
Figure 16. Number of SOMB Juvenile Polygraphers by County



ODVSOM Shared Services Office Model

The Office of Domestic Violence and Sex Offender Management (ODVSOM) office structure was reorganized in 2022. In the prior model, the SOMB and DVOMB functioned fully independently, with two staff members splitting a small proportion of duties between the two offices. In the reorganized model, supporting staff with functions common to both Boards work as a group of shared services while separate Program Coordinators and Implementation Specialists are dedicated to each Board. The new office structure is shown in Figure 17. The reorganization was driven by a need to better align both offices' with the focus on implementation and research-informed practices, the similar statutory mandates and administrative functions shared by the offices, and a need to be a responsive organizational framework going forward.

Figure 17. ODVSOM Shared Services Office Structure



Ongoing implementation

Ongoing implementation refers to the steps taken by the SOMB to help providers apply the *Standards and Guidelines* correctly and consistently.

A key part of implementation support is the regular sharing of information about the *Standards and Guidelines* to Approved Providers. One important way information is shared is through the SOMB website. The SOMB continued to work on website development to provide a positive user experience and make the website the first point of contact for staying up to date with the *Standards and Guidelines*. The current versions of the Adult and Juvenile *Standards and Guidelines* continued to be easily accessible to view and download on the website. Updates and announcements were regularly

posted about the various stages of proposed revisions, along with information about training opportunities, committee and SOMB meetings, and the other reports and resources produced by the SOMB. In 2022 efforts began toward ensuring all new web content is accessible to users with sensory, cognitive, and mobility disabilities in accordance with the Governor's Office of Information Technology Accessible Web Services policies.

In tandem with the website, regular emails and newsletters to Approved Providers are an important way for information and updates to be directly shared. The SOMB quarterly newsletter was sent that provided announcements and updates on research, policy, practice, training, and committee work. The SOMB Adult and Juvenile Standards Update Bulletin was also regularly sent, providing detailed information about proposed and ratified revisions to the *Standards and Guidelines*. Included was information about how Approved Providers can review and provide public comment on proposed revisions and be involved in committee work. All newsletters and bulletins were posted on the SOMB website. Another strategy used increasingly in 2022 was surveys of Approved Providers about implementation issues. The surveys gave another avenue for providers' experiences and opinions about implementation issues to be sought and heard by the committees and workgroups.

Another significant aspect of implementation support is the provision of training to Approved Providers and stakeholders on the *Standards and Guidelines* and a range of topics relevant to best practices. In 2022, the SOMB staff began the process of reorganizing its core introductory training into a three-step series; SOMB 100 (Introduction to the Colorado SOMB), SOMB 101 (Standards Overview), and SOMB 102 (Standards and Policy Implementation). Each training is delivered in a half or full-day workshop at various times and locations throughout the year and is required training for Approved Providers. A series of pre-recorded webinars introducing each section of the Adult *Standards and Guidelines*, and specific sections of the Juvenile *Standards and Guidelines*, were also available on the website.

In addition to the core training, the SOMB provides training to support established providers stay up to date with revisions to the *Standards and Guidelines* and with best practices. A 90-minute bi-monthly lunch-and-learn webinar series covered Adult and Juvenile *Standards and Guidelines* Booster training and a range of other topics. The webinars were delivered virtually and then subsequently offered as pre-recorded webinars. Additional advanced training included training on using specific risk assessment instruments, workshops by subject matter experts, and the annual conference. Further, the Adult and Juvenile Standards Coordinators were available for monthly technical assistance and regularly fielded emails and calls to help providers apply the *Standards and Guidelines* in specific instances.

The final tier of ongoing implementation support is conducting and applying research. The SOMB continued to manage and develop the performance of the SOMB Provider Data Management System (PDMS) and use this data to monitor client outcomes and provider applications and numbers. Ongoing implementation strategies in 2022 included training for adult and juvenile providers on data entry, converting provider applications from a mix of online and paper-based processes to a fully integrated online process, improving data reporting mechanisms, and conducting analyses of the PDMS data. Another aspect of conducting and applying research involved supporting the work of the committees and workgroups by providing research literature reviews and consultation on topics under consideration. Research reviews were typically developed as written annotated bibliographies and summaries and subsequently available to providers as an SOMB resource document linked to the *Standards and Guidelines*. Brief research updates on a range of topics were included in the SOMB Quarterly newsletter to providers.

Training

In 2022 the SOMB provided 26 standalone training events to over 1650 attendees using a mix of in-person, online, and hybrid formats. The events were delivered by SOMB staff and other subject matter experts. The topics covered a range of issues related to the treatment and supervision of individuals convicted or adjudicated for sexual offenses. In addition, the SOMB included over 10 presentations at monthly SOMB meetings across the year that focused on EDI issues, victim issues, and the intersecting area of domestic-family violence.

Training Topics:

- *Adult* and *Juvenile Standards and Guidelines* Introduction Training
- *Adult* and *Juvenile Standards and Guidelines* Booster Training
- Introductory Training on the Vermont Assessment of Sex Offender Risk -2 (VASOR – 2) and Sex Offender Treatment Intervention and Progress Scale (SOTIPS) Risk Assessment
- Train the Trainor Training on the Vermont Assessment of Sex Offender Risk -2 (VASOR – 2) and Sex Offender Treatment Intervention and Progress Scale (SOTIPS) Risk Assessment
- Tackling Heterogeneity and Whitewashing in Treatment Training
- Evaluating Individuals Charged with Child Pornography Possession
- Informed Supervision and Safety Planning
- Teams and Safety Planning
- Continuity of Care
- Victim Clarification
- Implementation of 5.7 (Contact with Victims, Children, and Vulnerable Adults) and Child Contact Screening
- Using Polygraph in a Risk-Informed Way
- Juvenile Sex Offender Registration
- Evidence-Informed Sex Offender Registration and Notification: A State-Level Approach
- SOMB Provider Data Management System: Adult Providers Data Collection Training
- SOMB Provider Data Management System: Juvenile Providers Data Collection Training

Summary of Year-End Accomplishments

The following highlights some of the many achievements of the SOMB in 2022:

- Appointed seven new Board members and reached full Board membership of 25 representatives.
- Updated SOMB policy on gathering formal public comment.
- Celebrated SOMB 30th Anniversary.

- Continued to emphasize and integrate EDI throughout SOMB processes.
- The SOMB Family Education, Engagement, and Support Working Group published a *Resource Guide for Families of Adults Accused, Charged, or Convicted of Sexual Offenses in Colorado*.
- Completed a provider recruitment and retention project.
- Continued to adapt the way the SOMB conducts business in response to the COVID-19 pandemic, moving to a hybrid model for meetings, training, and conference.
- Managed 14 SOMB committees and workgroups
- Approved 185 applications for placement or continued placement on the SOMB Approved Provider List during 2022.
- As of November 2022, there are **246** adult treatment providers and **185** juvenile treatment providers approved by the SOMB in Colorado. There are **28** adult polygraph examiners and **15** juvenile polygraph examiners.
- Reorganized the ODVSOM office structure to better utilize a shared services model and support the implementation of the *Standards and Guidelines*.
- Reviewed the extent the criteria in the Adult and Juvenile *Standards and Guidelines* are supported by evidence-based and research-informed sources.
- Supported implementation through multiple communication strategies, training, and individualized technical assistance. Continued to support the work of the SOMB committees and workgroups, as well as the implementation of the *Standards and Guidelines* by the provider community, by providing research literature reviews on topics being addressed.
- Conducted 26 training events with over 1,650 attendees from across Colorado. The events covered a range of topics related to the evaluation, treatment, and supervision of individuals convicted of or adjudicated for sexual offenses. In addition, the SOMB provided over 10 presentations at SOMB monthly meetings.
- Published the 2023 SOMB Annual Legislative Report and the 2022 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 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 assessment and treatment of sexual offenders has 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 *Standards and Guidelines* with fidelity. The SOMB will implement the new online application and complaint processes through the Provider Data Management System to continue to streamline the application and administrative requirements for providers. As well, the SOMB will begin Phase II of the data collection project and examine longer-term outcomes, including recidivism, for individuals who received offense-specific treatment in Colorado. As part of the ODVSOM, the SOMB will fully operationalize the shared services office model to evolve implementation support, research-informed practice, and administrative functions. 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 to ensure victim clarification procedures and the Victim Advocate role are being optimized for the benefit of victims.

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Appendices

Appendix A. Full Results for Table 4 Logistic Regression Models.

Table 9. Adjusted Odds Ratios[a] Predicting Non-Compliant Discharge Amongst the Lower-Risk Subgroup (n=439)

Variables	Model 2	Variables	Model 2
Male	.49	Treatment Risk Modifications	
Race		Adjust frequency of treatment	1.19
Black	1.04	Implemented mod. to supervision	3.61*
Hispanic	1.47	Recommended modify supervision	0.55
Asian	1.03	Treatment Responsivity Modifications	
Age (20-92 yrs.)	0.98*	Individualized treatment plan	0.25†
DDID	2.12	Increased resources	1.33
Urban	2.67**	Recommended modify supervision	1.17
Treatment Duration	0.13*	Modified treatment expectations	1.27
Treatment Duration Sq (TD*TD)	1.86	Modified supervision conditions	0.19*
Treatment Duration Cubic (TD*TD*TD)	0.93	Other adjustments	0.84
Previous Offense-Specific Treatment	0.89	Total sum	1.05
Concurrent Substance Use Treatment	1.66	Client Responsivity Barriers	
Risk-Offense Characteristics		Standards	0.36
Unrelated Victim	1.49	Lacks supports	1.37
Contact Offense	3.03**	Client Factors	2.77***
Victim less than 15	1.56	Substance Use	2.65**
Denial Level		Lack community engagement	2.07*
Beginning Denial	1.63*	Terms of Supervision	2.39
Change Denial pre-post	0.43***		
Model X^2	207.12***		
df	33		
Nagelkerke R Square	0.52		

Source of Data: SOMB PDMS Year 1 and 2 data. †p<.10; *p<.05; **p<.01; ***p<.001.

a. Adjusted Odds Ratios is an Odds Ratio that has been adjusted to account for other predictor variables in a model. OR > 1 (Probability of Event Occurring); OR: < 1 (Probability of Event Occurring Decreases)

Table 10. Adjusted Odds Ratios[a] Predicting Compliant Discharge Amongst the Higher-Risk Subgroup (n=274)

Variables	Model 3	Variables	Model 3
Male	5.27	Treatment Risk Modifications	
Race		Adjust frequency of treatment	0.74
Black	1.021	Implemented mod. to supervision	0.16*
Hispanic	0.36*	Recommended modify supervision	1.75
Asian	0.60	Treatment Responsivity Modifications	
Age (20-92 yrs.)	1.01	Individualized treatment plan	7.59*
DDID	2.33	Increased resources	2.07
Urban	0.40**	Recommended modify supervision	0.91
Treatment Duration	7.77***	Modified treatment expectations	1.32
Treatment Duration Sq (TD*TD)	0.76***	Modified supervision conditions	0.39
Treatment Duration Cubic (TD*TD*TD)	0.76***	Other adjustments	0.28
Previous Offense-Specific Treatment	0.77	Total sum	0.88
Concurrent Substance Use Treatment	0.69	Client Responsivity Barriers	
Risk-Offense Characteristics		Standards	1.41
Unrelated Victim	0.77	Lacks supports	0.96
Contact Offense	0.91	Client Factors	0.26**
Victim less than 15	1.53	Substance Use	0.39*
Denial Level		Lack community engagement	0.28**
Beginning Denial	0.99	Terms of Supervision	0.91
Change Denial pre-post	1.70†		
Model X^2	163.32***		
df	33		
Nagelkerke R Square	0.60		

Source of Data: SOMB PDMS Year 1 and 2 data. †p<.10; *p<.05; **p<.01; ***p<.001.

a. Adjusted Odds Ratios is an Odds Ratio that has been adjusted to account for other predictor variables in a model. OR > 1 (Probability of Event Occurring); OR: < 1 (Probability of Event Occurring Decreases)

Appendix B. Efforts to Recruit New Providers: Orange Circle Summary

The Office of Domestic Violence and Sex Offender Management (ODVSOM) provides support to the Domestic Violence Offender Management Board (DVOMB) and the Sex Offender Management Board (SOMB) that uphold the standards of practice for the assessment, evaluation, and treatment of individuals charged with domestic violence or sex offenses (DV/SO). To showcase the importance of an Approved Provider's role in delivering services in this field, the ODVSOM sought to develop an outreach plan to help reach the right people with the right tactics. The foundation of this work began with a communications goal of attracting new providers to this field of work. Together with marketing and research partner, Orange Circle Consulting (Orange Circle), ODVSOM completed formative research to better understand the existing audience and build audience profiles that will translate into messaging and outreach materials that will help attract qualified providers to this important work.

Orange Circle implemented a two-pronged approach for collecting audience data that included an online survey with individuals in pursuit of work, and currently working in, the field of therapy and counseling in Colorado and nationwide, as well as stakeholder focus groups and individual stakeholder interviews. The survey was intended to identify core values among individual who choose the field of therapy and counseling. It also sought to determine any familiarity with the Colorado Standards and identify what might motivate an individual to consider applying to become an approved provider.

All demographics data collected are outlined in the full report. A total of 309 people completed the survey. The priority was to obtain a representative sample based on location (Colorado resident preferred) age, gender, and race. The prioritization of Colorado respondents resulted in a much higher number of female respondents (79%) compared to male respondents (18%). There was a good representation of respondents from several ethnic groups including African American/Black (12.3%) and Hispanic/Latino (14.2%).

The following quantitative data results represent important content for consideration:

- Respondents indicated key influences for choosing work in the field of therapy including a desire to help people with their emotional and mental journey, followed closely by understanding the value and benefit of therapy, and to help clients address their concerns. The pay was rated the least influential for choosing a career in therapy.

- Over a fourth (27%) of respondents indicated they are familiar with Colorado Standards and Colorado respondents were more likely to be familiar than National. Around 5% of respondents indicated they are already approved providers.

- Over 87% of respondents indicated that "yes" or "maybe" they would consider becoming an approved provider.

    - There was a significant difference among Colorado and National respondents with National respondents being more willing to consider becoming an approved provider.

    - Students were more likely to say "maybe" to becoming an approved provider.

- Those that were open to considering becoming an approved provider were more interested in learning about what it was like to work with DV/SO clients; interested in learning the skills to work with DV/SO clients; and open to working with clients in the justice system.

- Those willing to consider becoming approved provider were influenced by helping provide victim safety through rehabilitation of offenders; adding knowledge about the intersection between psychology, law, and forensics; and helping at a community level to rehabilitate offenders.

- Those that were more familiar with the Colorado Standards were more likely to say "yes" to considering becoming an approved provider.

- Individuals who indicated that "yes" or "maybe" they would consider becoming an approved provider, listed the following aspects of the work that appealed to them: ability to learn new skills; opportunity to provide a community service and increase victim and public safety; and work in a social and community justice area.

- Those that indicated they would "maybe" or "not consider" becoming an approved provider felt that they would need more training to provide this type of therapy.

- There were significant differences among ethnic groups - Black, White, and Latino - in their beliefs around working with DV and SO clients.

- Overall, respondents were most influenced to work with court-ordered offenders by helping to provide victim safety through rehabilitation; adding knowledge about the intersection between psychology, law, and forensics; and helping at a community level to rehabilitate offenders.

Stakeholders were categorized as DV/SO Board Members, Supervisors, providers, and partners including community-based organizations (CBOs) and correctional/ justice system representatives and participated in either a virtual individual interview or a virtual discussion group.

Research objectives included:

- Build an audience profile of current providers (skills; characteristics; motivators).

- Discover how current providers learned about the DV/SO approval application and uncover the specific reasons why they moved forward with seeking approval.

- Describe key motivators that help attract (and retain) individuals/groups to providing services for specialized clientele.

- Identify barriers that may keep other providers from applying to be approved.

The following qualitative results represent important content for consideration:

- Established providers do not typically seek out work specific to DV/SO clients.

- Therapist motivators for working in DV/SO field are primarily intrinsic including: a desire to make a difference for both individuals and communities; a curiosity to learn more and problem solve, positive shifts in social justice and promoting community safety as well as working in forensics and investigation.

- Motivators that draw people to the field of counseling/therapy (seeing progress and changes in clients paired with making an impact on interrupting "generational violence") also apply to those that choose to work in the field of DV/SO treatment.

- Cutting edge, evidence-based practices are motivating factors for working in the field of DV/SO.

- Important characteristics for providers of DV/SO clients include: intrinsic curiosity of being a change agent; interest in helping people; being firm and consistent with clients; enjoy group therapy; interested in uncovering root causes; capability to set strong boundaries and hold high standards; excellent case management skills; and a willingness to track a lot of detailed information.

- Almost all participants described working with DV/SO clients as challenging (while some do believe it can also be a motivator) both mentally and emotionally.

- Many participants suggested that there was an additional element of professional liability and risk associated with being an approved provider due to the nature of the DV/SO clientele.

- Most participants agreed that the pay scale for DV providers did not match the amount of work necessary.

- The costs associated with finding and completing continuing education to maintain approval status was mentioned as a barrier to approval and renewal.

- Systemic challenges exist that may keep some providers from applying for approval.

- Internships and Mentors are critical tools for attracting and training new providers.

- Many participants reported the lack of ethnic and bilingual representation among DV/SO approved providers.

- Veteran participants recognized progress and proactive efforts that have been made by the board and are headed in the right direction with their refinements to attract new providers.

Conclusions based on the data include:

- For marketing and communication purposes, it may be necessary to consider targeting different types of audiences other than current therapists such as students pursuing degrees in the field of behavioral health. Furthermore, investing in the development of

internships, and establishing more opportunities for mentorship programs can also help with recruitment of new approved providers.

- There are many intriguing and positive attributes of working with DV/SO clients that perfectly align with the values of why individuals go into the field of therapy and behavioral health services. Communications and targeted messaging should showcase the intrinsic benefits that motivate prospective providers and highlight the positive outcomes of being a part of the work.

- Although barriers to becoming involved in this field of work are not necessarily the focal point of messaging, transparency in outreach is important to help the audience gain confidence that some of those barriers are minimal or can be overcome.

- A concerted "positive public relations" outreach effort with internal audiences could help promote the proactive efforts ODVSOM is taking to address application renewal concerns.

- Black and Latino survey respondents indicated they are open to considering work with DV/SO clients but do still have some concerns about working with these types of clients. Targeted messaging to address this concern could offer ODVSOM the opportunity to capitalize on increasing the ethnic diversity of approved providers.

Implications for Communications Outreach

Defining the appropriate approach to reach the identified communications goal is dependent on specific variables including time, budget, and success measures. ODVSOM will work together with Orange Circle to pinpoint audiences, messaging, tactics, and addressing barriers to help define the right tactics for an outreach effort.

Appendix C. 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 8 of the 12 months in 2022. The Committee managed the SOMB agenda and had oversight of the work occurring in the other committees. The Committee contributed to a Standard Operating Procedure Policy for SOMB Committee Operations that established professional guidelines for improving the quality, consistency, and overall effectiveness of committee meetings facilitated through the Office of Domestic Violence and Sex Offender Management (ODVSOM).

   Future goals: The Committee will continue to maintain the mission of the SOMB and will develop a plan to implement the outcomes from the 2022 Sunset Review.

2. **Best Practices Committee**
   Active
   Committee Chairs: Kim Kline and Hannah Pilla

   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 2022. The Committee reviewed and approved the teletherapy standard and appendix recommended by the Application Review Committee to address the appropriate use of teletherapy in the post-pandemic environment. The SOMB approved the revisions in early 2022. The Committee conducted a follow-up survey of Approved Providers' implementation of the new requirements to inform an understanding of compliance and the need for implementation support. The Committee established a subcommittee to review and revise Appendix P, Approved 2018 Sexual Behavior Disclosure Packet. A survey of Approved Providers was conducted to gather information about implementation of the Appendix and areas needing revision. Further work on the revision will continue in 2023. The Committee established a subcommittee to review and revise the Adult and Juvenile Standards Appendix E Guidelines for the Evaluation and Treatment of Sex Offenders with a New Non-Sex Crime. The subcommittee recommended a new set of guidelines based on research and best practices, and these are going before the Board for approval in January 2023. The Committee established a subcommittee to produce a resource document on Children with Problematic Sexual Behavior, as some are adjudicated and under the purview of the SOMB and

because Approved Juvenile Providers are frequently sought for assistance in such cases. The subcommittee developed a resource document which is going before the Board for approval in January 2023. The Committee discussed housing issues experienced by persons on the sex offender registry and requested that a user-friendly research document be developed on the topic. SOMB staff developed a variant of a research-based white paper written in plain language and designed to be used as an educational handout, which the SOMB approved at the end of 2022. The Committee reviewed and approved recommended revisions made by the Adult Standards Revision (ASR) Committee to the formal public comment policy. The Committee reviewed and approved revisions proposed by the ASR Committee to Section 2.000 Standards for Sex Offense-Specific Evaluations and by the Juvenile Standards Revision Committee to the Introduction and Guiding Principles and Sections 2.000 Evaluation and Ongoing Assessment of Juveniles Who Have Committed Sexual Offenses, 3.000 Standards of Practice for Treatment Providers, 5.000 Establishment of a Multidisciplinary Team for the Management and Supervision of Juveniles Who Have Committed Sexual Offenses, and 9.000 Victims and Potential Victims: Clarification, Contact, and Reunification. In addition to these major accomplishments, the Committee also discussed and addressed a range of practice and standards-related issues raised by various committee members, SOMB staff, and stakeholders throughout the year.

Future Goals: The Committee will continue to review and provide feedback to the Adult and Juvenile Standards Revision Committees regarding proposed Standards and Guideline revisions. 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 met 21 times during 2022. The Committee continued to review provider applications and complaints in a timely manner. The Committee managed, assessed, and resolved a number of complaints, with three appeals being heard before the SOMB. In two of the appeals, the SOMB upheld the finding of the ARC, and the remaining appeal was vacated by the SOMB. The Committee continued to monitor variances and the application process to ensure proper oversight of listed providers. The criteria drafted for Teletherapy in 2021 were approved by the SOMB and included as a standard and appendix. The Committee did not conduct any compliance reviews in 2022 due to a lengthy compliance review under investigation by the ARC that resulted in an appeal before the SOMB.

Future Goals: Continue reviewing applications, complaints, and variances. Implement the new online application process developed by the SOMB in 2022 that is now provided to Applicants through the SOMB Provider Data Management System.

4. **Adult Standards Revisions**
Active
Committee Chair: Taber Powers

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 11 of the 12 months in 2022. The Committee focused on reviewing and substantially revising Section 2.000 Standards for Sex Offense-Specific Evaluations. The best practice research for using interpreters in forensic settings was reviewed. A standard on Language, Culture, and Ethnic Considerations was revised and expanded, including guidance on using interpreters in offense-specific evaluations. The research literature on treatment responsivity factors for individuals with a sex offense conviction was reviewed. Many standards were revised to incorporate updates in the research literature and the evidence-based assessment framework developed by the SONICS workgroup in 2020-2021. The proposed Section 2.000 revisions are approved and implemented or in the final stages of approval and are expected to be implemented in early 2023. In addition, the ASR revised Section 4.000 Qualifications of Treatment Providers, Evaluators, and Polygraph Examiners Working with Sex Offenders to align licensing and clinical supervision standards with updates made for mental health professionals by DORA. The Committee also began reviews of Appendix S, Use Immunity Determination. A survey of Approved Providers was conducted to get feedback about the use of the appendix and its effectiveness. Pending revisions will occur in 2023. The ASR also reviewed the SOMB public feedback policy and process for proposed revisions to the *Standards and Guidelines*. The policy was revised and approved by the Board, bringing the formal public comment period earlier in the decision-making process.

Future Goals: The ASR Committee intends to review and revise Section 3.000 Standard of Practice for Treatment Providers in 2023 and the related Appendices P and S. The ASR will also 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 reviews and revises *the Juvenile Standards and Guidelines* as needed, based on emerging research and best practices. 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 8 of the 12 months in 2022, with some monthly meetings falling on public holidays. The Committee reviewed and revised parts of the Introduction and Guiding Principles and Sections 2.000 Evaluation and Ongoing Assessment of Juveniles Who Have Committed Sexual Offenses, 3.000 Standards of Practice for Treatment Providers, 5.000 Establishment of a Multidisciplinary Team for the Management and Supervision of Juveniles Who Have Committed Sexual Offenses, and 9.000 Victims and Potential Victims: Clarification, Contact, and Reunification. The recommended revisions included clarifying the language about the use of

the Standards for juveniles who are not under the statutory purview of the SOMB, adding information to guide making recommendations about sex offender registration with juveniles, and adding guidance about the introduction of the Family First Prevention Services Act (FFPSA). Several revisions addressed EDI issues and included enhancing the requirements to attend to cultural identity factors and practice with cultural competency. Revisions also addressed when juveniles have filed an appeal, expanded guidance about confidentiality, and added clarifications to treatment recommendations and discharge summaries to reflect current best practices. The Committee worked closely with the Victim Advocacy Committee to clarify and strengthen the standards addressing when multiple victim representatives are part of the multi-disciplinary team, victim clarification procedures, and when maximum benefit discharges can apply. The proposed standards revisions have either been approved and implemented or are in the final stages of approval, with implementation expected in early 2023.

Future Goals: The Committee will work on finalizing and implementing the recommended revisions currently in process. The Guide for School Personnel document prepared in past years by the Committee will be updated.

6. **Victim Advocacy Committee**
Active
Committee Chair: Katie Abeyta

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 on 9 of the 12 months in 2022. 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. The Committee discussed the potential impacts of the Family First Prevention Services Act (FFPSA) on victim safety and reunification and shared feedback with the Juvenile Standards Revision Committee in this regard. The Committee planned and presented to the SOMB on Victim Issues in honor of Sexual Assault Awareness Month. The Committee reviewed the research on the effectiveness for victims of clarification interventions in offense-specific treatment. The Committee discussed issues arising from the field about the role of the Victim Advocate in community supervision and multidisciplinary teams. The Committee began designing a survey of Approved Treatment Providers to gather information about victim clarification interventions in offense-specific treatment and the role of the Victim Advocate. The survey information is intended to inform future implementation support, additional training, and any necessary revisions to the *Standards and Guidelines* to ensure victim clarification and Victim Advocates are utilized effectively for victims. The Committee continued to work on a resource guide for victims and established a working group to aid the completion of this project. The Committee continued to support Victim Advocates and provide an avenue for victims to have a voice within the SOMB. Finally, the Committee continued to provide feedback to various other SOMB committees on their work to ensure it was victim-centered and to provide education to the SOMB.

Future Goals: The Committee aims to complete the victim resource guide, continue identifying victim research pertaining to the SOMB, and gather feedback from victims on the SOMB standards. The Committee will survey Approved Treatment Providers regarding victim clarification

interventions and the role of Victim Advocates in the community supervision and multidisciplinary team. The Committee has a Victim Advocacy Panel presentation planned for an upcoming SOMB monthly meeting to inform the SOMB and stakeholders about these projects. The Committee will continue to support the SOMB in a victim-centered approach to sex offender management and work toward increasing victim services stakeholder presence at committee and Board meetings.

7. **ODVSOM 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 on 10 of the 12 months in 2022. The Committee prepared for the 2022 Domestic Violence and Sex Offender Management Conference, which had 568 attendees. The conference was held in person, with a virtual option available for three months following the conference. The committee continued to explore how to maximize effective training opportunities using hybrid mediums.

Future Goals: The Committee is continuing to plan for training events, including the 2023 Domestic Violence and Sex Offender Management Conference. The Committee will explore opportunities to provide additional conjoint SOMB and DVOMB training events, to optimize efficiencies and meet common needs, as well as support offense-specific training events.

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

Purpose: The Sex Offender Surcharge Committee makes recommendations to the SOMB about allocation of moneys in the Sex Offender Surcharge Fund, and the coordination of such allocations with any moneys 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 2023-24 to the SOMB in September 2022, which were approved, as follow:

- $ 245,387 to the Division of Criminal Justice (DCJ) for administration and implementation of the Standards (personnel, contract, operating, and POTS dollars). $3,500 of these funds will be used for provider 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.

Future Goals: The Committee will meet as needed to create recommended allocations in 2023 for the 2024-25 financial year.

9. **Sex Offender Registration Legislative Workgroup**
Active
Committee Chair: Jeff Shay

Purpose: The Sex Offender Registration Legislative Work Group strives to ensure that sex offender registration and community notification is working effectively by addressing system-level concerns of stakeholders. The Committee works with law enforcement to examine and suggest improvements to registry processes. The Committee meets intermittently.

Major Accomplishments: The Committee did not meet in 2022 but a new 2022 AWA grant has been obtained to further enhance the Colorado Sex Offender Registry (COSAR) and provide training for law enforcement.

Future Goals: The Committee will continue to address key registration issues as needed. The Committee will continue to work on further registration training for law enforcement personnel.