

**An External Evaluation of
The Colorado Sex Offender Management Board Standards and Guidelines**

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Executive Summary

The present evaluation is in response to a request by the Colorado State Legislature to the Colorado Department of Public Safety to engage external experts to conduct a thorough review, based on Risk-Need-Responsivity principles and the relevant literature, with recommendations for improvement as warranted, of the efficacy, cost-effectiveness and public safety implications of Sex Offender Management Board programs and policies with particular attention to:

- (1) The Guidelines and Standards to treat adult sex offenders
- (2) The criteria for release for incarceration, reduction in supervision, discharge and progress in treatment
- (3) The application and review for treatment providers, evaluators and polygraph examiners who provide services for adult sex offenders.

Our evaluation provides many detailed findings and recommendations. Overall, we conclude that the Sex Offender Management Board is to be congratulated for making a significant contribution to the public safety of the citizens of the state of Colorado. However, the SOMB can maintain, and arguably even increase, public safety at significantly less cost by refining its Standards and Guidelines to better reflect recent research and more closely conform to the Risk-Need-Responsivity principles.

These principles and the associated research are well described in the 2013 report that this collaborative conducted upon the Colorado Department of Corrections (DOC), Sex Offender Treatment and Monitoring Program (D’Orazio, Thornton and Beech, 2013). Readers are referred to this report to better understand the relevance of these principles to Colorado’s response to the problem of sexual offending. Further, several areas of opportunity for improvement are shared by both the DOC in prison treatment program and the SOMB Standards and Guidelines

The main opportunity for improvement is in more systematically taking account of how risk varies between sexual offenders and how it varies within sexual offenders across time. Initial assessment should allow sexual offenders to be triaged into at least three broad levels of risk: lower risk; moderate risk; higher risk. Resources allocated for treatment and management should be proportionate to risk level. Modern risk assessment instruments can identify a significant category of lower risk sexual offenders that present a risk for future sexual offending not significantly different from that presented by non-sexual criminals released from prison. These individuals do not require intensive supervision and treatment over an extended period. Instead the risk they present can more efficiently be managed with the level of resources used to manage non-sexual offenders. The risk presented by moderate risk sexual offenders effectively reduces if they complete treatment, manage their criminogenic, needs and remain offense-free in the community for five years. Higher risk sexual offenders require more intensive and longer-term management.

Specific recommendations are made with regard to existing procedures for identifying low risk sexual offenders and Sexually Violent Predators. In both cases it is advised better empirically-validated methods be introduced than those currently utilized.

The model of treatment progress in use will benefit from updating to focus more closely on factors that have been empirically demonstrated to relate to sexual recidivism and to apply these in a more individualized way so that offenders are treated and assessed in response to the empirically-supported risk factors that most clearly contributed to their past problems, thus better following the Need principle. This would also allow treatment to facilitate significant reduction in risk in a more time efficient manner. Research in other jurisdictions has demonstrated that for

some offenders risk can be significantly reduced after just 12 to 18 months treatment.¹

The SOMB has an abundant opportunity to improve conformity with the Responsivity principle. This would result in placing greater emphasis on building up protective factors rather than attending so singularly to external control. Additionally, offenders' engagement in treatment and response to supervision would be greatly enhanced by stronger use of a motivational approach; careful attention to the interactions between offenders and members of the Community Supervision Team, and alterations in wording and tone of the Standards and Guidelines. As a medium for outreach to the various stakeholders involved in the problem of sexual offending in Colorado, the SOMB will benefit from enhancing its dispatch and reception of communications; likewise solicitation of consumer satisfaction feedback from its offender participants and their loved ones as well as the professionals and agencies that come under its purview will go far in both improving treatment outcome and enhancing the credibility of the board .

Criteria for release, reduction in supervision, and discharge will benefit from revision in light of a shift in understanding about what is involved when offenders' make progress in their treatment. This will be facilitated by taking account of the lesser degree of treatment progress required for offenders who present less risk at the outset of treatment. Similarly, the current requirements regarding contact with children as written seem to under value protective factors and over estimate risk and as such, will benefit from revision by the SOMB.

Criteria for application and review of treatment providers, evaluators and polygraph examiners are, overall, in accord with generally accepted practice although it was difficult to ascertain whether the density and detail of the

¹ The SOMB has shown awareness of the need to introduce more structured and empirically validated measures and has recently secured federal funding from the SMART office to have training

requirements dissuade potential quality providers from applying/maintaining applicant status. However, the SOMB presently has no effective mechanism for quality assuring how well its practitioners routinely perform.

This review additionally identified significant barriers in the effective implementation of new knowledge and standards. This is an area warranting serious attention, that the SOMB is already aware.

Finally, for revisions to the Standards and Guidelines to be made effective the SOMB will need to embark on an effective education program aimed not only at the professionals for whom it sets standards but also critically at the supervising officers for whom it provides guidelines. Likewise, SOMB board members, judges and the parole board will benefit from enhanced education about effective sexual offender treatment and management.

Introduction

In 2013 the Colorado Department of Public Safety commissioned a review, to be based on Risk-Need-Responsivity Principles and the relevant literature, and include recommendations for improvement as warranted, of the efficacy, cost-effectiveness, and public safety implications of the Sex Offender Management Board (SOMB) programs and policies with particular attention to the following:

1. The Guidelines and Standards to treat adult sex offenders issued by the SOMB
2. The Criteria for Release from Incarceration, Reduction in Supervision, Discharge for Certain Adult Offenders, and Measurement of an Adult Sex Offender's Progress in treatment issued by the SOMB
3. The application and review for treatment providers, evaluators and polygraph examiners who provide services to adult sex offenders as developed by SOMB.

This report describes the results of the review so commissioned by the Colorado Department of Public Safety.

The Colorado Sexual Offender Management Board was created by the Colorado legislature in 1992. In 1996 it first produced a document prescribing Standards and Guidelines for the management of sexual offenders. These have been repeatedly revised, the most recent revision being in 2011, although there have been piecemeal changes to specific elements of it approved since that time. Because of its early formation, the Colorado SOMB, commendably, has been a model for SOMBs of other states. Its front-runner position among SOMBs has meant that CO SOMB shoulders

the responsibility of keeping current with developments in research into sexual offenders and their management in evolving its Standards and Guidelines.

The Colorado Standards promulgated in 1996 were, unavoidably, based on the rather limited research knowledge about sexual offending available at that time. As well, the 1980s and 1990s were a period when many felt that the problem of sexual abuse was taken too lightly by the general public and legislatures. The rights of women and children and victimization statistics brought further attention to the societal problem of sexual offending during this period. As a consequence of these factors, there was a tendency to frame available information in a way that highlighted the threat posed by sexual offenders. Central to the Colorado Standards and Guidelines which emerged out of that socio-historical context was a vision of sexual offenders as chronically dangerous individuals from whom the community can only be protected by constant vigilance. In response to this a containment approach was proposed (e.g. English, 1998; 2004), which has the following central principles:

1. The primary objectives of sex offender management are victim protection, public safety, and reparation for victims.
2. Implementation strategies should involve agency coordination and multidisciplinary partnerships, supported by multi-agency policies and protocols allowing collaborative teams that enable better communication, sharing of information, expertise and coordination.
3. Case management should be is containment focused but individualized based on the individual offender's characteristics. Multiple technologies, including specifically polygraph examinations are used to obtain a more complete and accurate picture of the offender's deviancies and modus operandi. This in turn allows case managers to reduce the offender's access to the people they are most likely to try to victimize.

4. Program monitoring and evaluation should be employed to sustain and improve quality

A central part of the containment approach is the integration of case managers, treatment providers and polygraph examiners into a single team.

The current Colorado SOMB Standards and Guidelines are intended to enable sexual offender management in Colorado to intelligently implement this overall containment approach.

During the course of the present evaluation members of the Colorado SOMB and staff communicated to the evaluation team awareness that the original vision of offenders on which the containment model was based warrants revision. In particular, they articulated a desire to incorporate the Risk-Need-Responsivity principles into a more modern interpretation of the containment model. At the same time, and by default, the Colorado SOMB inherits the legacy of previous formulations of its Standards and Guidelines, a wider sex offender management culture that has been informed by these earlier versions, and no doubt some organizational need to maintain coherence by only making changes when they are inevitably required.

It is hoped that the present report will assist the CO SOMB in their diligent continuing efforts to develop and adapt the Standards and Guidelines so that they are grounded in contemporary understandings of sexual offenders and sexual offender management.

The main findings of the current evaluation are presented in response to the following topic areas:

- 1) The Guiding Principles of the Standards and Guidelines are reviewed in relation to current research regarding the treatment and management of sexual offenders
- 2) The Standards and Guidelines are reviewed in relation to the Risk-Need-Responsivity Principles of effective correctional programming
- 3) The current implementation of the Standards and Guidelines is reviewed in relation to a fourth principle which we call Integrity, meaning the how well are they implemented in practice
- 4) Empirical Support for the Containment Model and other assumptions underlying the Standards and Guidelines
- 5) Specific Issues within the Standards and Guidelines are considered

The main body of the report concludes with a general Discussion. Detailed findings underlying the main body of the report are contained in the subsequent Appendices followed by a list of References.

Review of the Colorado SOMB Guiding Principles

Central to the 2011 Revision of the CO SOMB Standards and Guidelines are thirteen Guiding Principles. These Principles are reviewed in detail in Appendix A which also provides examples of how those warranting improvement might be rephrased. The conclusions of the review of the Guiding Principles are summarized thematically in the current section. Research findings in support of this review are described in Appendix B.

Most of the Guiding Principles are commendable statements of good practice that are consistent with available research. They are consistent with those aspects of the Containment Approach that are more broadly regarded as good practice in the management and treatment of sexual offenders.

This applies to Guiding Principles 6, 7, 8, 9, 10, 11 and 12.

Three of the Guiding Principles communicate a view of sexual offenders' risk which is unsupported by current research and which impedes the implementation of Risk-Need-Responsivity principles and cost-effective risk management.

These are principles 1, 2, and 4.

Between them they convey that sexual offending is invariably a disorder which cannot be "cured"; that all sex offenders continue to present a dangerously high risk even when they successfully complete treatment; that this danger can only be managed by constant vigilance, active control, restriction and treatment; that without this ongoing high level of containment persons with a history of sexual offending may at any time revert into being highly dangerous.

A revision of Guiding Principle 1 has been approved by the SOMB that deletes the “disorder” and “no cure” language, however, it continues to convey a similar underlying message. Sexual offenders are purported to pose a continuing high risk of re-offending that can only be managed by treatment, supervision and active self-management.

There are three difficulties with this. First, it paints all sexual offenders as being the same when in fact they differ markedly in the level of risk they present. Second, it takes no account of the systematic and substantial decline in risk that occurs as sexual offenders succeed in achieving time in the community without sexual offending. Third, it implies a wasteful allocation of resources to monitoring, controlling and treating offenders whose risk could be managed much more efficiently.

Allocating resources to the management of sexual offenders that are substantially more expensive and specialized than those allocated to manage of other (non-sexual) offenders only makes sense if the identified sexual offenders in reality pose a substantially greater risk for committing new sexual offenses than non sexual offenders. However, available data does not support this disparate resource allocation for all sexual offender risk levels. Sexual offenses are committed by about 2% of non-sexual offenders² over a medium term (4 to 5 year) follow up. This rate is comparable to that of “lower risk” sexual offenders.. Consequently expending special and expensive resources on managing low risk sexual offenders wastes public money.

Similarly, the re-offense likelihood of many moderate risk offenders who complete treatment declines over a period of five years when they are in the community without further offending. This declines to a level of sexual offending similar to that

² The phrase “non-sex offender” is here used to refer to males who have been convicted and sentenced for the wide range of criminal offenses that are non-sexual in nature.

of non-sexual offenders. Accordingly, cost-effective risk management requires that the management of moderate risk offenders who have completed treatment and achieved five years community time offense free should be reduced to a level comparable to that for non-sexual offenders.

From a perspective that balances community safety with cost-effectiveness Principles 1, 2 and 4, especially in the light of widely communicated “no cure” language, are naturally interpreted as precluding either of the above described efficiencies.

As an example of a Guiding Principle that would avoid some of these difficulties, in the box below is the version of the first Guiding Principle recently approved by SOMB and also an alternate version that would be more accurate and helpful.

COSOMB Proposed New First Guiding Principle

Sexual offending behavior is often repetitive and there is a continuing risk that adult sex offenders will reoffend.

The Sex Offender Management Board (SOMB) has reviewed the considerable body of research concerning the treatment of adult sex offenders. This guiding principle establishes a treatment and management philosophy which recognizes that there is currently no way to ensure that adult sex offenders will not re-offend.

This does not mean that all adult sex offenders will re-offend. With effective treatment, supervision and self-management, sex offenders can internalize changes that may decrease their likelihood of re-offense.

The offender must take responsibility for his or her behavior and commit to continually manage the behaviors that led to his or her offense(s) in order to prevent future offenses, future victims and to enhance public safety.

A More Research Supported Version

Risk for future sexual offending varies enormously. The intensity and duration of supervision and treatment should respond in a flexible and cost-effective way to these differences in risk.

Sexual offending is a behavior, not a disorder. Some men with a history of sexual offending present a risk for future sexual offending that is relatively similar to that of criminals with no known history of sexual offending. These lower risk offenders can be effectively managed in the community through ordinary supervision processes of limited duration. Others present a markedly elevated risk and may require supervision and treatment that is more intensive, more specialized and of greater duration. In Colorado, criminal sexual offenders are first assessed and referred for a sex offense-specific evaluation during the pre-sentence investigation conducted by the Probation Department. This initial assessment should at least triage sexual offenders into lower, medium and higher risk groups with this categorization informing subsequent decisions about the intensity and duration of supervision and treatment that is appropriate for cost-effective risk management.

Three of the Guiding Principles are incomplete in ways that make them unbalanced.

These are principles 3, 5 and 13.

The third Guiding Principle states “community safety is paramount”. It perhaps would be more apropos if this were the first Guiding Principle but, apart from that, the principle, as written, is unbalanced. No social policy objective can be pursued without regard for cost. After all, money spent on managing and treating sexual offenders could alternatively be spent on providing treatment services for victims, on other means of preventing future victimization, on quite different social priorities, or savings in this area could go to balance over-stretched budgets so that

the state does not have to raise taxes. By stating this principle without reference to other priorities the reader is given the notion that anything that might contribute to public safety without regard to cost or effectiveness.

The current version of Principle 3 and a more balanced alternate version are provided in the box below.

<p><i>Existing Principle 3</i></p> <p><i>Community safety is paramount.</i></p> <p><i>The highest priority of these Standards and Guidelines is community safety.</i></p>
<p><i>A More Balanced Version</i></p> <p><i>Community safety is paramount.</i></p> <p><i>The highest priority of these Standards and Guidelines is to maximize community safety in the most cost effective manner possible.</i></p>

The other two unbalanced Guiding Principles are principles 5 and 13.

Guiding Principle 5 states that community supervision is a privilege and emphasizes the need for offenders to be held strictly accountable. Keeping in mind that this is a communication to professionals working with sexual offenders, not to sexual offenders themselves, the current phrasing of the principle neglects to emphasize the responsibility that the professionals working with sexual offenders shoulder to behave in ways that facilitate the required degree of cooperation with supervision from sex offenders. It also neglects to emphasize the findings from the wider supervision literature that supervision is less effective when focused purely on external controls and the offenders' accountability for complying with conditions of supervision and more effective when it employs a motivational approach that

attends to offender responsivity, and the criminogenic needs that contributed to past offending.

Guiding Principle 13 similarly is unbalanced as written. It properly highlights the value of involving family and friends in the management of sexual offenders but it emphasizes solely their role in helping hold the offender accountable. It fails to mention equally important positive contributions like the way pro-social law-abiding people in the offender's life can model prosocial attitudes and decision-making, provide non-collusive social support, healthy attachment experiences, and facilitate opportunities for the offender to start living a more "normal" life. For example, church leaders who participated in the focus groups opined that in preventing offenders access to religious congregational services, the Standards and Guidelines facilitated isolation, shaming, and inability to counsel offender members during their journey toward rehabilitation. The SOMB itself is aware that a more balanced approach is desirable and has begun to take steps to facilitate prosocial support of offenders. For example, they have recently taken efforts to collaborate with Circles of Support and Accountability, an organization that seeks to provide support as well as accountability. Nonetheless, the verbiage of the Principle seems to require revision such to reflect the value for varied prosocial supports.

In conclusion, the SOMB Guiding Principles would benefit from a more thorough revision than the SOMB has so far attempted.

Analysis of the Standards and Guidelines in Relation to the Risk-Need-Responsivity Principles

The best-established ways of distinguishing more effective forms of correctional programming are undoubtedly the *Risk, Need and Responsivity* (RNR) principles first articulated by Andrews et al. (1990). Subsequent meta-analytic results support that program efficacy is indeed related to the degree of adherence to these three principles (Andrews & Bonta, 2006). More recently, Hanson et al. (2009), in a meta-analysis of the better quality studies of sexual offender treatment, notes that the same trend was apparent in the sexual offender treatment arena, that is, the more sexual offender programs conformed to the Risk, Need and Responsivity Principles the more effective they were in reducing sexual recidivism.

Andrews and Bonta also found that when the three RNR principles are held constant, demonstration projects had substantially better results than routine treatment practice. This reflects that in demonstration projects greater care is taken to implement treatment the way it was as intended to be run while in routine practice there tends to be corner cutting and drift away from therapeutic models. Similarly Lösel and Schmucker's (2005) meta-analysis of sexual offender programs found that well-specified programs that were run by researchers, and operated on a small scale (all factors expected to lead to more careful implementation) had greater efficacy. As such, in addition to developing standards consistent with RNR principles, maintaining a high level of integrity to the principles within programs is essential.

The Risk Principle

The Risk principle means that correctional services are most effective when the degree of resources assigned to treating and managing offenders is made

proportionate to the level of risk they present. Applied to sexual offenders the risk principle is articulated as follows:

Low risk sexual offenders represent a risk for sexual offending that is about the same as that presented by non-sexual offenders under supervision. Accordingly they do not require exceptional resources allocated to their management. When offending was against members of their own family particular precautions may be required regarding the terms of contact and reunification they with prior victims. In most cases, this should be manageable with normal supervision resources.

Moderate risk sexual offenders represent a risk for sexual offending that is significantly higher than that presented by non-sexual offenders under supervision. Accordingly, allocation of specialized and more costly resources than those for low risk sexual offenders is reasonable.

High risk sexual offenders represent a risk for sexual offending that is significantly higher than that presented by moderate risk sexual offenders. Accordingly, the allocation of exceptional resources for the management of this group is warranted.

As currently written, the Guiding Principles do not encourage managing sexual offenders in accord with the Risk Principle. As noted in the previous section, several of the Guiding Principles suggest the idea that all sexual offenders should be regarded as presenting a high level of risk. In effect they encourage over-allocation of treatment and supervisory resources to lower risk offenders and fail to encourage an appropriate prioritization of resources for higher risk offenders.

The SOMB has developed detailed guidance on the classification of some sexual offenders as Sexually Violent Predators (SVPs). This is a classification required pursuant to Colorado law. Persons so classified by a court must register their address and are subject to kinds of community notification beyond what is required for other felony sexual offenders. The basic procedure for classification includes

determination that the offender is someone for whom the classification is legally required and applying a locally created statistical risk assessment instrument. However, unlike SVP determination in other states, nothing in this process seems to automatically assign more intensive supervision or treatment for persons classified as SVPs. This is probably because the SVP classification process was instituted in response to a federal initiative and not as an attempt to apply the Risk principle. In principle the SVP classification could be used as a springboard to an implementation of the Risk principle by creating policy and procedures that systematically assigned more resources to the management and treatment of this group. Unfortunately there are significant flaws with the current SVP classification methodology that requires amending before it can sensibly be used in such a way.

The SOMB has also developed and included in the Standards and Guidelines a protocol to allow sexual offenders under community supervision to be classified as Low Risk. This protocol does not, however, represent an accurate attempt to apply the Risk Principle. Rather, it appears to be an effort to identify extremely exceptional cases. The description implies a lack of belief in the concept of a Low Risk offender. Although the protocol includes some items that are potentially relevant to risk, only someone who had only ever committed one sex offense – as identified not only through their official record but also through polygraph supported self-report potentially qualifies. Additionally, any use of coercion or threats of violence excludes someone from being so classified. While it is intuitively plausible that offenders who meet these criteria will indeed represent a Low Risk, many offenders who do not these criteria will also in fact represent a Low Risk for sexual recidivism. More generally, this protocol does not provide a meaningful basis for triaging offenders to different levels of intervention and management on the basis of level of risk.

In sum, the Standards and Guidelines do not mandate or suggest following the Risk Principle, nor do they support professionals in following the Risk Principle. Indeed several of the guiding principles are liable to deter professionals from attempting to

follow the Risk Principle. As a consequence, the pattern of practice that is naturally suggested by the Standards and Guidelines is insufficiently cost-effective.

The Need Principle

The Need Principle means that correctional services are more effective when interventions target the social and psychological factors empirically associated with (and predispose to) future offending.

While future research will refine our knowledge of these factors, there is now a sound empirical basis for identifying a fairly comprehensive set of psychological risk factors. This research is summarized in the meta-analytic review described by Mann et al (2010). Broadly the same set of psychological factors have been incorporated into available instruments such as Sex Offender Treatment Intervention and Progress Scale, SOTIPS (McGrath et al, 2012), the Violence Risk Scale: Sex Offender Version, VRS-SO (Olver et al, 2007), STABLE-2007 (Hanson et al, 2007), or the forensic version of Structured Risk Assessment, SRA-FV (Knight & Thornton, 2007; Thornton & Knight, 2013).

Applied to sexual offenders the Need principle involves (a) systematically assessing this group of psychological factors and (b) utilizing treatment curricula that systematically prioritizes addressing the psychological risk factors that are relevant for the individual. In the box below is a summary of the most established psychological risk factors.

<p><i>Sexual Preoccupation</i></p> <p><i>Sexual Preference for Children</i></p> <p><i>Sexual Interest in Coercion/Violence</i></p> <p><i>Multiple Paraphilias</i></p> <p><i>Offense-supportive attitudes</i></p>
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Emotional Congruence with Children

Difficulty with emotionally close romantic relationships with adults

Grievance Thinking/Hostility

General self-regulation problems

Poor problem-solving

Resistance to Rules and Supervision

Negative Social Influences (associates include more negative than prosocial persons)

As currently written the Standards and Guidelines do not explicitly identify a comprehensive set of relevant psychological risk factors, nor do they explicitly mandate or even support that treatment services programs should apply the Need principle they do provide some good indirect support for the Need principle. First, there are the wide-range of areas required to be assessed in Sex Offense Specific Evaluations, including recommending the use of a need assessment instrument, the STABLE-2007. Second, there are specific requirements for the content of sexual offense specific treatment (see box below); these are consistent with empirically supported psychological risk factors. Further, some parts of the Standards and Guidelines draw particular attention to specific empirically supported psychological risk factors, for example relevant kinds of sexual deviance, non-compliance with supervision, and pro-offending attitudes.

Additionally, the Need Principle is somewhat supported in the requirements for the treatment plan required by treatment providers to formulate.

The treatment plan shall:

- *Provide for the protection of victims and potential victims and not cause the victim(s) to have unsafe and unwanted contact with the offender*
- *Address the issue of ongoing victim input (will the victim be involved, in what manner, at what stage of treatment, etc.)*

- *Be individualized to meet the unique needs and risks of the offender*
- *Identify the issues to be addressed, the planned intervention strategies, and the goals of treatment*
- *Define expectations of the offender, his/her family (when possible), and support systems*

The third bullet above could be interpreted as encouraging treatment providers to adhere to the Need principle. However, it doesn't mandate it, and the reader will not necessarily interpret "risks of the individual" as "empirically supported risk factors".

Mandated Content of Sex Offender Specific Treatment

1. Hold offenders accountable for their behavior and assist them in maintaining their accountability;
2. Require offenders to complete a full sex history disclosure and to disclose all current sex offending behaviors;
3. Reduce offenders' denial and defensiveness;
4. Decrease and/or manage offenders' deviant sexual urges and recurrent deviant fantasies;
5. Educate offenders and individuals who are identified as the offenders' support systems about the potential for re-offending and an offender's specific risk factors, in addition to requiring an offender to disclose critical issues and current risk factors;
6. Teach offenders self-management methods to avoid a sexual re-offense;
7. Identify and treat the offenders' thoughts, emotions, and behaviors that facilitate sexual re-offenses or other victimizing or assaultive behaviors;
8. Identify and treat offenders' cognitive distortions;
9. Educate offenders about non-abusive, adaptive, legal, and pro-social sexual functioning;
10. Educate offenders about the impact of sexual offending upon victims, their

families, and the community;

11. Provide offenders with training in the development of skills needed to achieve sensitivity and empathy with victims;

12. Provide offenders with guidance to prepare, when applicable, written explanation or clarification for the victim(s) that meets the goals of: establishing full perpetrator responsibility, empowering the victim, and promoting emotional and financial restitution for the victim(s);

13. Identify and treat offenders' personality traits and deficits that are related to their potential for re-offending;

14. Identify and treat the effects of trauma and past victimization of offenders as factors in their potential for re-offending (It is essential that offenders be prevented from assuming a victim stance in order to diminish responsibility for their actions);

15. Identify deficits and strengthen offenders' social and relationship skills, where applicable;

16. Require offenders to develop a written plan for preventing a re-offense; the plan should identify antecedent thoughts, feelings, circumstances, and behaviors associated with sexual offenses;

17. Provide treatment or referrals for offenders with co-existing treatment needs such as medical, pharmacological, psychiatric needs, substance abuse, domestic violence issues, or disabilities;

18. Maintain communication with other significant persons in offenders' support systems to the extent possible to assist in meeting treatment goals;

19. Evaluate existing treatment needs based on developmental or physical disabilities, cultural, language, sexual orientation, and gender identity that may require different treatment arrangements;

20. If clinically indicated, every effort should be made to provide services in the client's primary language using professional interpretive and translation resources as needed;

21. Identify and address issues of gender role socialization; and,

22. Identify and treat issues of anger, power, and control.

In relation to the mandated content of treatment, of concern is the emphasis on factors that are not empirically supported as related to sexual recidivism. This includes the strong emphasis on targeting denial and minimization and on developing empathy for past victims. Targeting the former (denial) is often useful in enabling a better identification of risk factors and treatment compliance. However, full disclosure is not necessary for the identification of risk factors and excessive time allocated to seeking it can unbalance a treatment program, leaving too little attention on treating psychological risk factors. Helping the offender to develop empathy for past victims could be a worthwhile activity in its own right. However, the degree to which offenders appear to express empathy for past victims is generally unrelated to how likely they are to re-offend so working on empathy for past victims does not contribute to following the Need principle whereas working on being more empathic and less callous in general is consistent with the Need principle.

A particular hazard with how the Standards and Guidelines are written is that they may inadvertently encourage treatment providers to run groups in a way that routinely treks through each of the required content areas without regard to how applicable they are to the individual offender. They do not adequately foster an individualized approach to treatment and management.

Thus, as currently written, the Standards and Guidelines provide some good support for the Need principle but also present some barriers to applying the Need principle in an individualized way.

The Responsivity Principle

The Responsivity principle means that correctional services are more effective when treatment and management services use methods which are generally more effective with offenders and when these services are individualized in response to the culture, learning style, cognitive abilities, etc. of the individual.

The *Responsivity Principle* is succinctly summarized, by Andrews and Bonta (2006) as follows: “Treatment should use methods and be delivered in such a way as to maximize participants’ ability to learn. To achieve this, treatment programs should selectively employ methods that have generally been shown to work. Further, participants’ response to treatment will be enhanced by effortful attendance to their individual learning style, abilities, and culture”

The idea of effective methods and delivery is multi-faceted. Research has identified two kinds of methods that are generally effective: cognitive-behavioral methods such as cognitive restructuring, prosocial modeling, and structured skill development (McGuire, 2002; Lipton et al, 2002) coupled with hierarchical therapeutic communities (Lipton et al., 2002).

Regardless of the general therapeutic method, therapist micro-behaviors, sometimes called ‘therapist style’ significantly affect how well treatment participants are able to learn from any method. These include nurturing behaviors like therapists communicating warmth and accurate empathy, stimulating behaviors such as using reflections and Socratic questions to encourage cognitive and emotional processing of material, and shaping behaviors such as systematic use of praise to encourage small changes towards healthier functioning. These general factors are known to be influential in general psychotherapy and have been demonstrated to be equally important in sexual offender treatment (Marshall, 2005; Serran & Marshall, 2010).

Where group psychotherapy is the predominant modality, in addition to therapist style, the overall quality of the group environment becomes profoundly important. The effectiveness of group therapy and the degree to which it inculcates change depends on groups being run in a way that produces cohesiveness, appropriate group norms and the instillation of hope for the future (Belfer & Levendusky, 1985; Yalom, 1975). Development of a cohesive group leads to higher engagement (Yalom, 1975). A program of research by Beech and colleagues (e.g., Beech & Fordham, 1997; Beech & Hamilton-Giachritsis (2005) has demonstrated that the speed of change in individual treatment participants was greater when they experienced their treatment group as cohesive, well-organized and well-led; the open expression of feelings was encouraged, and a sense of group responsibility and hope was instilled in members. In contrast, over-controlling group leaders had a detrimental effect upon group climate.

A thread running through many of these research findings is that effective programs need to be respectful of treatment participants' sense of autonomy. While staff that work with offenders have to exercise authority to interrupt antisocial behavior and create a safe environment, little internal motivation for change will be created if participants feel they are being brutally coerced into compliance (Miller & Rollnick, 2012). Treatment needs to feel like respectful help rather than bullying. Unsurprisingly then, voluntary programs are more effective at reducing recidivism, and the more treatment participation is coerced the less it has an effect upon recidivism (Parhar et al., 2008).

It is always challenging for therapists and supervising officers working with sexual offenders to avoid falling into a hostile and punitive attitude towards sexual offenders. Like members of the general public, therapists and supervising officers naturally react to sexual offenses with some mixture of fear, anger and repugnance and easily apply these feelings to the people who commit these offenses. To treat sexual offenders effectively, however, therapists need to learn how to suspend these

natural feelings, and to behave towards offenders in a way that is experienced by the offenders as warm, empathic and respectful. If they fail to do this they are liable to seriously impair their ability to effectively elicit change and reduce risk.

The Standards and Guidelines partially support the Responsivity principle. The third bullet from the requirements for the treatment plan – “Be individualized to meet the unique needs and risks of the offender” may be interpreted as supporting the notion of individualizing the delivery of treatment in accord with the learning style, culture etc. of the offender. In addition, the Standards and Guidelines indicate that offenders should be treated with dignity and respect. Further, the Standards and Guidelines have specific prescriptions for lower functioning offenders. However, the Standards and Guidelines would probably be interpreted as supporting the Responsivity principle only by someone who was already familiar with this principle. In effect, the quoted passage gives therapists permission to follow the principle but does not affirmatively encourage or require it.

Additionally, some parts of the Guiding Principles seem liable to undermine following the Responsivity principle. There is a recurrent and strong emphasis on the negative and controlling aspects of the supervision and treatment process, a deliberate emphasis on accountability and compliance without a corresponding emphasis on the development of protective factors or strengths or therapeutic engagement. These features are likely to produce a climate of managing offenders through fear and demands for absolute submission and compliance. This is likely to impede the development of internal controls and internal motivation.

The Integrity Principle

The Integrity principle refers to the degree to which practice follows principle. The authors of the Risk-Need-Responsivity principles have shown that the practical value of following these principles depends on the care and conscientiousness with

which they are applied in practice. Essentially then, the Integrity principle is a matter of the degree to which routine practice under the Standards and Guidelines implements the Risk-Need-Responsivity principles. We investigated this by attempting to understand the experience of different interest groups impacted by the Standards and Guidelines through a series of focus groups. Specifically, we obtained input from groups who are more directly subject to the Standards and Guidelines such as Supervising Officers, Treatment Providers, Evaluators, and Polygraph Examiners, and also from interested parties who may be highly affected by the operation of the Standards and Guidelines such as Prosecutors, Victim advocates and Victim therapists, Defense Attorneys and Offender Advocates. We also spoke with SOMB staff. Detailed findings are presented in Appendix O. Commendably, the Integrity principle is an area that the Colorado SOMB has recently invested itself in. They have carried out their own focus groups, and demonstrated an interest in working out better ways to see that the intent of the Standards and Guidelines is implemented in practice.

A recurrent theme from the focus groups was that the SOMB Standards and Guidelines do not adequately support treatment and management anchored in the Risk-Need-Responsivity Principles. The different groups we obtained input from consistently expressed this idea. In particular, they reported that the Risk principle wasn't followed: supervision and treatment decisions are often not risk-based, and the intensity of treatment and management is not responsive to the level of risk. They reported that the Need principle is in part not being followed in that treatment is not effectively individualized to target the offender's criminogenic needs. They report that the Responsivity principle is not being followed in that suspiciousness and negative attitudes toward the offenders under supervision undermines the ability of therapists to engage offenders in the treatment process and undermines the ability of supervising officers and therapists to motivate offenders. Indeed we were advised that the supervision process is experienced as so oppressive that some offenders prefer to spend the whole of their sentence in prison so as to avoid what they saw as impossible behavioral and financial demands. Relatedly, the SOMB was

seen as over-emphasizing external control of offenders while giving insufficient attention to the development of internal protective factors, strengths and healthy functioning.

A recurrent meta-comment was that in failing to follow the Risk-Need-Responsivity principles in practice the SOMB supported system was inefficient and unnecessarily costly.

It should be noted that the SOMB does not have complete control over how sexual offenders are managed in Colorado. Judges or the parole board, neither of whom are subject to the Standards and Guidelines, may make decisions that constrain practice. On the other hand, the problems observed in practice were often seen by our respondents as manifesting from the Standards and Guidelines and they are consistent with our analysis of the limitations of the current version of this document.

Special Issues in the Standards & Guidelines

Continuity of Information and Services

The Standards and Guidelines clearly require sharing of information within a collaborative multi-disciplinary team. In our earlier evaluation of Colorado's prison treatment program we noted that men placed in prison following some technical revocation were required to complete the full sexual offender treatment program without regard to the work they had done in the community. Earlier polygraph assisted sexual histories completed in the community would be discounted for example, and much of the basic curriculum they had already worked on in the community would then be repeated. Somewhat similarly we now were told that offenders who had completed the treatment program in prison were required to again complete essentially the same work in the community.

This clearly represents a failure to provide effective continuity of services and involves a significant waste of public money. In part the underlying problem seemed to be a lack of trust in and respect for work done by other providers.

Relatedly, there is often a lack of effective collaboration between supervising officers and treatment providers. Treatment providers describe themselves as feeling compelled to accede to what supervising officers wanted, largely for fear of not receiving future work from these supervisors. As a consequence they would deliver treatment that they knew to be unnecessary, thus wasting public money.

This appears to reflect supervising officers having bought into the "no cure, perpetually dangerous offender" image conveyed in the Guiding Principles. If supervising officers are to permit treatment providers to follow the risk principle in

practice they will need to be re-educated by the SOMB into a more nuanced view of sexual offender risk.

Sexually Violent Predator (SVP) Assessment

The Standards and Guidelines prescribe the use of a specific protocol for determining whether sexual offenders should be categorized as SVPs. The consequences of this categorization is to require the offender to notify the police of his address and for information about the offender to be placed on a public website. The designation does not necessarily bring with it additional resources to manage the offender.

The final determination of whether someone is an SVP is made by the court or by the parole board. This decision is informed by a package of information that includes the mental health sex offense specific evaluation, the PSIR and a Sexually Violent Predator Assessment Screening Instrument (SVPASI). This package is assembled by probation officers and SOMB-approved evaluators or SVP-trained DOC staff or contractors on contractors on men and women who qualify for screening. The SVPASI involves determining whether the offender has committed qualifying offenses and completion of a locally developed actuarial instrument (the Sex Offender Risk Scale – SORS).

The overall protocol appears to provide a comprehensive set of information. There are, however, some problematic aspects of the SORS. In its current, revised, version the SORS has five items

<p>SORS Items</p> <p>Item 1: Age of offender at the time of the index offense.</p> <p>Score 2 if the offender was age 25 or under, score 1 if the offender was between the ages of 26 and 35, or score 0 if the offender was over the age of 35.</p>

Item 2: The offender was known to the victim.

Two points are scored if the offender was known to any victim

Item 3: The offender has been revoked from community supervision as an adult 2 or more times in the past.

One point is scored if this applies; zero is scored otherwise

Item 4: The offender had NOT graduated from high school at the time of arrest.

Score 1 if the offender did not graduate, and score 0 if the offender did graduate from high school OR did attend a post secondary program after receiving their GED.

Item 5: The offender has one or more prior adult convictions

This includes adult felony and misdemeanor convictions and deferred judgments and sentences that occurred prior to the index sex offense. Misdemeanor traffic convictions such as DUI are also included, but lesser traffic citations and adjudications as a juvenile are not.

Item 6: The offender moved 2 or more times in the 2 years prior to arrest for the actual index/current offense.

If the offender has resided at 3 or more different addresses during the two years prior to arrest for the current offense 2 points are scored; otherwise score 0.

A score of 8 is taken as designating High Risk and qualifies the person for designation as an SVP

According to the 2010 SVPASI handbook the current revision of the scale was developed by a statistical analysis of data relating to a sample originally composed from sexual offenders under community supervision and offenders in prison from December 1996 to November 1997. The sample was non-random in that particular community areas were involved while the prison sample were participating in the

prison sex offender treatment program. Of the 494 original subjects, 218 were on probation, 47 on parole and 229 were in prison. For the new analysis the sample was comprised of the offenders who were located and at risk in the community. Those who were not located in the State of Colorado and those who had been incarcerated continuously since the time of the original 1998 data collection were excluded from the original sample. Additionally, those who had less than five years at risk were excluded, leaving a sample of 371. Of these included in the analysis almost one quarter (24.3%) of the sample was rearrested for a sexual crime within five years. Preliminary statistical analysis of an unspecified pool of 200 potential risk factors identified those associated with sexual recidivism and then logistic regression was applied to reduce the pool to those that held the greatest predictive power when used in combination with one another and to develop weights for each factor. Six items were identified for inclusion in the final scale. The handbook reports the scale as having an AUC of 0.67. Table 3 then reports the minimum score on the scale as being associated with a sexual recidivism rate of 24.3% with risk then rising slightly as scores increase until it rises increasingly sharply from a score of 6 (34.7% recidivism), and score of 7 (50.0% recidivism), a score of 8 (60.0% recidivism) and a score of 9 (66.7% recidivism).

There are several significant problems with this process that raise real questions as to whether this instrument should be used in making decisions about offenders.

1) The original sample is unrepresentative. It is a combination of ill-defined convenience samples. It is not clear what population they could be expected to generalize to.

2) The way in which sexual offenders are managed in Colorado is now very different from how they were managed at the time the data was collected. It is therefore not clear that the results of the study would be expected to generalize to the present day.

3) The sexual recidivism rate in this Colorado sample, reported as 24.3%, is remarkably high as compared to that involved in other DOC samples from the same era. For example, in a study of 9,691 sexual offenders released in 1994 from representative samples from the prisons of 15 States in the USA, Langan et al (2003) found that 95% of sexual offenders were free of arrests for sexual offenses during a three year follow up (or to put this another way, just 5.3% recidivated for a sexual offense).

4) The recidivism rates reported in the handbook's table 3 appear to be inconsistent with the recidivism rate reported in the handbook for the whole sample. A recidivism rate of 24.3% is reported for those making the minimum score (supposedly, less than 2% of the sample). All other risk scores are associated with higher recidivism rates. It is difficult to see how this is logically possible. It would appear some errors were made in preparation of the table or in the underlying data analysis.

5) The handbook describes an analysis used to construct the prediction scale. Scales normally do better in construction samples than they do in other samples, a phenomenon known as shrinkage. For this reason, you only learn about the true predictive properties of a scale when it is tested with offenders who were not used in its construction. Since no cross-validation has been carried out, the properties of the scale are presently unknown.

These represent serious flaws with the construction of the current version of the SORS. The first two flaws suggest that one cannot safely assume results with the present sample are generalizable to the general run of sexual offenders currently being managed in Colorado. The third and fourth points suggest that there were flaws in how recidivism data was collected, in the data analysis, or in how the research was written up. The fifth point means that there is currently no credible data on how predictive the SORS is.

In the light of this there is an urgent need to replace the SORS with an instrument that is soundly developed and cross-validated.

Low Risk Protocol

The Standards and Guidelines indicate that the community supervision team should use the Low Risk Protocol during the initial phase of treatment. For offenders who meet the designation of low risk per the Low Risk Protocol (LRP) by unanimous decision of the Community Supervision Team, the provider shall make a recommendation for discharge from sex offense specific treatment. The Low Risk protocol was not empirically devised and appears to represent a consensus formed among professionals who believe that sexual offenders are invariably dangerous as to who might be the rare exception to such a rule. To be categorized as low risk the person must have committed no more than one sexual offense (defined through both official records and through polygraph-supported self-report) and not have used or threatened physical violence. They have also to meet a range of other criteria relating to sexual deviancy, personality disorders, substance abuse etc.

The problem with this approach is that it is far too conservative. It is liable to fail to identify many offenders who in fact present no greater risk for future sexual offending than is presented by the routine non-sexual criminal released from prison.

It is recommended that the current protocol be replaced with some empirically-derived risk assessment protocol with the category calibrated to have an average five-year official recidivism within 2% of the five year rate of arrests for sexual offenses for routine non-sexual criminal released from Colorado prisons. Until such locally developed categorization can be developed and cross-validated the Low Risk category from Static-99R or a similar instrument might be used.

The Criteria for Release from Incarceration, Reduction in Supervision, Discharge for Certain Adult Sex Offenders, and Measurement of an Adult Sex Offender's Progress in Treatment issued by the Sex Offender Management Board

These topics are considered together as much the same issues apply. Detailed consideration of them is provided in Appendices A through O.

Many elements in these criteria are justifiable and consistent with contemporary good practice and they clearly represent the result of careful thought. Nevertheless there are number of concerns that should be addressed and it is time for them to be updated.

1) Elements of the criteria are dated and in need of being refreshed based on research carried out over the last decade.

In general the way the criteria are defined at the moment is too dependent on very dated research and takes too little account of how knowledge has developed over the last 15 years. A number of concepts used repeatedly in the criteria, and especially in talking about treatment, were current but subject to significant criticism in 2000, and now are definitely outdated. These include concepts like Offense Cycles and Relapse Prevention plans.

2) Accountability, Denial, Victim Empathy and Sexual History polygraph examinations are given too much emphasis

Central to these therapeutic concepts is the notion that risk is reduced if the person fully discloses all their offending, blames themselves for it rather than blaming other people or circumstances, and fully recognizes the harm they did to others and empathizes with those affected by their antisocial behavior. This idea was accepted

uncritically in the early 1990s. Subsequent research has called it into question. Denial is not consistently related to sexual recidivism. Indeed sometimes denial and evasion of responsibility is associated with lower recidivism. Incest offenders are the only group for which there are consistent findings associating denial with increased recidivism. The most that can be supported regarding denial from a risk point of view is that it can impede some kinds of risk reduction procedures (i.e. some kinds of treatment).

Relatedly, these criteria give too critical a role to polygraph examinations. Like other assessment tools the polygraph is fallible. The relevant research literature indicates that the polygraph can attain accuracy of close to 90% when testing well-defined single issues. Unfortunately Sexual History polygraphs are not well-defined single issues and the accuracy level is likely significantly lower. This means that there are liable to be a significant number of false findings of Deception and false findings of Non-Deception in Sexual History polygraphs.

Public protection is not entirely dependent on a complete disclosure of all past sexual crimes. Indeed, jurisdictions that don't use Sexual History polygraph examinations in this way have nevertheless achieved low sexual recidivism rates. More critical than full disclosure to preventing future offending is that the treatment team is able to determine (a) the main patterns of past offending (b) the main psychological risk factors that contributed to past offending. These achievements would more appropriately replace the requirement for Sexual History polygraphs in these criteria, with participation in Sexual History polygraphs being one way of generating information about patterns of past offending and psychological risk factors but not the only way.

3) These criteria do not embody the Risk-Need-Responsivity Principles

Specifically they make it harder to follow the Risk principle. They are liable to be interpreted in ways that do not support individualizing treatment in response to the

specific risk factors that apply to the individual. And they too easily generate patterns of practice that are demotivating for treatment participants.

4) Conservative Bias in Administrative Process

The Standard and Guidelines often require all members of the team to agree to any decisions that reduce the intensity of treatment or supervision. Any overly cautious member of the team can block reasonable decisions to reduce supervision or move towards discharge. The effect of this is to fail to identify when reduced supervision is indeed warranted and potentially make the system function in an unduly costly way for little gain in community safety. Further, as described by stakeholders in the Focus Groups, in actuality the supervision officer essentially makes all case decisions and treatment providers are pressured to comply.

The SOMB should consider creating a mechanism for independent review in cases where the team cannot come to a consensus. It is further recommended that the SOMB conduct a thorough internal analysis of the stakeholder reported problem that concerns about getting referrals and other pressures undermine the CST from functioning as intended. Lastly, regarding the discussion point, failure to progress in treatment or in meeting a lower supervision requirement does not necessarily mean more supervision is required but often rather, is a cue that treatment efforts must be adjusted. Unless failure to progress is associated with increased risk factors for re-offense, it should not trigger concern that more intensive supervision is warranted.

5) Insufficient influence of the Offender's Initial Level of Risk

What is required of offenders for release or reduction of supervision or discharge should depend on the initial level of risk they present. Much more should be expected from person's who initially present a greater risk. Presently the criteria do not prescribe such a practice.

6) These criteria do not use soundly developed, empirically-validated tools to anchor the decision-making process

Decisions could be made in a more cost-effective way if such tools are used. Without them professionals either run inappropriate risks or default to unnecessarily excessive, and expensive, caution.

Guidance Regarding Developmentally Disabled Offenders

Having separate guidance for assessing and treating this sub group of sexual offenders is necessary and it is clear that CO SOMB has begun to seriously consider the marked differences between developmentally disabled and non disabled sexual offenders. This feedback of the current evaluation on this topic is discussed in more detail in Appendix D. We recommend the use of assessment instruments that have been specifically validated for this population and suggest a particular instrument that could appropriately provide a foundation for both treatment planning and risk management. We recommend particular caution in using polygraph examinations with this group as problems with comprehension and memory mean that both Deceptive and Non-Deceptive results may be hard to interpret.

Guidance on Contact with Children

The research basis for the practice indicated by the Standards and Guidelines is dated and subject to methodological limitations that have not been sufficiently taken into account. The Child Contact Assessment has not been empirically validated. While it appeals to common sense it appears to be unduly cumbersome. We recommend a streamlined process be developed. In particular the SOMB should reconsider the grounds for prohibiting contact between children and sexual offenders who only have adult victims taking into account that the disruption of a

child's relationship with his father is in itself potentially harmful to the child. In such cases an expeditious balancing of risks is necessary. We noted that victim advocates in our focus groups were among those who saw the present guidance as over restrictive.

Provider & Evaluator Qualifications / Approval to Practice / Continuing Education / Complaints

We reviewed the SOMBs policies and obtained feedback during the focus groups. In general these were in line with commonly accepted practice. We would encourage the SOMB to attend to feedback obtained in our focus groups.

More generally, we would encourage the SOMB to attend to feedback from the offenders who are subject to the supervision and treatment processes. Clearly any such feedback would need to be sifted judiciously. Nevertheless, it would be better to develop a relationship with these offenders in which they felt their feedback was listened to since this will encourage treatment engagement and potentially allow the SOMB access to information that they would not otherwise have about how the Standards and Guidelines work out in practice.

Victim Perspectives

One of the strengths of the Standards and Guidelines is their wholehearted attempt to be responsive to the perspective of victims. Appendix N details our review of how this works out in practice. One comment from some victim advocates was that the very expensive system for managing offenders contrasted with the difficulty obtaining therapeutic services for victims. In this regard, developing a more cost-effective treatment and supervision system for offenders might allow more resources for victims.

Our main feedback in this area though was that the Standards and Guidelines are not always consistently followed, that the restrictions on offenders sometimes interfere with victims being able to be treated as they would like to be, and that victims who choose not to enter therapy have difficulty having a voice inside the present system.

Discussion

It is not possible to review the Standards and Guidelines without being impressed by the thought and dedication that has been invested into their development. The Colorado SOMB is to be congratulated on the contribution it has made to public safety.

Nevertheless, as with any enterprise that has operated for an extended period of time, there are strains and limitations on the current system and significant scope for improvement. The SOMB articulated to us their desire to improve the Standards and Guidelines and have been implementing their own initiatives to achieve this. We hope the findings and recommendations in this report contribute this ongoing process for self-improvement.

We conclude that significant aspects of the Standards and Guidelines warrant revision in the light of the research on sexual offending that has burgeoned over the past fifteen years. In reading the SOMB documents one gleans the impression of an organization that has at times drifted into reading or reviewing research selectively, or dismissing research conducted outside of Colorado, in the service of guarding positions that were formed many years ago. Where this might be the case we hope this document will stimulate a more profound examination of present assumptions.

The image of all men with a history of having committed a sex offense as perpetually highly dangerous, barely contained by never ending treatment and intensive supervision was formed in Colorado many years ago based on very limited research available at that time. Even though key members of the SOMB are aware that this is not an accurate, the image still appears to pervade the Standards and Guidelines.

This image combines with key features of how decisions are made in practice to create a systematic bias towards decisions that make the system operate in an inefficient manner. There is no doubt that public safety could continue to be maintained at a great deal less cost if modern research and principles of effective correctional practice were made more central to the Standards and Guidelines.

With regard to the Risk-Need-Responsivity principles which have been a primary focus of this review:

(1) There is substantial scope for better implementation of the Risk Principle. Initial assessment should at least triage offenders into Lower, Medium and Higher Risk groups with expectations being different for these groups and resources for supervision and treatment paralleling the level of risk. Treatment and supervision intensity should be reduced in response to demonstrated management of relevant risks and needs. For example, the risk presented by some offenders in prison treatment is such that they are ready to titrate to community based treatment and supervision. Further, some offenders do not need lifetime treatment and supervision to prevent re-offense.

(2) The Need principle is at least partly being followed. However, there is scope for applying the Need principle more systematically, in particular for treatment being more individualized in response to the particular criminogenic needs that are most relevant in individual cases. There appears to be too much resource allocation to treatment targets that are not closely related to risk.

(3) The Responsivity principle is supported by some aspects of the Standards and Guidelines but the practice associated with the Standards and Guidelines sometimes undermines it. The principle could be better followed by a greater emphasis on developing offenders' strengths and protective factors, community integration, and by greater use of the spirit of motivational interviewing in both treatment and supervision. Further, reexamination of the role of the polygraph as a tool to

facilitate treatment and treatment engagement, rather than primarily to coerce accountability, is an important opportunity for growth.

Further, the SOMB will benefit from explicit incorporation of the RNR principles into both the words and spirit of the Standards and Guidelines. In their outreach and training efforts, they will benefit from including specific modules on these principles. In developing such training materials, they may want to consider the materials created by this collaborative for the CO DOC: *The Principles of Program Design, Criminogenic Needs Relevant to Sexual Recidivism, and Treatment Style when Working with Sexual Offenders*. It is important that SOMB Board Members and all relevant stakeholders, including offender participants, be appropriately educated about the Standards and Guidelines and have viable opportunities to ask questions and communicate concerns.

Lastly, it is recommended that the SOMB thoughtfully consider the suggestions and recommendations of this evaluation in guiding their ongoing efforts for improvement. It is recommended that an external audit of the SOMB Standards and Guidelines be commissioned in approximately 24 months to determine the degree of progress has been made regarding the recommendations and provisions of this report.

Appendix A: Review of the Guiding Principles

Central to the 2011 Version of the CO SOMB Standards and Guidelines are thirteen Guiding Principles preceding the text of the individual Standards and Guidelines. This appendix provides a research and best practice informed analysis of these principles as they are written. Each guiding principle and its accompanying text is excerpted from the Standards and Guidelines and presented in italics followed by a discussion of its merits and limitations. Where appropriate, specific ways to rephrase the principle are suggested.

1. Sexual offending is a behavioral disorder which cannot be “cured.”

Sexual offenses are defined by law and may or may not be associated with or accompanied by the characteristics of sexual deviance which are described as paraphilias. Some sex offenders also have co-existing conditions such as mental disorders, organic disorders, or substance abuse problems. Many offenders can learn through treatment to manage their sexual offending behaviors and decrease their risk of re-offense. Such behavioral management should not, however, be considered a “cure,” and successful treatment cannot permanently eliminate the risk that sex offenders may repeat their offenses.

The phrasing of the first principle is misleading. The accompanying text is technically accurate although it does not include important facts. As a consequence, it is partially misleading.

The term “behavioral disorder” is not defined in the Standards and Guidelines. Perhaps some of those who signed off on this verbiage understood it as meaning no more than that sexual offending is a behavior liable to cause harm, however this would not be the common interpretation. Characterizing sexual offending as a disorder suggests to the reader that there is some enduring entity, “the disorder” that exists separately from the act of sexual offending itself but which invariably

accompanies and drives it. It also suggests that the person with this “disorder” will continue to commit sexual offenses unless managed or treated.

The accompanying text acknowledges that only some sexual offenders have known disorders that can be defined distinct from the commission of a sexual offense which is correct but the last sentence continues the idea that all sex offenders present a continuing substantial risk of offending which at best can be managed by continuing supervision and treatment but which may well resurge as soon as containment is relaxed.

This language therefore contains a number of implicit assumptions. These assumptions are either unsupported by available research evidence or represent an over-simplification of available evidence.

An important fact that is missing from the accompanying text is that, as far as can be determined from available research, for many men who have committed sexual offenses, the experience of arrest, conviction and punishment appears sufficient for them to desist from further sexual offending without requiring sustained treatment and management. Approximately 95% of sexual offenders statistically identified as “lower risk” stay free of further charges for sexual offending even when followed up for fifteen years. This very low rate of known sexual recidivism is found even in jurisdictions that do not provide the kind of extended and intensive supervision and treatment that is currently provided in Colorado. It is, of course, possible to speculate that any proportion of these “lower risk” offenders commit further sexual offenses without getting caught. However, speculation unsupported by evidence is not a sound basis for criminal justice policy. The question of how much higher actual recidivism rates are than rates of re-arrest is discussed in Appendix C.

A version of the first principle that would be more consistent with available research would read something like the following.

Risk for future sexual offending varies enormously. The intensity and duration of supervision and treatment should respond in a flexible and cost-effective way to these differences in risk.

Sexual offending is a behavior, not a disorder. Some men with a history of sexual offending present a risk for future sexual offending that is relatively similar to that of criminals with no known history of sexual offending. These lower risk offenders can be effectively managed in the community through ordinary supervision processes of limited duration. Others present a markedly elevated risk and may require supervision and treatment that is more intensive, more specialized and of greater duration. In Colorado, criminal sexual offenders are first assessed and referred for a sex offense-specific evaluation during the pre-sentence investigation conducted by the Probation Department. This initial assessment should minimally triage sexual offenders into lower, medium and higher risk groups with this categorization informing decisions about the intensity and duration of supervision and treatment that is appropriate for cost-effective risk management.

Since the publication of the 2011 Standards and Guidelines, the CO SOMB has decided a change in the first principle is warranted. The SOMB agreed to the following alternate first guiding principle.

COSOMB Proposed New First Guiding Principle

Sexual offending behavior is often repetitive and there is a continuing risk that adult sex offenders will reoffend.

The Sex Offender Management Board (SOMB) has reviewed the considerable body of research concerning the treatment of adult sex offenders. This guiding principle establishes a treatment and management philosophy which recognizes that there is currently no way to ensure that adult sex offenders will not re-offend.

This does not mean that all adult sex offenders will re-offend. With effective treatment, supervision and self-management, sex offenders can internalize changes that may decrease their likelihood of re-offense.

The offender must take responsibility for his or her behavior and commit to continually manage the behaviors that led to his or her offense(s) in order to prevent future offenses, future victims and to enhance public safety.

This revision is a modest but insufficient improvement. It does not bring the first principle in line with research. Although it is true that there is no way to ensure that a sexual offender will not re-offend, it leaves the reader with the impression that all sexual offenders will reoffend unless prevented by treatment and supervision. The recidivism literature does not support this idea. To the contrary, many sexual offenders seem to desist after being caught and punished for prior offenses without either extended supervision or treatment. Yet, for other sexual offenders sexual offending is repetitive. It is recommended that any revision to the first principle highlight the need to respond to the great variation in risk presented by sexual offenders.

2. Sex offenders are dangerous.

When a sexual assault occurs there is always a victim. Both the literature and clinical experience suggest that sexual assault can have devastating effects on the lives of victims and their families. There are many forms of sexual offending. Offenders may have more than one pattern of sexual offending behavior and often have multiple victims. The propensity for such behavior is often present long before it is detected. It is the nature of the disorder that sex offenders' behaviors are inherently covert, deceptive, and secretive. Untreated sex offenders also commonly exhibit varying degrees of denial about the facts, severity and/or frequency of their offenses. Prediction of the risk of re-offense for sex offenders is in the early stages of development. Therefore, it is difficult to predict the likelihood of re-offense or future victim selection. Some offenders may be too dangerous to be placed in the community and other offenders may pose enough risk to the community to require lifetime monitoring to minimize the risk.

The second guiding principle is an over-simplification that in the context of the rest is misleading. “Dangerous” means liable to do serious harm. “Dangerous” suggests

both that there is a high probability of each known sexual offender committing further sex offenses and that there is an equally high probability that these offenses when they occur will invariably traumatize the persons victimized. In fact, however, there are many sexual offenders for whom there is no credible empirical basis for asserting that they are “likely” to commit further sex offenses.

The text then expands an argument that implicitly assumes that we know that sexual offenders in general are likely to reoffend and that limitations on our risk assessment technology mean that we can’t accurately identify the exceptional sexual offender who is at low risk of sexual offending. This has the real situation exactly backwards, we know that there are a large group of sexual offenders (the lower risk offenders referred to above) who seem very unlikely to commit further sexual offenses (a long-term recidivism rate of just 5%). Limitations on our risk assessment technology mean that while we can reliably identify a substantial group who present an elevated but still relatively low rate of sexual recidivism, it is only exceptional individuals who can be identified as truly likely to re-offend.

A version of the second principle that would be more consistent with available research would read something like the following.

Sexual Offenses should always be taken seriously as they can have devastating effects on the lives of victims and their families.

When a sexual assault occurs there is always a victim. Both the literature and clinical experience suggest that sexual assault can have devastating effects on the lives of victims and their families. There are many forms of sexual offending. Convicted sexual offenders may sometimes have more than one pattern of sexual offending behavior and often have multiple victims. The propensity for such behavior is often present long before it is detected. It is the nature of sexual offending that is carried out covertly with the intention of avoiding detection, Untreated sex offenders also commonly exhibit varying degrees of denial about the facts, severity and/or frequency of their offenses. In addition to the direct negative effect of the sexual offense, victims may be traumatized again by their experiences during the legal process. Especially where

the perpetrator is a family member the victim may have mixed feelings about the perpetrator's legal punishment, other family members may wish the victim had not disclosed and blame the victim for the family's troubles, and even after a man has been convicted of a sexual crime he may persist in denying or minimizing the offense and in trying to sell a victim-blaming version of events to other family members. Professionals working with sexual offenders should be alert to how such behaviors may inflict further harm on persons they have previously victimized.

3. Community safety is paramount.

The highest priority of these Standards and Guidelines is community safety.

Most people would surely agree that community safety should be the highest priority and some would agree that this should be the first guiding principle. It is appropriate to simultaneously articulate some of the other priorities in managing and treating sexual offenders that need to be taken into account.

One of these is cost-effectiveness. The most effective way to assure community safety is to keep all known sexual offenders in prison for the rest of their lives. This, however, would be prohibitively costly. The annual cost per prison inmate for Colorado was estimated in 2012 by the Vera Institute for Justice as \$30,374. A man imprisoned at the age of 40 who lived until he was 75 would therefore cost the state about a million dollars (35 x \$30,374). Remembering that for lower risk offenders the long term rate of new sexual charges is just 5%, this means that on average you have to apply lifetime imprisonment to 20 lower risk sexual offenders in order to avoid one charge for a new sexual offense. The cost of this strategy is therefore \$20 million per charge prevented. In the present era no policy objective can be pursued without regard to cost. Surely there are ways of spending \$20 million that will prevent more than one charge for a sexual offense, for example primary prevention strategies and victim services.

One way of restating this guiding principle in a more balanced manner is the following.

Community safety is paramount.

The highest priority of these Standards and Guidelines is to maximize community safety in the most cost efficient manner possible.

4. Assessment and evaluation of sex offenders is an ongoing process. Progress in treatment and level of risk are not constant over time.

The effective assessment and evaluation of sexual offenders is best seen as a process. In Colorado, criminal sexual offenders are first assessed and referred for a sex offense-specific evaluation during the pre-sentence investigation conducted by the Probation Department. Assessment of sex offenders' risk and amenability to treatment should not, however, end at this point. Subsequent assessments must occur at both the entry and exit points of all sentencing options, i.e. probation, parole, community corrections and prison. In addition, assessment and evaluation should be an ongoing practice in any program providing treatment for sex offenders. In the management and treatment of sex offenders there will be measurable degrees of progress or lack of progress. Because of the cyclical nature of offense patterns and fluctuating life stresses, sex offenders' levels of risk are constantly in flux. Success in the management and treatment of sex offenders cannot be assumed to be permanent. For these reasons, monitoring of risk must be a continuing process as long as sex offenders are under criminal justice supervision. Moreover, the end of the period of court supervision should not necessarily be seen as the end of dangerousness.

While the principle is accurate, the subsequent elaboration is somewhat misleading. The text implies a state of maximum vigilance should be employed for all sex offenders at all times. Regardless of how someone's risk may seem to have declined, according to this principle, they may at any moment "flux" into a state of higher dangerousness. Whereas it is true that sexual offenders may relapse to re-offense rapidly or gradually, perpetuating a view that sexual offenders are all chronically

and persistently at high risk for re-offense is misleading. Such a view is factually inaccurate and mitigates against cost-efficient strategies for managing sex offenders.

Available research indicates that the strong general pattern is that risk of future charges for sexual offenses halves for every five years sexual offenders are in the community without offending. While it is undoubtedly true that, there are always individual exceptions, overall there is a steady decline in risk over time, with the first five years being the period when most of the re-arrests for sexual offenses happen. Somewhat similarly, where progress in treatment is assessed using structured empirically-developed instruments like SOTIPS (McGrath et al, 2012) those rated as progressing over the first 12 months of treatment show significantly reduced risk of longer term recidivism compared to those who do not progress in treatment. Indeed, the SOMB has reported a plan for training and use of this instrument. If utilized in a manner consistent with the findings of this report, this will be a marked improvement over current practice.

A version of the fourth guiding principle that would be consistent with available research might read as follows.

4. Assessment and evaluation of sex offenders' risk is an ongoing process. The intensity of external controls should be responsive to changes in risk.

The effective assessment and evaluation of sexual offenders is a process. Effective management of risk balances the use of external controls and the development of internal protective factors and controls. Treatment and supervision should aim to gradually build up internal protective factors and controls and gradually reduce the intensity of external controls so that professionals can determine how well improved behavior is sustained when the individual has more freedom. This will better prepare for the end of court supervision and also allow for more cost effective low intensity supervision when internal protective factors and controls are stronger. At the same time systems need to be alert for indications that risk has temporarily increased (for example: the individual's life has become acutely more chaotic or stressful; the individual has acutely become less cooperative with supervision or treatment; the individual appears to be seeking access to

potential victims) and quickly be able to increase the intensity of management in response.

The assessment of sex offenders' risk, internal protective factors and external controls, and amenability to both treatment and supervision that takes place as part of the initial sex offense-specific evaluation during the pre-sentence investigation should be supplemented by further assessments at both the entry and exit points of all sentencing options, i.e. probation, parole, community corrections and prison. In addition, assessment and evaluation should be an ongoing practice in any program providing treatment for sex offenders. Risk decreases typically become evident when offenders show meaningful progress as measured with structured evidence-based instruments after 12 to 18 months specialized community treatment. It also decreases very substantially when the offender spends five years in the community without further sexual offending. It should be exceptional for an offender who has met either of these criteria to continue to receive intensive supervision and treatment. A rational strategy would be to reduce the intensity of supervision and treatment once meaningful progress has been identified and to consider it no longer required if progress is sustained and the offender succeeds in spending five years in the community without further sexual offending.

5. Assignment to community supervision is a privilege, and sex offenders must be completely accountable for their behaviors.

Sex offenders on community supervision must agree to intensive and sometimes intrusive accountability measures which enable them to remain in the community rather than in prison. Offenders carry the responsibility to learn and demonstrate the importance of accountability, and to earn the right to remain under community supervision.

While it is correct that community supervision is a privilege, it is arguably more helpful to emphasize that from the perspective of the taxpayer, community supervision is a more cost-effective form of risk management than incarceration. The purpose of the Standards and Guidelines is to influence the behavior of treatment providers, probation and parole supervisors, and other professionals working with convicted sexual offenders. Viewed from this perspective the emphasis in this guiding principle as written is likely to be unhelpful. It suggests a

punitive and unyieldingly demanding attitude towards persons being supervised with nothing less than total compliance being acceptable. This is likely to encourage revocations that could and should have been avoided. The phrasing of this guiding principle discourages professionals from attending to how their own behavior affects the conduct of offenders they supervise.

With these considerations in mind the fifth guiding principle could be re-revised in a manner consistent with the following.

Community Supervision is a more cost-effective form of risk management than imprisonment but it depends on sexual offenders adequately cooperating with supervision processes. Accordingly, those that work or interact with sexual offenders should do so in such a manner so as to maximize offender cooperation and accountability.

Community supervision generally works better when supervisors, evaluators, and treatment providers employ a motivational approach to eliciting cooperation and focus their attention on discussion of risk and protective factors rather than being excessively and solely attentive to compliance with conditions. The greater cost-effectiveness of community supervision means that revocation of supervision should be a last resort, only pursued when it is essential for public safety or when treatment compliance cannot be otherwise obtained.

6. Sex offenders must waive confidentiality for evaluation, treatment, supervision and case management purposes.

All members of the team managing and treating each offender must have access to the same relevant information. Sex offenses are committed in secret, and all forms of secrecy potentially undermine the rehabilitation of sex offenders and threaten public safety.

This guiding principle is well founded and consistent with current available literature and best practices in treating and managing sexual offenders.

7. Victims have a right to safety and self-determination.

Victims have the right to determine the extent to which they will be informed of an offender's status in the criminal justice system and the extent to which they will provide input through appropriate channels to the offender management and treatment process. In the case of adolescent or child victims, custodial adults and/or guardians ad litem act on behalf of the child to exercise this right, in the best interest of the victim.

This guiding principle is well founded and consistent with current available literature and best practices in treating and managing sexual offenders.

8. When a child is sexually abused within the family, the child's individual need for safety, protection, developmental growth and psychological well-being outweighs any parental or family interests.

All aspects of the community response and intervention system to child sexual abuse should be designed to promote the best interests of children rather than focusing primarily on the interests of adults. This includes the child's right not to live with a sex offender, even if that offender is a parent. In most cases, the offender should be moved or inconvenienced to achieve the lack of contact, rather than further disrupting the life of the child victim.

This guiding principle is well founded and consistent with current available literature and best practices in treating and managing sexual offenders.

9. A continuum of sex offender management and treatment options should be available in each community in the state.

Many sex offenders can be managed in the community on probation, community corrections, and parole. It is in the best interest of public safety for each community to have a continuum of sex offender management and treatment options. Such a continuum should provide for an

increase or decrease in the intensity of treatment and monitoring based on offenders' changing risk factors, treatment needs and compliance with supervision conditions.

This guiding principle is well founded and consistent with current available literature and best practices in treating and managing sexual offenders.

10. Standards and guidelines for assessment, evaluation, treatment and behavioral monitoring of sex offenders will be most effective if the entirety of the criminal justice and social services systems, not just sex offender treatment providers, apply the same principles and work together.

It is the philosophy of the Sex Offender Management Board that setting standards for sex offender treatment providers alone will not significantly improve public safety. In addition, the process by which sex offenders are assessed, treated, and managed by the criminal justice and social services systems should be coordinated and improved.

This guiding principle is well founded and consistent with current available literature and best practices in treating and managing sexual offenders.

11. The management of sex offenders requires a coordinated team response.

All relevant agencies must cooperate in planning treatment and containment strategies of sex offenders for the following reasons:

- Sex offenders should not be in the community without comprehensive treatment, supervision, and behavioral monitoring;*
- Each discipline brings to the team specialized knowledge and expertise;*
- Open professional communication confronts sex offenders' tendencies to exhibit secretive, manipulative and denying behaviors;*
- Information provided by each member of an offender case management team contributes to a more thorough understanding of the offender's risk factors and needs,*

and to the development of a comprehensive approach to treating and managing the sex offender.

This guiding principle is well founded with exception the first bullet. It is not necessary for most low risk sexual offenders to have lifelong comprehensive treatment, supervision and behavioral monitoring.

12. Sex offender assessment, evaluation, treatment and behavioral monitoring should be non-discriminatory and humane, and bound by the rules of ethics and law.

Individuals and agencies carrying out the assessment, evaluation, treatment and behavioral monitoring of sex offenders should not discriminate based on race, religion, gender, sexual orientation, disability or socioeconomic status. Sex offenders must be treated with dignity and respect by all members of the team who are managing and treating the offender regardless of the nature of the offender's crimes or conduct

This guiding principle is well founded and consistent with best practice standards. It is recommended that the list in the first sentence include a prohibition against discriminating due to offender status.

13. Successful treatment and management of sex offenders is enhanced by the positive cooperation of family, friends, employers and members of the community who have influence in sex offenders' lives.

Sexual issues are often not talked about freely in families, communities and other settings. In fact, there is often a tendency to avoid and deny that sex offenses have occurred. Successful management and treatment of sex offenders involves an open dialogue about this subject and a willingness to hold sex offenders accountable for their behavior.

This principle captures one aspect of the way pro-social law-abiding people in the offender's life may be a good influence. It might profitably also emphasize other protective aspect of prosocial support. These would include these figures modeling prosocial attitudes and decision-making, providing non-collusive social support, and facilitating opportunities for the offender to start living a more "normal" life.

With these considerations for improvement in mind this guiding principle could be revised in a manner consistent with the following.

Families, friends, employers and members of the community who have influence in sexual offenders' lives can meaningfully contribute to their safe re-integration into society.

Sexual issues are often not talked about freely in families, communities and other settings. In fact, there is often a tendency to avoid and deny that sex offenses have occurred. Successful management and treatment of sex offenders involves an open dialogue about this subject. Prosocial individuals in the offender's environment can model prosocial attitudes and decision-making and can challenge antisocial / risky attitudes and decision-making. They can also create opportunities for the individual to live a more normal life and so encourage the individual in the sense that living in a prosocial way can be worthwhile.

Appendix B: Sexual Recidivism Risk

Early Research

Early research into sexual offending concentrated on the past behavior of convicted sexual offenders. These studies commonly reveal that under some conditions convicted sexual offenders will report having committed large numbers of sexual offenses. For example, Groth, Longo and McFadin (1982) surveyed 83 rapists and 54 child-molesters using an anonymous questionnaire. They found that the rapists admitted to an average of 5.2 rapes each while the child-molesters admitted to an average of 4.7 sexual assaults. Freeman-Longo (1985) using the same procedure to study 23 rapists and 30 child-molesters in an institutional forensic mental health program found that these rapists self-reported an average of 221 sexual offenses while the child-molesters reported nearly six thousand sexual assaults on children. Abel et al (1987) reported that under research conditions 561 mixed sexual offenders who had sought evaluation or treatment at a specialized clinic reported having committed nearly a quarter of a million sexual offenses. Weinrott and Saylor (1991) reported that the 37 identified rapists in a treatment program run in a state hospital admitted to 433 rapes against an average of 11.7 victims while the 67 child-molesters reported over 8,000 offenses against children. Lisak and Miller (2002) found that, under research conditions, 6.4% of a sample of 1,882 students reported having engaged in sexual behaviors that met the legal definition of rape. Almost two-thirds reported having carried out more than one rape, and these repeat-rapists reported an average of 5.8 rapes each; none had been arrested for these offenses. Ahlmeyer et al (2000) used polygraph examinations to encourage admissions of past sexual offenses among imprisoned and paroled sexual offenders. This had little effect for the parolees but for inmates who had a mean number of victims of 2 according to their PSIR, by the end of the second polygraph examination a mean of 184 victims had been reported. The lack of effect on the parolees is thought to have been because at the time there were no consequences for them of failing the

polygraph. A subsequent, much larger study using the same combination of polygraph and treatment was reported by Heil et al (2003). Again the procedure made little difference for those on parole but for the 223 prisoners who had a mean of 2 victims described in their PSIR, a mean of 18 had been reported by the end of the polygraph process.

These early research findings seem to paint a picture of sexual offenders as highly prone to recidivate. Careful examination of the studies' methodology reveals, however, that it is not fully accurate to interpret them in that manner. As enumerated below, there are several difficulties with these studies.

1. **These studies relate to what offenders say they have done, not to what we know they have actually done.** This concern is most obvious in relation to the polygraph studies. Here substantial disclosure of sexual offending only occurs when offenders are put under strong pressure to say that they have committed additional offenses. In an evaluation by the current team of the Colorado prison treatment program several offenders reported that program participants invent offenses they hadn't committed in order to appease the program. Kokish et al (2005) similarly found that some offenders participating in polygraph assisted disclosure in California reported fabricating offenses to appease those working with them. Disclosures under research conditions are less subject to this problem though there is still the possibility of offenders telling researchers what they think the researchers want to hear. This means great caution has to be used in interpreting numbers from studies combining the polygraph and intense pressure to elicit reports.
2. **There is a problem with how sexual offenses are defined.** For example, Lisak and Miller included having "sexual intercourse with someone, even though they did not want to, because they were too intoxicated (on alcohol or drugs) to resist your sexual advances (e.g. removing their clothes)." Now

clearly this is describing a situation in which someone was likely unable to effectively express their consent or dissent to sexual activity. Nevertheless, it does not correspond to the common prototype of rape in which clearly expressed dissent and resistance is overcome by physical force or threats. Moreover, consent and dissent is a fluid thing in sexual interactions, someone may dissent from sexual activity at one point but then acquiesce to it (or even enthusiastically participate) later. Cowley (2013) provides a qualitative analysis of the way that alcohol, beliefs about the effect of alcohol, and sex role expectations can interact to lead to unwanted sexual behavior. These kind of complexities mean that it is not clear that the events Lisak and Miller defined as rape would necessarily have been defined that way by the participants (indeed in widely quoted college rape surveys nearly three-quarters of persons the researchers defined as having been raped did not themselves see what had happened as rape – Koss et al, 1987). Further this finding in particular fails to capture legally relevant aspects of rape as a criminal offense and so is liable to subsume many behaviors which are not in fact crimes (Gyls & McNamara, 1996). Similarly where offenders participate in treatment they are often taught a refined sexual sensibility in which they now come to see as abusive sexual behaviors those that they did not previously see as abusive. These abusive behaviors that are in a gray zone (commonly not socially recognized as criminal) may make up a significant proportion of disclosures in these studies. For example, in the Lisak and Miller study sexual intercourse with an intoxicated person was by far the most common form of sexual aggression reported in this sample. By contrast, it appears that 0.6% (6 in a 1,000) reported using threats or force to coerce sexual intercourse.

3. **The distribution of self-reported offenses tends to be skewed so that means misrepresent what is typical.** This means that many people report a smaller number of offenses while a small number report a very large number of offenses. Thus the average and total number of victims reported

will be highly misleading. For example, in Ahlmeyer et al (2000)'s study, for inmates the mean number of reported victims was more than seven times the median (midpoint in the distribution) number. In Heil et al's study the mean number of victims report by inmates was twice the median. In Lisak and Miller's study, even though the mean number of self-reported rapes was 5.8, in fact a majority of those reporting any rapes reported no more than 2.

4. **The samples tend to be unrepresentative, probably over-representing those who are more deviant.** Many of the samples are from treatment programs or forensic populations where offenders were sent specifically due to having serious sexually deviant behavior.

5. **These studies primarily relate to sexual offending prior to arrest and punishment.** In other words, they don't provide information about how sexual offenders continue to behave after their offending has been interrupted by the criminal justice system.

These methodological problems, taken together mean that these studies significantly over-represent how repetitive sexual offenders were prior to arrest, and more critically, provide no information about how they behave after they have been arrested and punished. In short, they bias our perception of sexual offenders without providing real information about recidivism after punishment.

Modern Studies of Sexual Recidivism Rates

To find out about sexual recidivism after punishment we must turn to studies that follow convicted sexual offenders over time and determine which are charged for further offending. These are sometimes referred to as studies of official recidivism rates.

Official recidivism rates for modern American DOC sexual offenders are low. In a monumental study of 9,691 sexual offenders released in 1994 from the prisons of 15 States in the USA, Langan et al (2003) found that 95% of sexual offenders were free of arrests for sexual offenses during a three year follow up (or to put this another way, just 5.3% recidivated for a sexual offenses). In a more recent study, Zgoba et al (2012) found that rates have sexual offenders released from four States DOCs had an average sexual re-arrest rate of 5% over a five-year follow up. A limitation of these studies is that the real follow up period may have been shorter than it appeared as offenders may have been revoked for technical reasons or for non-sexual offenses. In fact, in the Langan et al study nearly 4 in 10 were returned to prison within three years of release – almost always for a technical violation or a non-sexual offense.

The box below reproduces table 2 from a Minnesota DOC report on the three-year sexual recidivism rates on sexual offenders released from their prisons from 1990 to 2002. The Minnesota statistical studies are important because they carefully allowed for non-sexual reasons for an offender being removed from the community, so their three-year recidivism rates correspond to a full three years in the community with an opportunity to commit new sexual offenses.

As their table 2 shows, the three-year rate started high (10 to 15 percent sexual recidivism being typical for those released between 1990 and 1994) but then steadily declined so that from 2000 to 2002 it has been under 4 percent. This decline has been associated with the selective use of more intense supervision and with apparently effective prison treatment. However, another possible factor is the general decline in violent offending in general and sexual offenses against children in particular that has taken place from the early 1990s onwards. Finkelhor and Jones (2006) document declines of 40% to 70% in rates of child-maltreatment and victimization, including sexual offending, from 1993 to 2004.

Table 2. Three-Year Sexual Recidivism Rates by Release Year, 1990-2002

<i>Release Year</i>	<i>Sex Rearrest</i>	<i>Sex Reconviction</i>	<i>Sex Reincarceration</i>	<i>Number</i>
1990	19.0	16.7	4.8	126
1991	15.3	11.7	5.4	111
1992	10.9	7.4	4.7	256
1993	13.1	11.9	5.1	176
1994	10.7	9.8	6.7	225
1995	8.2	6.5	4.5	245
1996	6.5	4.5	2.4	246
1997	8.6	6.2	3.5	257
1998	4.2	2.9	2.6	312
1999	4.3	3.3	2.6	303
2000	3.3	2.6	1.3	302
2001	2.7	1.7	1.4	292
2002	3.8	2.5	1.0	315
Total	7.3	5.7	3.2	3,166

Variation in Sexual Offender Risk

Official recidivism rates are importantly affected by the offender's prior history. Items that index youth and the degree to which the offender has previously persisted in committing sexual and non-sexual crimes after punishment can be combined to produce risk scores and then recidivism rates can be examined for offenders grouped on the basis of their risk score. Table 1 below summarizes data from a large multi-national study of this kind in which results from smaller studies are averaged to give more reliable patterns. This is the most comprehensive study available using Static-99R to classify offenders' criminal history.

In table 1 "lower risk" offenders are those scoring from -3 to -1 on Static-99R; "higher risk" offenders are those scoring 5 and above; "moderate risk" offenders are those with intermediate scores. For each of these groups table 1 shows their rate of official recidivism after five years follow up. The last row shows rates of "out of the blue" sexual offenses committed by non-sexual criminals released from prison.

Several important points arise from this table.

1) Men convicted of sexual offenses who fall in the lower risk category have a rate of new charges for sexual offenses (2%) which is **similar to** the rate of “out of the blue” sex offenses committed by men discharged from prison who had no prior history of sexual offending.

2) Men convicted of sexual offenses who fall in the moderate risk category have a rate of new charges for sexual offenses that is about **3 or 4 times** the rate of “out of the blue offenses” and equally about 3 or 4 times the rate of new charges incurred by lower risk sexual offenders.

3) Men convicted of sexual offenses who fall in the higher risk category have a rate of new charges for sexual offenses that is about **10 times** the rate of “out of the blue offenses” and equally about 10 times the rate of new charges incurred by lower risk sexual offenders.

Table 1: Sexual Recidivism Rates by Risk Categories based on Static-99R

Risk Category	Point follow up starts	N	5-Year Sexual Recidivism Rate
Lower Risk Sex Offender	From Release	890	2%
Moderate Risk Sex Offender	From Release	4,858	7%
Higher Risk Sex Offender	From Release	1,992	22%
<i>Non-Sex Offender Criminals</i>	<i>From Release</i>	<i>Averaged across studies</i>	<i>1 – 3% over about 4-years</i>

In light of these statistics it is grossly unjustified to assign the same level of resources, intensity of treatment and/or supervision to all three groups.

Lower risk sexual offenders seem to warrant no more than routine supervision practice, with one caution that care needs to be taken in relation to their potential contact with persons they have previously victimized. In addition, even an offender that scores very low on a risk assessment instrument may indeed present an atypically high level of external risk factors or offense characteristics such as to warrant atypical elevation in supervision and treatment intensity. In contrast, moderate and higher risk sexual offenders genuinely present a risk of sexual offending that is significantly above that presented by non-sexual offenders and extra resources are warranted to manage this extra risk.

Table 2 repeats the information from Table 1 but adds information about how risk changes if a man previously convicted for sexual offending spends five years in the community without further known sexual offending. It turns out that five years in the community without known sexual offending signals approximately a halving of the risk for sexual recidivism in the following five years. So, for example, the Moderate risk categories recidivism rate reduces from 7% to 4% while the higher risk categories recidivism rate reduces from 22% to 9%.

These results indicate that being in the community for five years without further known sexual offending is a strong sign of reduction in risk. Accordingly, it would be rational for the intensity of sexual offender management to normally be materially reduced at this point, though with an assessment to check for exceptional factors that might indicate that this normal practice should not be followed in the individual case. And it is important to note that “higher risk” offenders continue to show some elevation of risk even after five years in the community (presenting a risk more or less equivalent to the risk presented by “moderate risk” offenders immediately after release).

Table 2: Sexual Recidivism Rates by Risk Category and Time Offense-Free

Risk Category	Point follow up starts	N	5-Year Sexual Recidivism Rate
Lower Risk Sex Offender	From Release	890	2%
	After 5 years offense-free	601	1%
Moderate Risk Sex Offender	From Release	4,858	7%
	After 5 years offense-free	3,081	4%
Higher Risk Sex Offender	From Release	1,992	22%
	After 5 years offense-free	1,053	9%
<i>Non-Sex Offender Criminals</i>	<i>From Release</i>	<i>Averaged across studies</i>	<i>1 – 3% over about 4-years</i>

Another factor that is relevant for those who enter treatment programs is the severity of the problems they start with and how these problems respond to treatment (McGrath et al, 2012). The SOTIPS is a rating scale developed in Vermont that allows treatment needs relevant to sexual offenders to be rated according to severity. These needs fall into three broad areas: (i) deviant sexual interests, attitudes and behaviors; (ii) oppositional, antisocial criminal attitudes and behaviors; (iii) and (lack of) social stability and support. Non-recidivists and recidivists show quite different patterns of rating over time. Non-recidivists show Need scores that steadily decline during treatment while recidivists typically show no improvement.

One final set of findings should be noted. Denial and minimization of past sexual offending is pervasive among sexual offenders but it appears that this problem has not been shown to be generally related to risk for sexual recidivism (Mann et al, 2010). There is, however, an important exception. Among statistically lower risk

sexual offenders, notably those who have offended against their own children, denial does seem to be related to sexual recidivism (e.g. Thornton & Knight, 2007; Nunes et al, 2007; Harkins et al, 2010). In contrast, among higher risk extra-familial child-molesters denial is actually associated with lower recidivism rates.

These results suggest another rational basis for reducing intensity of treatment and supervision although again this is relative to how risky the individual was to start with. An illustration of a rational risk-based guide to decision-making is provided in the box below.

Lower risk sexual offenders generally do not need supervision or treatment that is specialized for sexual offenders. Instead the routine kind of supervision that is used with non-sexual offenders would likely be sufficient. An exception to this is where these offenders continue to deny offenses for which they have been convicted or seek to make contact with past victims. Another exception is when the offender present a markedly high level of external risk factors or has severe offense characteristics (i.e. sexual homicide).

“Moderate risk” offenders require moderate intensity treatment and supervision specialized for sexual offenders but those who have both shown a reduction in Need according to SOTIPS and five years in the community without known offending might appropriately have this reduced to routine levels of supervision.

“Higher risk” offenders require high intensity treatment and supervision specialized for sexual offenders and while this can be reduced in intensity if they respond well to treatment and spend five years in the community without known offending, even achievement they will continue to require specialized supervision.

Appendix C: Official versus Actual Recidivism Rates

A challenge shared by all current instruments for assessing sexual recidivism risk is that they were validated using indicators of official, as opposed to actual, recidivism. Further, the official detection rate for sexual offenses is hard to determine precisely and likely varies significantly between types of offenders and types of sexual offense. Hanson, Thornton and Price (2003) reviewed data from multiple different sources and methodologies examining detection rates for sexual offending. They found that for contact sexual offenses against adults, or children, the detection rate per victim was on average between 5% and 20% (see their Table 1). This means that for only 5 to 20 of every 100 victims is the offender officially detected. Since, however, recidivists normally re-offend against multiple victims, their individual chances of eventually getting caught are much higher than this.

Hanson et al. (2003) used multiple sources of data to estimate the frequency of new victims among those who go on to re-offend. They found a range of rates at which recidivists re-offend. Grouping all recidivists together, the average yearly rate of new victims was about one in every 18 months. When combined with the detection rate per victim described in the preceding paragraph, this means that the true recidivism rate over 15 years is about 150% of the officially detected rate. The impact of detection versus the true rate of recidivism for individual offenders depends on the number of new victims that sexual recidivists offend against. Logically, the sexual recidivists who re-offend against no more than one victim over the rest of their lives will be much less likely to be caught than those sexual recidivists who re-offend against multiple victims. Considering this empirical information on detection versus actual re-offense rates, a reasonable conclusion is to conceptualize risk assessment instruments as a gauge of density of sexual offending. They distinguish those who are more likely to go on to have many future victims from those who will go on to have few or no future victims.

Appendix D: Working with Developmentally Disabled Sexual Offenders

1. Assessment

The standards and guidelines for an accurate risk assessment (Adult Standards 2.00, 2.050 DD) suggest that an accurate risk assessment includes an assessment of: cognitive functioning, mental health, medical/psychiatric health, substance use, stability of functioning, developmental history, sexual evaluation, risk, motivation/amenability to treatment, and impact on victims.

Further, it is noted that 'due to the complex issues of evaluating sex offenders with developmental disabilities, methodologies shall be applied individually and their administration shall be guided by' instruments that have relevance and have demonstrable reliability and validity, and which are supported by research as they relate to persons with developmental disabilities. It is also noted that evaluators shall carefully consider the appropriateness and utility of using the PPG, or VRT assessment, with this group.

Considerable guidance is given in Sections 2.060/2.061 regarding: cognitive functioning (i.e., intellectual functioning, neuropsychological functioning, and academic achievement); mental health (i.e., character/personality pathology, sadism, mental illness, self concept/self esteem), medical/psychiatric health, substance abuse, stability of functioning, developmental history, sexual evaluation (i.e., sexual history, reinforcement structure for deviant behavior, arousal/interest pattern, sexual crimes details, sexual deviance, medical dysfunction, sexual preferences, attitudes cognitions; risk motivation and amenability to treatment, impact on victim. Additional information related to 2.061 includes the following: level of planning in the crimes, 'street smarts', expressive/receptive languages skills,

social judgment/ability to participate in group settings, adaptive behavior, support systems, executive functioning.

As regards a specific risk assessment tool 2.070DD suggests that 'if the sex offender with developmental disabilities meets the statutory requirements for completion of the Sexually Violent Predator Risk Assessment, the instrument shall be completed using the existing instruments as required. The evaluator shall document any concerns regarding this instrument's validity for the client.' This is an interesting comment given that it is also noted in 2.061, that 'many widely used risk assessment tools have not been created specifically for adults sex offenders with developmental disabilities [therefore] the evaluator shall use caution when choosing to use such instruments and when interpreting the resulting data'. We have noted elsewhere in this report that there are significant problems with the SVP risk assessment so it should not be mandated for use with this population either.

Recommendation

Therefore, given the potential unwieldy nature of all of the material that needs to be completed and collated for DD offenders; and the fact that it is noted that the instruments being recommended by the SOMB for use have not been specifically validated with DD populations, we would suggest utilization of a valid and reliable tool such as the Assessment of Risk and Manageability of Individuals with Developmental and Intellectual Limitations who Offend - Sexually (ARMIDILO -S). This is an instrument designed specifically for use with individuals with a borderline or mild intellectual impairment, who have offended sexually or have displayed sexually offensive behavior. The ARMIDILO-S has been shown to have good predictive validity with different samples of sexual offenders and has been positively evaluated in qualitative studies as a case management instrument. Research involving one of the authors of this reports (Blacker, Beech, Wilcox, & Boer, 2011, - The assessment of dynamic risk and recidivism in a sample of special needs sexual offenders. *Psychology, Crime and Law*, 17, 75-92) has found that the ARMIDILO instrument was a moderate predictor for sexual reconviction among

offenders with special needs (ARMIDILO-Stable, AUC = .60; ARMIDILO-Acute, AUC = .73), compared to the RRASOR (AUC = .53) and the RM2000-V (AUC = .50). US training can be provided by: James L. Haaven, MA, Portland, Oregon, USA Telephone: (503) 490-7394 Email: jhaaven@comcast.net

The ARMIDILO assessment would be an appropriate foundation for individualized treatment planning and decisions about progress with this population.

The SOMB has communicated to the evaluation team that it is aware of the concerns regarding the use of the Sexually Violent Predator Risk Assessment Instrument with adult sexual offenders who persons with intellectual disabilities. A SOMB Committee reviewing concerns related to the SVP assessment process considered whether to recommend use of the ARMIDILO-S as a tool for SVP determination, but decided against it based upon the inclusion of dynamic risk factors in the instrument since there is no statutory provision for SVP designation to be changed. Whereas current legislative mandates seem to preclude use of this tool, nonetheless, it is appropriately suited for assessment of this population.

Polygraph examinations should be used with particular caution with this population as difficulties with memory and cognitive understanding may mean that both Deceptive and Non-Deceptive findings can be misleading.

PPG assessment is reasonably valid with this population so long as they can understand the instructions and sustain attention. PPG materials and protocols adapted for DD or MR offenders are available from one of the standard PPG suppliers (MONARCH).

2. Treatment of DD offenders

As regards treatment for DD offenders, it is most pertinent to consider the following standards of practice for treatment providers – 3.110DD, 3.120DD, 3.160D.DD, 3.160F.DD, 3.16G.DD, 3.16H.DD, and 3.16I.DD, 3.16M.DD, 3.310DD, 3.550DD.

A summary of these standards and guidelines would suggest that modifications can be carried out to the ‘standards for practice for treatment providers’ and the guidelines can be used for those who exhibit inappropriate behaviors (but not convicted of a sexual offense). That treatment should be carried out with a smaller number of clients in a group than would be typical for non-DD offenders, with the size of the group being dependent on the ‘needs of the group’. Treatment planning should take into account the problems that DD offenders will have in terms of concrete thinking/ the inability to engage in abstract thinking, reduce denial, decrease/manage offenders’ deviant fantasies.

Recommendation

It is worth noting, as to whether DD individuals can really properly participate in all of the phases of the program, as for example, in Phase 1 of the program there are requirements for sex offense admittance, and discussion of their problems in treatment, and for example the punitive recommendation to provide a to provide a full sex history disclosure (see 3.16H.DD, points 1, 2). Hence, we would suggest that rather than adapting the mainstream program for DD offenders, that a treatment program should be developed that is more specific to the treatment needs of DD sex offenders. Of course this would be designed, as the current program outlines, to increase sexual knowledge, modify offence-justifying thinking, develop ability to recognize feelings in themselves and others, to gain an understanding of victim harm, and develop relapse prevention skills, but perhaps in a way that is more specifically targeted towards DD sex offenders. This recommendation would also sidestep the problem and the potential heavy use of resources that is implied in

3.550DD for individuals who are in 'Level 3' denial which is especially not a good fit for a DD offender population.

Appendix E: Limitations of the Research Relevant to Limits Imposed upon Sexual Offender Contact with Children

In Section 5.700 of the 'Standards And Guidelines' that contact is restricted until more is known about the level of offender's risk. Although this seems very sensible the statements provided here are referenced from rather old research (footnote 20, for example contains references from 1984, 1987, 1989, 1990,1998, 2000, with the latest reference being 10 years old at 2003) and the guidelines do not take into account either later research or methodological limitations of the studies on which it relies. For example, studies need to take into account of the age of the perpetrator as well as the age of the victim, to distinguish cross-over between adult and teenager victims from cross-over between adult and younger child victims, and to establish rates of cross-over in reoffenses, not solely in past offending.

Recommendations

The SOMB should re-examine the research foundation for prohibiting contact between children and offenders who have only victimized adults. In the light of the methodological issues noted it is possible that the present restrictions are over-cautious.

Appendix F: Offenders Requesting Access to Their Own Children: The Colorado Sex Offender Management Board Child Contact Assessment (CCA)

If an offender is attempting to have contact with their own children, the Colorado Sex Offender Management Board Child Contact Assessment (previously the parental assessment) is used to assesses the appropriateness of an offender's contact with his/her own children, and is intended to estimate the potential risk a convicted adult sex offender may pose to his or her own children. However, in the standards the following exclusion criteria, before the CCA is conducted, are noted:

- The offender does not meet any of the exclusionary criteria in 5.725 (i.e., has a diagnosis of Pedophilia (DSM-IV), has a score on the MCMI of > 85 for Antisocial Personality Disorder, Narcissistic, Paranoid, on the DSM-IV), or has been identified as having a mental abnormality on the Psychopathy Checklist-Revised (Hare, 1991, 2002), and a diagnosis of sexual sadism, and has ever committed an offenses against their own child/children;
- The offender does not have two or more pre-screen factors;
- The offender wants contact with his/her own minor child as defined in under the age of eighteen (18);
- The offender does not have a history of victimizing any of his/her own minor child(ren), regardless of the victim's age, as substantiated by criminal or civil court history or by self-report.

The CCA itself consists of some of the same protocols employed in post-conviction sex-offense-specific evaluations, but also involves additional assessment instruments and interviews designed to explore more fully a client's sexual history, personality style, empathy and capacity for attachment. The assessment also addresses family functioning. From Appendix I, of the Standards a flow diagram is provided as regards determining sexual contact of the offenders with their own

child(ren). Experts such as Dr. Stephen Brake and his associates (see http://stephenbrakeassociates.com/html/child_contact_assessments.html) provide child contact assessments for the Colorado Sex Offender Management Board which an individual has to pay for. Costs for evaluations (from the website) range from \$800-1800 depending on the type of evaluation needed.

From the Brake and associates website, assessments are described as involving 'extensive psychological testing with the offender (personality testing, sexual interest testing employing the Abel Assessment, tests measuring empathy and attachment capacities) and interviews with the client. A sexual history polygraph test is also carried out, as well as interviews with the client's wife or partner (or the client's children's mother are also conducted, when feasible. The family's children are also interviewed. Such a report also includes recommendations about whether contact between a client and his children should proceed and how that contact should be structured. It would also appear from their website that Stephen Brake and partners have been involved in the development of the CCA, and previously the original Parental Risk Assessment.

Recommendations

- It might be considered overly punitive that an offender who has ever victimized any of his or her own children (regardless of their age and when the abuse occurred) is ineligible for the Child Contact Assessment process. We noted that in our focus groups victim advocates thought that this was too restrictive. We suggest that more flexibility could be built into the system.
- The documentation is very comprehensive as regards the CCA, but the process seems excessively burdensome and costly. In prison it also seemed impossible for the process to be completed in a timely way. We recommend that a streamlined process be developed.

- From the documentation, in the Standards, there would appear to be no credible research evidence to support the use of the Child Contact Assessment tool. We would recommend an empirical validation of this tool should be carried out on a reasonable timescale and that it should be modified or replaced if necessary.
- In considering revisions of this process the SOMB should be mindful that managing the risk for child-molestation is not the only issue at stake. Hope of seeing their children again can be a powerful motive for offenders to reform. And disruption of a non-abusive attachment to a father is harmful to the child. The present process does not seem to properly balance these issues.
- It would appear that only a list of 'approved' providers could be an approved evaluator. As it would appear that at least one provider has been involved in the evolution of the CCA, there is at least the appearance of a conflict of interests here. This again is something that the Board may wish to consider.
- The SOMB has communicated to the evaluation team that they seeking to collect data and receive feedback on the implementation of the CCA for possible future revisions to the assessment. It is hoped the outcome of these effort by the SOMB will result in CCA guidelines that reflect the recommendations of this report.

Appendix G: The Containment Model

Description

Kim English (2004) notes that through a series of studies the Colorado Division of Criminal Justice have identified a promising approach for protecting victims by “making it difficult for sex offenders to reoffend”. This is called the containment approach. The five components consists of the following aspects:

1. A philosophy that values victim protection, public safety, and reparation for victims as the paramount objectives of sex offender management;
2. Implementation strategies that depend on agency coordination and multidisciplinary partnerships;
3. A containment-focused case management and risk control approach that is individualized based on each offender’s characteristics;
4. Consistent multi-agency policies and protocols;
5. Quality control mechanisms, including program monitoring and evaluation.

Further, it is noted from the Outcome Evaluation of the Colorado Sex Offender Management Board Standards and Guidelines that ‘the Containment model is a method of case management and treatment that seeks to hold offenders accountable through the combined use of offenders’ internal and external control measures (such as polygraph testing and relapse prevention plans. A containment approach requires the integration of a collection of attitudes, expectations, laws, policies, procedures, and practices that have been designed to work together. The containment approach operates in the context of multi-agency collaboration, explicit policies, and consistent practices that combine case evaluation and risk assessment, sex offender treatment, and intense community surveillance, all designed specifically to maximize public safety.

This approach is 'victim centered', in that victim protection and community safety are the primary objectives of sex offender management. English notes that the containment model for managing sexual offenders in the community requires the creation of intra-agency/inter-agency/inter-disciplinary teams. The success of the containment approach is that such Community Supervision Teams provide a unified and comprehensive approach to the management of sex offenders', and allow for improved communication among agencies, quicker, less intrusive responses to victims, promote the exchange of views, expertise etc. and share important information between agencies.

Currently in Colorado the containment approach can be summarized as having five basic components:

1. [a] victim centered philosophy
2. multidisciplinary collaboration
3. containment focussed risk management
4. informed and consistent public policies
5. [good] quality control mechanisms.

Such an approach can also be seen as attending to both the internal controls developed through treatment treatments and the external control provided by supervision. In their report entitled 'Outcome Evaluation of the Colorado Sex Offenders Management Boards Standards and Guidelines: A Report of Findings Regarding Program Effectiveness' Dethlefsen and Hansen (2011) note that the Community Supervision Teams use a variety of external controls such as unanticipated home visits, urinalysis testing for substance usage, detailed presentence investigations, employment restrictions, clear and consistent sanctioning practice, and the employment of a post-conviction polygraph. In fact, great reliance is placed on the post-conviction polygraph to give an idea to the Community Supervision Team of what the offenders actually think and how they actually behave. Dethlefsen and Hansen note that through the use of these measures

the Community Supervision Team “holds convicted abusers accountable despite being in an environment that is embedded in the community.”

As for evidence for the Containment approach success Dethlefsen and Hansen (2011) report a table (Table 3, p 13) that they suggest indicates that the containment model reduces the likelihood that individuals will engage in new crimes by a combination of deterrence (increased supervision) and treatment. However, no details are given here of how this has been concluded, or for that matter what the control groups would be, and their relative rates of recidivism. In fact, it would be very unusual for sexual offenders to be released with absolutely no supervision restrictions in place. Hence, it is hard to see what the reductions are being measured against. Consequently this evaluation does not in fact provide evidence that this implementation of the Containment Approach produced better outcomes than could have been produced with far fewer resources.

The SOMB also referred us to a number of other papers purporting to provide empirical support for the Containment Approach. A difficulty common to these papers is the question of what it is to be compared to. Supervision and treatment are common features of many jurisdictions management of sexual offenders. All jurisdictions the writers are familiar with would claim that their supervision processes prioritize public safety. What seems to distinguish the Containment Approach is the emphasis on the polygraph, very long supervision and treatment, greater reliance on external control, and scepticism about the possibility of men with a history of sexual offending changing their behaviour without intense external coercion, seeking to make an alliance with organizations advocating for or supporting victims, and giving negligible priority to the rights or quality of life of the offenders being managed. The popular detestation of sexual offending and sexual offenders, has produced tendencies in this direction in most jurisdictions but in some (the European Union for example) there seem to be stronger legal protections for the rights of unpopular groups and a generally less punitive approach to offenders than is found in the USA. Both prison sentences and periods of community

supervision tend to be much longer in the USA than in most other Western countries. Advocates of the Containment Approach would doubtless argue that its particular strength is the encouragement of multi-agency and multi-disciplinary cooperation into teams that manage offenders in a cohesive way. However, systematic coordination of multiple agencies in the management of sexual offenders is by no means the exclusive preserve of the Containment Approach. For example, multi-Agency Public Protection Arrangement (MAPPA) found in the United Kingdom on a national scale provide wide-ranging and even more comprehensive coordination of agencies, including the systematic involvement of the police in the prevention of future offenses by known offenders. The merit of the Containment Approach in Colorado then is perhaps that includes some elements that are generally regarded as good practice and does so in a way that is particularly congruent with local values.

Given this perspective it is perhaps better to ask, “How can the Containment Approach be improved?” rather than asking “Is the Containment Approach better or worse than other approaches?”

Analysis regarding the use of the Containment Model

In their report Dethlefsen and Hansen note that each of the five containment components is seen as adding to the “overall restorative justice framework” to “administer a holistic intervention and treatment strategy”. However, it is somewhat hard to see where the offender fits into this strategy and what the holistic approach really is. Other points that are touched upon by Dethlefsen and Hansen (2011) is the ‘no known cure’ concept employed by the SOMB suggesting that all sex offenders will carry on being inherently dangerous.’ This coupled with the risk management emphasis where there is an over-reliance on avoidance-goals (e.g., recognising where not to go, what not to do etc.) and less focus on the overall well-

being of the offender, likely means that the approach is liable to have difficulties engaging offenders' internal motivation for change.

An approach that has a more positive focus is the Good Lives Model (GLM) rehabilitation framework (Ward, Mann, & Gannon 2007). To examine the Good Lives approach in detail, Ward and colleagues (Willis, Yates, Gannon, & Ward, 2013) note that human beings are naturally inclined to seek certain types of experiences or 'human goods' and experience high levels of well-being if these goods are obtained. Ward et al. (2007) note that primary goods are defined as 'states of affairs, states of mind, personal characteristics, activities, or experiences that are sought for their own sake and are likely to achieve psychological well-being if achieved' (p. 4). Ward and others suggest that harmful sexual behaviour arises as a result of an attempt to obtain these goods in an inappropriate manner, out of frustration at being unable to achieve these goods in a 'normal' manner, or out of an imbalance between goods acquisition, so that some goods are prioritised over others (e.g., sexual gratification taking precedence over emotional intimacy). Therefore, harmful sexual behaviours are seen as ways of achieving goods either through: (i) a direct route where an individual does not have the skills or competencies to achieve these in an appropriate manner; or (ii) through an indirect route where the behaviour takes place to relieve the negative thoughts and feelings individuals have about their inabilities of achieving the goods they are striving for.

We would recommend consideration of incorporating into the Containment Approach more positively oriented intervention strategies stemming from Wards' work as a better way of motivating offenders to build up internal protective factors.

Appendix H: Criteria for Release from Prison to Parole

The Standards and Guidelines contain criteria for Release from Prison to Parole. Criteria for Determinate-Sentenced Sex Offenders are as follows:

Parole Guidelines for Discretionary Release on Determinate-Sentenced Sex Offenders

Approved September 16, 2011

These guidelines are designed to inform the Parole Board of information regarding progress in treatment, or criteria information for those not currently in treatment, for determinate-sentenced sexual offenders. Those offenders who have demonstrated treatment progress or meet certain criteria may be better suited for consideration of discretionary parole. These guidelines may be considered as a component in the decision-making process of the Parole Board among other components considered (e.g. lack of mandatory parole, Code of Penal Discipline/institutional behavior, risk assessment, victim input, etc.).

I. In treatment at the Department of Corrections

A. Use the same treatment criteria as the indeterminate sentence offenders based on the standard format

1. *Meets the criteria for successful progress in treatment in prison, or*
2. *Does not meet the criteria for successful progress in treatment in prison*

II. Not in treatment at the Department of Corrections

A. Not on wait list for treatment (Signified by a “D” designation)

1. *Lack of recommendation for discretionary parole*

B. On wait list for treatment (Signified by a “R” designation)

1. Not designated Sexually Violent Predator (SVP), and
2. No history of prior sex crime conviction or adjudication (1 sex crime conviction), and
3. No history of parole or community corrections revocation during the current sentence to the Department of Corrections, and
4. Does not have a “P” designation signifying a treatment placement refusal or failure.
 1. *No objection to recommendation for discretionary parole*

C. On wait list for treatment

1. Designated a SVP, or
2. Have 2 or more sex crime convictions or adjudications, including factual basis, or
3. History of parole or community corrections revocation during the current sentence to the Department of Corrections, or
4. On the waitlist with a “P” designation signifying a treatment placement refusal or failure
 1. *Objection to recommendation for discretionary parole*

Overall these criteria are in general reasonable however they are somewhat overcautious in that they give no basis for making a recommendation for parole, even in the case where successful progress in treatment is made.

There are two potential concerns. First, they rely on the validity of the process for designating someone as an SVP. Unfortunately that process is problematic at present. Second, they rely on the criteria for “successful progress in treatment” which is discussed as part of the more general discussion of the criteria for Lifetime Supervision offenders.

In addition to addressing those two concerns it is recommended that the SOMB develop criteria that would support a positive recommendation for parole.

The Standards and Guidelines contain criteria for Release from Prison to Parole for Lifetime Supervision Sexual Offenders.

The Standards and Guidelines indicate “in order to demonstrate that the sex offender would not pose an undue threat to the community if released from prison to parole, he or she must meet the criteria in each of the following areas of focus:” (A to J). Since the criteria are numerous and each is held to indicate that someone is unsuitable for parole they are commented on separately.

A. Criminal Behavior Past and Present

1. The offender acknowledges and takes full responsibility for the crime of conviction.
2. The offender has adequate plans to address components of the crime(s) that pose current risk as identified in the mental health sex offense-specific evaluation, treatment plan or relapse prevention plan. Such components may be, but are not limited to:
 - Initial charge versus the conviction or plea
 - Facts and circumstances of the crime
 - Premeditation, grooming or predatory behavior
 - Nature of the crime was incidental to another crime or was spontaneous
 - The use of threats, violence or weapons
 - Age of victim(s) or the presence of any mental or physical disability in the victim(s)
 - Any conviction other than the instant offense for a violent crime per CRS 16-11-309

These criteria seem reasonable and are generally common considerations of parole boards.

B. Sentence Failures

1. The offender acknowledges reasons for sentence failures (which could include, but are not limited to deferred prosecutions or judgments, probation, community correction, or parole), as verified by official record, and has made progress in addressing those reasons or demonstrates the presence of a plan that addresses those issues.

Although this criterion is generally reasonable some account should be taken of the seriousness of the sentence failure and the likelihood that the problem would reoccur. Revocations for technical violations unrelated to risk for violent or sexual offending should be weighted less.

C. Participation in Programs

1. Required participation in the Sex Offender Treatment and Management Program (SOTMP). SOTMP program staff report offender compliance with recommended program plan and sufficient progress in treatment.
2. Demonstrated participation in all recommended programs. Positive participation and

recommendations from staff of each program (based on program compliance) or a clearly established plan to obtain recommended programming in the community where placement in the community does not pose an undue risk.

3. If the offender is placed in community corrections, he or she has demonstrated positive participation and progress as indicated by recommendation from Community Corrections staff and SOMB approved sex offense-specific treatment provider.

This criterion is generally reasonable so long as the SOTMP itself follows the Risk-Need-Responsivity principles and offenders can access treatment timely. Our earlier evaluation of that program indicated that some improvements were advised. We believe the Department of Corrections have commenced efforts to implement them.

D. Code Of Penal Discipline Rules Convictions, Escapes or Absconds

Discussion: Non compliance with rules in a highly structured environment like DOC is highly related to risk of re-offense.

1. No COPD rules convictions in the last 12 months.
2. No drug violations and demonstrates all clean UAs for the last 12 months.
3. No sexual violations in DOC for a minimum period of the last 2 years.

E. Classification Level Changes

1. The offender has had no increase in classification level in the last 12 months.

This criterion is reasonable though the discussion gives the misleading impression that non-compliance with prison rules is highly related to rates of future sexual recidivism. The discussion overstates the strength of this relationship.

F. Risk Assessment

1. The offender has completed the SOTMP evaluation (in adherence to SOMB Standards and including the administration of the DCJ Sex Offender Risk Scale) and has a recommendation from the SOTMP program staff, which is based on the evaluation, for release to parole.

As noted elsewhere, there are important problems with the SORS. The guidelines would benefit from not referencing it until these issues have been addressed. Use of an established actuarial instrument would be desirable.

- G. Victim Input (Pursuant to 17-22.5-404 (2) (a) (I) this may include the victim or a relative of the victim)
1. The offender has had no contact with the victim, other than therapeutically approved contact. (Contact means any kind of communication either direct or indirect by the offender with the victim and includes but is not limited to physical proximity, written correspondence, electronic, telephone or through third parties.)
 2. The offender is not engaging in victim blaming.
 3. The offender is not engaging in harassment, manipulation or coercion of the victim.
 4. Offender has demonstrated support for the victim's recovery, minimally at the level of no contact, as verified by SOTMP staff.

These guidelines are reasonable and consistent with best practice standards.

- H. Age of Offender at Offense vs Date of Parole Hearing
1. The offender demonstrates the emotional maturity necessary to predict a successful release to parole.

The term "emotional maturity" is undefined and capable of many interpretations. However, older offenders are generally more compliant, less impulsive and better able to tolerate frustration.

- I. Parole Plan
1. The offender's Parole plan minimally includes the following:
 - No undue level of risk is indicated in any part of the parole plan or recommendations from any DOC staff.
 - The offender has an appropriate plan to safely transition back to the community.
 - The home living situation is free from former and potential victims.

- The offender has appropriate employment plans with lack of access to potential victims.
- The offender has access to and demonstrates willingness to participate in sex offense specific treatment and other recommended treatment if released on Parole.
- The appropriate level of supervision and containment is available where the offender plans to live.
- The offender has a realistic plan to pay restitution based on his or her ability to pay.

This criterion is reasonable and consistent with generally accepted practice standards.

J. Honesty

1. The offender demonstrates truthful, complete and non-evasive answers to all questions posed by the parole board members.

This criterion is reasonable and consistent with generally accepted practice standards.

Appendix I: Criteria for Reduction in Supervision or Discharge from Parole

The Lifetime Supervision Criteria of the SOMB Standards and Guidelines indicate:

In order to demonstrate that the sex offender would not pose an undue threat to the community if placed on a lower level of supervision while on parole, he or she must meet the reduction in supervision criteria in each of the following areas of focus; in order to demonstrate that he or she would not pose an undue threat to the community if discharged from parole, he or she must meet the discharge criteria in each of the following areas of focus:

Each area of focus is commented on in this report separately and as follows.

A. Community Supervision Team Staffing

Reduced Supervision: The team considers all information below and other appropriate information to make any determination regarding movement to lower levels of supervision. All team members must agree to the reduction in the level of supervision. No exceptions will be made for reduction in supervision from level 1 (maximum). Any exception made to the requirements for movement from levels other than level 1 must be made by a consensus of the community supervision team and the parole board. In such a case, reasons for movement to a lower level of supervision when criteria are not met must be documented as well as any resulting potential risk to the community.

Discharge: In any case when an offender is being considered for recommendation of discharge from lifetime supervision, the offender must demonstrate that he or she would not pose an undue threat to the community if allowed to live in the community without supervision. The team considers all information below and other appropriate information to make any determination regarding discharge from lifetime supervision.

All team members must agree to the discharge from supervision. The supervising officer will document what criteria are met or not met at any consideration of reduction in level of

supervision or discharge and the decision of the community supervision team.

Discussion: If an offender is consistently failing to meet criteria for progression, the team should evaluate whether the current level of supervision is intensive enough to adequately contain the offender. In such cases, regression to a higher level of supervision should be considered.

This approach is generally reasonable. The agreement requirements are, however, skewed in the direction of increased cost and caution. Any overly cautious member of the team can block reasonable decisions to reduce supervision or move towards discharge. Since complete agreement is required for key decisions an overly cautious person can block progress for reasons that are irrational. The effect of this is to fail to identify when reduced supervision is indeed warranted and potentially make the system function in an unduly costly way for little gain in community safety. Further, as described by stakeholders in the Focus Groups, in actuality the supervision officer essentially makes all case decisions and treatment providers are pressured to comply.

The SOMB should consider creating a mechanism for independent review in cases where the team cannot come to a consensus. It is further recommended that the SOMB conduct a thorough internal analysis of the stakeholder reported problem that concerns about getting referrals and other pressures undermine the CST from functioning as intended. Lastly, regarding the discussion point, failure to progress in treatment or in meeting a lower supervision requirement does not necessarily mean more supervision is required but often rather, is a cue that treatment efforts should be adjusted. Unless failure to progress is associated with increased risk factors for re-offense, it should not trigger concern that more intensive supervision is warranted.

B. Polygraphs

Reduced Supervision: The offender must complete at least two consecutive non-deceptive

polygraph examinations before moving to the next lower level of supervision. The examinations must be the two most recent exams each time.

Discharge: The offender must have completed a non-deceptive baseline (sex history) polygraph examination and complete at least two consecutive non-deceptive polygraph examinations for each of the three levels of supervision before discharge.

Any exception made to the requirements for movement from level to level or for discharge must be made by a consensus of the community supervision team. In such a case, reasons for movement when criteria are not met must be documented as well as any resulting potential risk to the community.

This criterion gives too critical a role to polygraph examinations. Like other assessment tools the polygraph is fallible. The relevant research literature indicates that the polygraph can attain accuracy of close to 90% when testing well-defined single issues. Unfortunately Sexual History polygraphs are not well-defined single issues and the accuracy level is likely significantly lower. This means that there are liable to be a significant number of false findings of Deception and false findings of Non-Deception in Sexual History polygraphs.

Additionally, public protection is not entirely dependent on a complete disclosure of all past sexual crimes. Indeed, jurisdictions that don't use Sexual History polygraph examinations in this way have nevertheless achieved low sexual recidivism rates. More critical than full disclosure to preventing future offending is that the treatment team is able to determine (a) the main patterns of past offending (b) the main psychological risk factors that contributed to past offending. These achievements would more appropriately replace the requirement for Sexual History polygraphs in the above criteria, with participation in Sexual History polygraphs one key way of generating information about patterns of past offending and psychological risk factors but it is not the only way.

Maintenance polygraph examinations (checking compliance with supervision conditions etc.) on the other hand are both more likely to be accurate and more directly relevant to the ability of supervision processes to provide effective external control of offenders' behavior. Accordingly we suggest that the role of these examinations be retained in the criteria. It is further our opinion that polygraph requirements must be sufficiently flexible to allow for cases where such assessment is determined contra-indicated as can sometimes occur with assessing developmentally disabled, cognitively impaired (i.e. dementia, organic brain impairment, etc), acute co-morbid diagnoses (i.e. Schizophrenia, PTSD). Some further concerns with polygraph implementation in Colorado is the report by stakeholders that inconclusive results are treated akin as deceptive, that the cost to offenders is often prohibitive and that wait lists for assessment, particularly in prison, delay treatment progress. We recommend the CO SOMB conduct a thorough internal analysis of these stakeholder reported potential barriers.

C. Progress in Treatment

Reduced Supervision: The sex offender's monthly reports are consistently indicating the following (consistency is defined as 6 months or longer):

- Regular attendance with no un-excused absences in the last 6 months.
- Active participation.
- Progression with the established treatment guidelines.
- Payment.
- The offender acknowledges and takes full responsibility for crime of conviction.
- Completion of a non-deceptive polygraph regarding the offender's sex history.
- The treatment provider reports that any other denial issues are being consistently and adequately addressed in treatment.
- The offender understands the offense cycle.
- The offender has and is utilizing an appropriate relapse prevention plan.
- No unsuccessful terminations.
- Full compliance with established treatment guidelines.
- Full compliance with recommended medications.

Discharge: For discharge from parole, the treatment provider must be reporting successful termination of treatment or successful progress in treatment to date and actively recommending discharge from parole. (Successful completion indicates active, consistent practice of a treatment aftercare program. Successful progress indicates an active plan to continue in treatment.)

Overall, these requirements for treatment progress are reasonable and consistent with best practice standards with exception a few concerns. The same comments apply here regarding the role of the Sexual History polygraph examination as well as the concerns that the professional judgment of treatment providers may be undermined in the way the CST is being implemented. We also suggest that treatment staff should be taught to administer the SOTIPS or some similar, evidence-based measure for which change scores have been shown to relate to reduced recidivism. Reduction in risk as indicated by this (or similar instrument) may usefully replace references to denial, offense cycle and relapse prevention issues. The SOMB might review the SOTIPS with its authors to agree how large a change score would need to be to be relevant. The SOMB staff have communicated to the evaluation team an intention to promote use of the SOTIPS instrument and have taken steps to implement some training.

D. Employment

Immediately upon release, providing there are no medical, mental or physical problems, the sex offender shall actively seek appropriate full time employment or enroll in an appropriate vocational training program, with consent of supervising officer. Appropriate employment limits contact with victims and potential victims and allows the supervising officer to consistently locate the offender.

Reduced Supervision: The offender must demonstrate of job stability, longevity and appropriate usage. In addition, a positive evaluation or progress report (written or verbal)

is required from the immediate work supervisor.

An exception may be made if the sex offender becomes unemployed for reasons beyond his or her control. Any exception must be agreed to by a consensus of the community supervision team. In such a case, reasons for movement when criteria are not met must be documented as well as any resulting potential risk to the community.

Discharge: The sex offender's employment record shall reflect the ability to seek and maintain appropriate long-term employment with no periods of willful unemployment during the past 5 years.

These are reasonable criteria that are consistent with best practice standards with possible exception limiting contact with potential victims, depending on how potential victims is defined. For example, whereas it would be contraindicated for a child molester to be employed in an industry that includes a high degree of contact with minors (i.e. children's clothing stores, toy stores, coach, school teacher) it may not be contraindicated for employment in an industry that involves limited contact with children especially when the offender is unlikely to be alone with a child (i.e. grocery store, barber shop, farm stand, janitorial). Further, any employment condition that excludes any contact with children for a sexual offender with no known child victims or sexual interest in children is also regarded as unnecessarily prohibitive.

E. Relationships

Relationships developed in the community shall be appropriate and of positive benefit to the sex offender. The safety of the community shall be considered a priority in all relationships. Appropriate relationships limit contact with all victims and potential victims and include an awareness of the offender's criminal history.

Reduced Supervision: Consideration for progression to a lower level of supervision will be based on the sex offender's ability to articulate the status and benefits of any relationships. The offender shall have had no unauthorized contact with victims or minors in the last 6

months.

Consideration for progression to level 2 (medium) will be based on the offender identifying an appropriate community support person who is willing to participate in offense specific education.

In a situation where the offender cohabits with or is in an intimate relationship, the co-habitor or significant other must be supportive of treatment, not supportive of the offenders' denial, and be willing to participate in treatment and sex offense specific education as needed. Significant other(s) and cohabitators, should also be able to articulate the status and benefits of relationship, demonstrate an awareness of the sex offender's criminal history including the current offense and have knowledge and awareness of the sex offender's risk to children and potential victims.

Exceptions may be made and documented when the offender is residing in a residential facility or hospital and it would be inappropriate to disclose the offender's history to all other residents. In such cases, the safety of the other residents shall be the determining factor regarding disclosure, not the offender's desire for confidentiality. In no case is it appropriate to keep any information regarding the offender and his or her history from staff of any facility in which they are being treated or in which they reside.

Discharge: The sex offender shall have demonstrated, over the course of supervision, the ability to maintain age appropriate, professional and personal relationships that are non-criminal. The sex offender shall demonstrate an understanding of how positive relationships in the community have influenced non-criminal behavior and thinking.

As written, these criteria are reasonable and within best practice standards with possible exception regarding how "limited contact with all victims and potential victims" is defined. This is discussed in the preceding section. Limiting contact with potential victims could be interpreted as disallowing any contact with any person, or disallowing any contact with a minor for an offender who has no history of or indication of sexual interest in minors. Lastly, it is recommended that some

consideration be given to developing resources for those sexual offenders who are too socially isolated to meet these criteria.

F. Sex Offender Registration

Each sex offender, domestic or interstate, if required by statute to register, shall upon becoming a temporary or permanent resident, register with the law enforcement agency within the jurisdiction where the offender's residence is located.

Reduced Supervision: Consideration for progression to a lower level of supervision will be based on consistent compliance with re-registration requirements, advising law enforcement of current residence, appropriately notifying original jurisdiction and timely filing of a change of residency card with law enforcement when moving to a new jurisdiction.

Progression to a lower level of supervision will not be considered if sex offender is not in compliance with state registration laws.

Discharge: The sex offender must currently be registered and have been in compliance with sex offender registration laws for the (5) five consecutive years immediately preceding consideration for discharge.

These criteria are reasonable and generally consistent with accepted practice standards. We are not commenting on the efficacy of registration as a community protection policy but if this is the policy of the state then it is reasonable to expect sexual offenders to comply with it.

G. Leisure Activities:

Immediately upon release, leisure activities engaged in or developed within the community shall be appropriate, legitimate, legal and of benefit to the sex offender.

Appropriate leisure activities limit contact with victims and potential victims and allow the supervising officer to consistently locate the offender.

Reduced Supervision: Consideration for progression to a lower level of supervision will be

based on sex offenders' ability to identify appropriate leisure activities and the benefit of each activity. In addition, the offender must be able to articulate how the relapse prevention plan is used when engaging in leisure activities.

Discharge: To be considered for discharge, the sex offender must have demonstrated the ability to participate in appropriate, legitimate and legal leisure activities from which he/she has benefited. In addition, the offender must have demonstrated consistent use of a relapse prevention plan as needed during leisure activities.

These criteria as written are reasonable and generally consistent with accepted practice standards. The previously described caution about how limiting contact with potential victims is interpreted also applies here.

H. Compliance with Conditions of Supervision

On a regular basis, the sex offender demonstrates compliance with all conditions of supervision.

Reduced Supervision: Consideration for progression to a lower level of supervision will be based on the sex offender's attitude, progress, participation and consistent compliance with all conditions of supervision.

The sex offender will not be considered for progression to a lower level of supervision if not actively in compliance with all offense specific conditions of supervision, or if the offender has a pending summons or complaint for any parole violation(s).

Discharge: To be considered for discharge sex offender must be in compliance with all conditions of supervision including successful discharge from treatment and active participation in an aftercare program.

These criteria as written are reasonable and generally consistent with best practice standards.

Appendix J: Criteria for Reduction in Supervision or Discharge from Probation

The Lifetime Supervision Criteria of the Colorado SOMB Standards and Guidelines indicate:

In order to demonstrate that the sex offender would not pose an undue threat to the community if placed on a lower level of supervision while on probation, he or she must meet the reduction in supervision criteria in each of the following areas of focus (For the purpose of these Criteria, reduction in level of supervision while on probation means movement from Sex Offender Intensive Supervision Probation to Regular Probation). For criteria that refer to reduction in levels of supervision while on Sex Offender Intensive Supervision Probation, please refer to the Sex Offender Intensive Supervision (SOISP) Guidelines and Standards published by the Colorado Judicial Branch, Office of Probation Services. In order to demonstrate that the sex offender would not pose an undue threat to the community if discharged from probation, he or she must meet the discharge criteria in each of the following areas of focus: [A to I]

Each set of criteria is reproduced below followed by comments from the evaluation team. Where the criterion is the same as that for the reduction in parole supervision standard, readers should apply the same commentary.

A. Compliance with the Treatment Contract to the Treatment Provider's Satisfaction

Reduced Supervision: The treatment provider is indicating a recommendation for reduced supervision based on the following indicators of progress in treatment:

- Regular attendance and active participation in sex offense specific treatment.
- Demonstrates increased internal motivation for treatment.

- The offender admits to committing the offense and acknowledges sexual assault intent.
- The offender demonstrates understanding and use of a written offense cycle.
- Completion of a written relapse prevention plan and demonstrated ability to use it.
- The offender appropriately confronts others in group treatment.
- Completion of non-deceptive maintenance polygraph examinations at least every 6 months.
- Completion of all homework assignments and evidence of an attempt to do a quality job.
- No violations of the treatment contract.
- A reduction in attempts to split team members.
- Demonstrates increased awareness of victim impact and the development of victim empathy.
- Verification that the offender is using techniques, such as covert sensitization, to interrupt deviant arousal.
- Non-deceptive disclosure polygraph. (Any exception to this criteria must be consistent with the requirements in the SOMB Standards located in the front section of this publication.)
- Demonstrates ability to recognize and correct thinking errors.
- Demonstrated the ability to express anger appropriately and without aggression.
- Full and consistent compliance with any medication requirements.

Discharge: For discharge from probation, the treatment provider must be reporting successful termination of treatment or successful progress in treatment to date and actively recommending discharge from probation. (Successful completion indicates active, consistent practice of a treatment aftercare program. Successful progress indicates an active plan to continue in treatment.)

It is unclear why the SOMB lists criteria that are not consistent with those listed in the analogous standard regarding reductions in parole supervision and may consider doing so for not the least reader friendliness. The basic notion that persons on probation should be expected to comply with treatment expectations is fairly standard in such settings. The clinical achievements required fall into 3 categories.

1) Treatment Engagement (attendance, homework completion, internal motivation, reduction in attempts to split the team, etc.)

These are reasonable and consistent with best practice standards.

2) Disclosure and Taking Responsibility

It is recommended that the SOMB consider developing a more nuanced view of the value of disclosure and taking responsibility. Full disclosure of every offense the person has committed is at times not possible and at times not necessary for their risk to be effectively managed. Disclosure is required to identify the main patterns of offending, factors which contributed to these patterns,, and for the offender to acknowledge that he has problems that need to be worked on. Additionally, in relation to incest offenders there is a particular need for offenders to acknowledge the full extent of their offending against family members as the available research suggests that denial is related to recidivism for this group.

3) Change in Psychological Risk Factors (deviant arousal, etc.)

It is recommended that an empirically-based measure of change, for example the SOTIPS, be adopted instead of the current piecemeal and incomplete listing of empirically-supported risk factors. The SOMB has reported a plan to train some supervision officers and treatment providers on this tool, however, to date there does not yet appear to be plan on how the instrument and scores will be utilized.

Overall it is further recommended that existing criteria be supplemented by criteria related to the development of internal strengths and protective factors, that less reliance be placed on offenders constructing elaborate written documents (Relapse Prevention plans etc.) and more reliance based on actual behavioral change.

B. Consistency Between Words and Behavior

Reduced Supervision:

- The offender can identify inconsistencies in his or her words and behavior and makes attempts to correct them.
- Evidence of consistency in what is said to the members of the community supervision team.

Discharge: The offender consistently displays consistency between his or her words and behavior in all areas of his life.

This is a reasonable expectation that is consistent with best practice standards.

C. Appropriate Relationships and Community Support

Reduced Supervision: The offender recognizes and terminates inappropriate relationships. The offender has establishment of some appropriate social relationships and community support. This may include a community chaperone if deemed necessary by the community supervision team. In a situation where the offender cohabits with or is in an intimate relationship, the cohabitor or significant other must be supportive of treatment, not supportive of the offenders' denial, and be willing to participate in treatment and sex offense specific education as needed. Significant other(s) and cohabitators, should also be able to articulate the status and benefits of relationship, demonstrate an awareness of the sex offender's criminal history including the current offense and have knowledge and awareness of the sex offender's risk to children and potential victims.

Exceptions may be made and documented when the offender is residing in a residential facility or hospital and it would be inappropriate to disclose the offender's history to all other residents. In such cases, the safety of the other residents shall be the determining factor regarding disclosure, not the offender's desire for confidentiality. In no case is it appropriate to keep any information regarding the offender and his or her history from staff of any facility in which they are being treated or in which they reside.

Discharge: The sex offender shall have demonstrated, over the course of supervision, the ability to maintain age appropriate, professional and personal relationships that are non-criminal. The sex offender shall demonstrate an understanding of how positive relationships in the community have influenced non-criminal behavior and thinking.

These are reasonable expectations consistent with best practice standards. Further consideration should be given to developing resources for offenders who are so socially isolated that this criterion cannot reasonably be met and flexibility in application to this subgroup.

D. Stable and Safe Residence

Reduced Supervision: The offender shall maintain a stable and safe residence. A safe residence is one that limits the offender's contact with victims, potential victims and minors and where any co-habitators are aware of the offender's criminal history including the current offense and have knowledge and awareness of the sex offender's risk to children and potential victims.

Discharge: The offender shall have demonstrated, over the course of supervision the ability to maintain a stable and safe residence.

E. Stable and Safe Employment

Reduced Supervision: The offender shall demonstrate the ability to maintain stable and safe employment. Safe employment limits contact with victims and potential victims and allows the supervising officer to consistently locate the offender.

Discharge: The offender's employment record shall reflect the ability to maintain stable and safe employment with no periods of willful unemployment during the past 5 years.

These are reasonable expectations. SOMB should, however, consider how resources can be deployed to assist homeless offenders.

F. Substance Abuse Treatment

This criteria applies only to those offenders who are recommended for substance abuse treatment.

Reduced Supervision: The offender has entered a recommended substance abuse treatment

program and is making and maintaining consistent progress in the program.

The offender has not used drugs or alcohol for at least 6 months prior to any reduction in level of supervision.

Discharge: The offender has completed any recommended substance abuse program and is actively and consistently involved in any recommended aftercare or maintenance programs.

These are reasonable expectations that are consistent with best practice standards.

G. Leisure Activities

Leisure activities engaged in or developed within the community shall be appropriate, legitimate, legal and of benefit to the sex offender. Appropriate leisure activities limit contact with victims and potential victims and allow the supervising officer to consistently locate the offender.

Reduced Supervision: Consideration for progression to a lower level of supervision will be based on sex offenders' ability to identify appropriate leisure activities and the benefit of each activity. In addition, the offender must be able to articulate how the relapse prevention plan is used when engaging in leisure activities.

Discharge: To be considered for discharge, the sex offender must have demonstrated the ability to participate in appropriate, legitimate and legal leisure activities from which he has benefited. In addition, the offender must have demonstrated consistent use of a relapse prevention plan as needed during leisure activities

These are reasonable expectations consistent with accepted practice standards with notation prior comment about limiting contact with potential victims.

H. Compliance with Conditions of Supervision

Reduced Supervision: Consideration for progression to a lower level of supervision will be based on the sex offender's attitude, progress, participation and consistent compliance with all conditions of supervision including but not limited to the following:

- Keeps probation and other related appointments and is generally on time.
- Is open to discussing the offense and treatment progress.
- The offender does not try to control the probation officer or content of visits.
- No technical violations within the last 6 months of probation related to the offense cycle.
- No alcohol or drug use at least 6 months preceding a supervision reduction.
- No unauthorized contact with the victim(s) or with minors.
- Full compliance with requirements for registration and DNA Genetic Marker collection.
- Consistent payment of restitution and fines imposed by the court.
- Any community complaints regarding the offender have been adequately addressed to the treatment team's satisfaction.

These are reasonable expectations consistent with best practice standards.

I. Community Supervision Team Staffing

Reduced Supervision: The team considers all information above and other appropriate information to make any determination regarding movement to a lower level of supervision. All team members must agree to the reduction in the level of supervision.

Discharge: In any case when an offender is being considered for recommendation of discharge from lifetime supervision, the offender must demonstrate that he or she would not pose an undue threat to the community if allowed to live in the community without supervision. The team considers all information below and other appropriate information to make any determination regarding discharge from lifetime supervision. All team

members must agree to the discharge from supervision.

The supervising officer will document what criteria are met or not met at any consideration of reduction in level of supervision or discharge and the decision of the community supervision team.

Discussion: If an offender is consistently failing to meet criteria for progression, the team should evaluate whether the current level of supervision is intensive enough to adequately contain the offender. In such cases, regression to a higher level of supervision, or revocation, should be considered.

This approach seems generally reasonable. The agreement requirements are, however, skewed in the direction of increased cost and caution. Any overly cautious member of the team can block reasonable decisions to reduce supervision or move towards discharge. Since complete agreement is required for key decisions an overly cautious person can block progress for reasons that are irrational. The effect of this is to fail to identify when reduced supervision is indeed warranted and potentially make the system function in an unduly costly way for little gain in community safety. Further, as described by stakeholders in the Focus Groups, in actuality the supervision officer essentially makes all case decisions and treatment providers are pressured to comply.

The SOMB should consider creating a mechanism for independent review in cases where the team cannot come to a consensus. It is further recommended that the SOMB conduct a thorough internal analysis of the stakeholder reported problem that concerns about getting referrals and other pressures undermine the CST from functioning as intended. Lastly, regarding the discussion point, failure to progress in treatment or in meeting a lower supervision requirement does not necessarily mean more supervision is required but often rather, is a cue that treatment efforts must be adjusted. Unless failure to progress is associated with increased risk factors for

re-offense, it should not trigger concern that more intensive supervision is warranted.

Appendix K: Criteria for Successful Progress in Treatment in the Community

The Standards and Guidelines describe the following general criteria for progress in treatment. Modified criteria for treatment in prison are described and discussed in the next appendix.

In order to demonstrate successful progress in treatment, the offender must meet the progress criteria in each of the following areas of focus; in order to meet the criteria for successful completion of treatment, the offender must meet all of the progress and completion criteria in each of the following areas of focus.

For the purposes of these criteria, successful progress in treatment indicates an active plan to continue treatment and supervision; successful completion of treatment indicates active, consistent participation in a treatment aftercare program, containment and monitoring to manage lifelong risk.

The above quote that this seems to imply that to “complete” treatment offenders have to volunteer for additional treatment to manage “lifelong risk”. It is worth noting that there is no empirical justification for the idea that sexual offenders need endless treatment.

The SOMB lists five criteria (A to E). They are somewhat overlapping and as such they are presented complete as follows then discussed as a group.

A. Relapse Prevention Criteria

1. Reduction in Denial

Progress:

- The offender discloses all victim(s) and sexual offending behavior in detail.
- The offender’s account must reasonably match or surpass the victim(s) accounts.
- The offender recognizes and admits the purposes of their sexually assaultive/offending behavior including sexual gratification, deviant sexual arousal and power and control.

· The offender completes non-deceptive polygraph examination(s) regarding sexual history.

Completion:

- The offender has met all progress criteria and continues to complete non-deceptive polygraph examinations.
- The offender no longer uses denial of responsibility in any arena of his or her life as a primary coping mechanism.

2. Decreased deviant sexual urges, arousal, and fantasies:

Progress:

- The offender demonstrates knowledge of his or her historical offense and relapse cycles including awareness of thoughts, emotions and behaviors that could facilitate sexual re-offenses or other assaultive behaviors.
- The offender demonstrates knowledge of his or her cognitive distortions and is working to correct them.
- The offender has developed and implemented a plan to alter his or her lifestyle to limit their ability to plan or groom potential victims and has developed skills to interrupt fantasies and inappropriate masturbatory behaviors and utilizes them.
- The offender has developed a comprehensive relapse prevention plan.
- Is, and consistently has been, in compliance with all recommended prescribed psychiatric medications used to reduce arousal or manage behaviors related to risk.
- The offender can identify objectification and inappropriate sexual gratification in relationships and is developing skills to address them.

Completion:

- The offender demonstrates control over arousal or interest through Plethysmograph or Abel Screen
- The offender consistently completes non-deceptive polygraphs regarding planning behavior or masturbation to arousal and fantasies.
- The offender consistently demonstrates self motivated use of the relapse prevention plan and has distributed written copies of the plan to any cohabitators or significant others.
- The offender consistently demonstrates self motivated use of a plan for identifying and correcting cognitive distortions.

· The offender demonstrates the development and maintenance of appropriate adult relationships. Appropriate relationships value the quality of the relationship over sexual gratification.

· The offender demonstrates an ongoing commitment to and active engagement in treatment or an aftercare treatment program, containment and monitoring to manage lifelong risk.

Discussion: Demonstrating improvement on these measures does not necessarily indicate reduced risk or that the offender will utilize his or her ability to control arousal or interest appropriately.

B. Environment Management Criteria

Progress:

· The offender demonstrates willing, active and knowledgeable participation in the treatment process and/or a milieu or residential treatment setting.

· The offender demonstrates the ability to identify anti-social behaviors and is working toward pro-social skills to replace them.

· The offender has disengaged from relationships that support his or her denial, minimization, and resistance to treatment.

· The offender is engaged in relationships which are supportive of treatment, and the people engaged in relationships with the offender demonstrate an awareness of the sex offender's criminal history including the current offense and of the sex offender's risk to children and potential victims. These people actively assist in limiting the offender's contact with children and potential victims. Additionally, those who are in either in intimate relationships with the offender or are co-habiting with the offender are willing to participate in treatment and sex offense specific education as needed.

· The offender's support system has been given permission by the offender to question and confront the offender about his or her behavior and to report their concerns to the community supervision team and law enforcement authorities when appropriate.

· The offender has demonstrated consistent and full compliance with all conditions of supervision and the treatment contract.

· The offender has demonstrated consistent ability to avoid high risk environments.

Completion:

· The offender demonstrates willing and active participation in only pro-social behaviors.

C. Community & Victim Responsiveness Criteria

Progress:

· The offender acknowledges the full impact of his or her sexually assaultive and offending behavior.

· The offender understands that the protection of victims and potential victims from unsafe and or unwanted contact with the offender outweighs the needs or desires of the offender.

· The offender changes his or her behavior to prevent unsafe or unwanted contact with victims or potential victims.

· The offender has started to pay restitution and has a realistic plan to continue.

· The offender has demonstrated consistent compliance with all registration, notification, HIV testing and DNA testing requirements and has an active plan to continue.

Completion:

· The offender has successfully completed victim clarification with his or her victims and secondary victims or victim surrogates when victim needs or desires indicate nonparticipation.

· The offender demonstrates the capacity, knowledge, willingness and ability to empathize.

Discussion: It should be noted that it can be dangerous to attempt empathy work with those offenders who may not have the capacity to develop real empathy (such as psychopaths and sadists). These offenders may utilize information about others= pain as a means to learn how to harm victims more effectively.

D. Offender Criteria

Progress:

- The offender recognizes and acknowledges his or her lifelong risk.
 - The offender does not project blame for his or her offending behavior.
 - The offender does not present himself or herself as entitled or as a victim.
 - The offender has identified cognitive distortions and has demonstrated a consistent ability to change them.
 - The offender has been able to demonstrate a primarily positive attitude toward supervision and treatment.
 - The offender has identified problems with stress management, social skills and anger management and is developing pro social skills to address them.
 - The offender can identify his or her unhealthy attitudes and behavior regarding sex roles and sexuality and is working to change them.
 - The offender can identify his or her misuse of power and control and is working to eliminate it.
- Completion:
- The offender consistently maintains a positive attitude toward supervision and treatment.
 - The offender is committed to permanently altering his or her lifestyle to reduce and control his or her lifelong risk.
 - The offender does not project blame or minimize personal responsibility.
 - The offender assumes full and appropriate responsibility for his or her actions.
 - The offender demonstrates primarily non-distorted thinking.
 - The offender has accepted and is actively and consistently working to address any diagnosed personality disorders.
 - The offender has addressed in treatment and demonstrated the ability to practice ongoing self care regarding: 1) previous trauma, 2) social skills, 3) stress management, 4) anger management, and 5) independent living skills.
 - The offender has consistently demonstrated realistic and healthy attitudes and behavior about sexuality and sex roles.
 - The offender has addressed power and control issues in treatment and has consistently demonstrated an ability to engage with others without abusing power and control.
 - The offender has willingly engaged in risk assessment and physiological monitoring and has an active plan to continue.
 - The offender has developed a positive life purpose which is internally oriented, value

driven and not outcome dependent.

E. Co-morbidity and Adjunctive Issues

Progress:

- The offender is addressing any domestic violence history with appropriate domestic violence treatment and has not engaged in domestic violence.
- The offender is addressing drug and alcohol problems in treatment and is maintaining abstinence of recommended.
- The offender is addressing any psychiatric conditions in treatment and is in compliance with all recommended medications.

Completion:

- The offender has not committed any new incidents of domestic violence, has addressed domestic violence in treatment and demonstrates a commitment to continue domestic violence treatment as needed.
- The offender demonstrates an ongoing commitment to participate in recommended substance abuse treatment and maintenance programs.
- The offender has addressed any psychiatric conditions in treatment and demonstrates an ongoing commitment to participate in recommended treatment, maintenance and medication programs.

There are good elements to these criteria though parts of them are very dated in relation to contemporary research and best practice standards. They show little awareness of the Risk-Need-Responsivity principles and seem likely to encourage treatment that is not sufficiently individualized. Not all of the areas covered by the criteria will be equally relevant to every offender.

It is recommended that the SOMB consider developing a more nuanced view of the value of disclosure and taking responsibility. Additionally, public protection is not entirely dependent on a complete disclosure of all past sexual crimes. Indeed, jurisdictions that don't use Sexual History polygraph examinations in this way have nevertheless achieved low sexual recidivism rates. More critical than full disclosure to preventing future offending is that the treatment team is able to determine (a)

the main patterns of past offending (b) the main psychological risk factors that contributed to past offending. These achievements would more appropriately replace the requirement for Sexual History polygraphs in the above criteria, with participation in Sexual History polygraphs one key way of generating information about patterns of past offending and psychological risk factors but it is not the only way. Additionally however, in relation to incest offenders, there is a particular need for offenders to acknowledge the full extent of their offending against family members as denial does seem to be related to recidivism for this group.

Although requiring the offender to equal or surpass victims' accounts of the offenses may seem respectful of the victims (a core value of the SOMB) it shows insufficient understanding of the fallibility of victim accounts. Like other eye-witnesses to crimes, victims may not accurately recall all that happen. Additionally, what victims say to investigators may have been complicated by feelings of shame, embarrassment, fear of the consequences, pressure from family members, anger, trauma reactions etc. Young children do not necessarily make good witnesses, and may have been asked leading questions etc. Indeed there is a large literature on how inappropriate questioning can implant false memories. As a consequence, sometimes there will be elements of the "official" victim account that may not fully correspond with what actually happened. Consequently, requiring offenders to equal or surpass victim accounts may sometimes amount to requiring them to convincingly lie to the treatment team.

Similarly, the rate of false findings of Deception from polygraph examinations means that sometimes offenders will actually have been being honest but to meet these requirements they will have been coerced by the treatment team into making up fictitious disclosures.

Police accounts, evidence tested in court, victim accounts, and the findings from polygraph examinations can contribute in a useful way to developing enough disclosure to serve treatment purposes. No one source should be treated as

infallible.

Other outdated elements include an over-emphasis on written relapse prevention plans and conceptualizing recurrent patterns in offenders' behavior as cycles.

More generally, it is recommended that these criteria should be rewritten starting from the factors listed in an instrument that assesses empirically supported risk factors, or from the Mann et al meta-analysis described in this report, so that they are focused on empirically supported risk factors. They should also be attentive to building up internal protective factors and to gradual reduction of external control so that the offender is tested in circumstances where they have increasing degrees of freedom. Finally, and most critically, there needs to be some triaging in terms of initial static risk levels. The kind and intensity of supervision and treatment that is appropriate depends critically on the level of prior risk and the supervision progress criteria should be differentiated accordingly.

Appendix L: Criteria for Successful Progress in Treatment in Prison

The SOMB conceptualizes treatment completion in a way that makes it impossible to achieve while someone is still in prison. It is necessary to have criteria to enable recognition of the kind of progress that is relevant in the prison setting. The SOMB have developed criteria for use by the Sex Offender Treatment and Management Program (SOTMP) run by the Colorado Department of Corrections.

The Standards and Guidelines state:

Sex offender treatment in the prison setting is always preliminary to continued treatment and supervision in the community post release from prison. Since sex offenders who participate in treatment in the prison setting cannot complete treatment in prison, the Sex Offender Treatment and Management Program has developed three formats for sex offender participation in prison treatment based on differing minimum sentences and time to parole eligibility. It should be understood that the availability of these specialized formats does not ensure sex offender cooperation with or success in treatment. The eligibility requirements for SOTMP apply for all of these formats. Sex offenders must meet all of the criteria for their assigned format to receive a recommendation for release to parole from the Sex Offender Treatment and Monitoring Program staff.

Criteria for the Standard Format are given as follows.

Criteria for the Standard Format

Offenders with 6 years or more minimum sentence will be assigned to the Standard Format.

1. The offender must be actively participating in treatment and applying what he or she is

learning.

2. The offender must have a complete full disclosure of their sexual history as verified by a non-deceptive polygraph assessment of his or her deviant sexual history.

3. The offender must have completed a comprehensive Personal Change Contract (relapse prevention plan) which is approved by the SOTMP team.

4. The offender must have, at a minimum, one approved support person who has participated in SOTMP family/support education. They also must have and has received an approved copy of the Offender's Personal Change Contract through their participation in a SOTMP therapist facilitated disclosure session with the offender.

5. The offender must be practicing relapse prevention as verified by any recent monitoring polygraphs and no institutional acting out behaviors within the past year (e.g. a history of engaging in high risk behavior or committing violations of institutional rules reflective of ongoing criminal behavior).

6. The offender must be compliant with any DOC psychiatric recommendations for medication which may enhance his or her ability to benefit from treatment and or reduce his or her risk of re-offense.

7. The offender must be able to be supervised in the community without presenting an undue threat (e.g., indications of undue threat may include a history of sadistic behavior or fantasy, a diagnosis of psychopathy based on the PCL-R, or a history of lethality in offense behavior or fantasy).

B. Criteria for the Modified Format

Offenders with 2 years to 5 years minimum sentence will be assigned to the Modified Format.

1. The offender must be actively participating in treatment and applying what he or she is learning.

2. The offender must have a complete full disclosure of their sexual history as verified by a non-deceptive polygraph assessment of his or her deviant sexual history.
3. The offender must have defined and documented his or her sexual offense cycle.
4. The offender must have, at a minimum, one approved support person who has participated in SOTMP family/support education. They also must have received an approved copy of the offender's sexual offense cycle through their participation in a SOTMP therapist facilitated disclosure session with the offender.
5. The offender must be practicing relapse prevention as verified by any recent monitoring polygraphs and no institutional acting out behaviors within the past year (e.g. a history of engaging in high risk behavior or committing violations of institutional rules reflective of ongoing criminal behavior).
6. The offender must be compliant with any DOC psychiatric recommendations for medication which may enhance his or her ability to benefit from treatment and or reduce his or her risk of re-offense.
7. The offender must be able to be supervised in the community without presenting an undue threat (e.g., indications of undue threat may include a history of sadistic behavior or fantasy, a diagnosis of psychopathy based on the PCL-R, and a history of lethality in offense behavior or fantasy).

C. Criteria for the Foundation Format

Sex Offenders with less than 2 years minimum sentence will be assigned to the Foundation Format.

1. The offender must be actively participating in treatment and applying what he or she is learning.
2. The offender must have a complete full disclosure of their sexual history as verified by a non-deceptive polygraph assessment of his or her deviant sexual history.
3. The offender must participate in a comprehensive sex offense-specific evaluation and have a SOTMP approved individual treatment plan.
4. The offender must have a plan to establish at least one approved support person.
5. The offender must be practicing relapse prevention as verified by any recent monitoring polygraphs and no institutional acting out behaviors within the past year (e.g. a history of engaging in high risk behavior or committing violations of institutional rules reflective of ongoing criminal behavior).
6. The offender must be compliant with any DOC psychiatric recommendations for medication which may enhance his or her ability to benefit from treatment and or reduce his or her risk of re-offense.
7. The offender must be able to be supervised in the community without presenting an undue threat (e.g. a history of sadistic behavior or fantasy, a diagnosis of psychopathy based on the PCL-R, and a history of lethality in offense behavior or fantasy).

We previously carried out an evaluation of the prison SOTMP that identified a number of areas in which improvement was desirable. Since our report is publically available and Colorado DOC is acting to make some improvements we will not repeat that detailed analysis here. Readers are referred to that report entitled "A Program Evaluation of In-Prison Components: The Colorado Department of

Corrections Sex Offender Treatment and Monitoring Program” dated 20 January 2013 for a complete analysis of the DOC sexual offender treatment program and related policies.

Further, the comments made previously in the current report on the general criteria for progress in treatment apply here as well. Until the SOMB has revised its general criteria it may be reasonable to allow the DOC SOTMP freedom to develop criteria for the prison program that are more consistent with the Risk-Need-Responsivity principles, and which, as suggested more generally, reduce the emphasis on sexual history polygraph examinations and increase the emphasis on empirically-supported risk factors, as included in instruments like the SOTIPS.

Appendix M: Provider and Evaluator Qualifications, Complaints, etc.

Standard 4.000 Qualifications of Treatment Providers, Evaluators, and Polygraph Examiners Working with Adult Sex Offenders

This standard describes the application requirements for treatment providers, evaluators and polygraphers who work with sexual offenders in Colorado. To follow is an examination of the appropriateness of this standard for treatment providers and evaluators who work with adult, non-developmentally delayed sexual offenders. The requirements of this standard mandate that only evaluators and treatment providers who conform with the Standards may provide such services to sexual offenders in Colorado. The preamble notes that it is incumbent upon the evaluator/treatment provider to practice ethically and responsibly within the scope of their qualifications and expertise

This standard defines three levels of applicants which are described then commented upon *in italics* as follows:

1. Intent to Apply

Requires a fingerprint card (background investigation); a supervision agreement co-signed by a Full Operating Level provider requiring 2 to 4 hours face to face supervision monthly depending upon how many direct clinical contact hours are provided; 100 hours of co-facilitation of offender services with the/a Full Operating Level or Associate Level provider; the Full Operating Level provider must sign off on the work of the supervisee.

Evaluation Team Comment

A criminal background investigation that is thorough and reasonably flexible in terms of what disqualifies a provider is a necessary feature of assuring therapist competency

and reducing potential harm to offender clients. Face to face supervision, co-therapy with senior colleagues and working under the license of a supervisor are common requirements for professional disciplines for pre-licensed providers. There is an absence of professional education requirement beyond the admonishment “to practice within the scope of his or her qualifications and experience” and “practice responsibly and ethically” and these junior level providers/evaluators are not fully qualified to provide sexual offender services. This results in services that are provided to sexual offenders by professionals in training. It is recommended this be clearly communicated to offender clients and members of the CST and the name of the provider’s supervisor be provided a route to field concerns about the provider.

2. Associate

All applicants begin at this level. Requires the same supervision requirements as Intent to Apply level; services can be provided only under supervision of a Full Operating Level provider. All providers in Colorado (Intent to Apply, Associate Level, and Full Operating Level) must be listed with the Department of Regulatory Agencies as either an unlicensed, registered psychotherapist or a licensed psychologist, social worker, professional counselor, marriage and family therapist, or addictions counselor. Providers under Intent to Apply status as well as Associate Level providers are not required to be licensed mental health professionals, however, all Full Operating Level providers are required to be licensed mental health professionals.

Evaluation Team Comment

Like the Intent to Apply applicants those applying to the Associate Level may also be unlicensed professionals. Typically licensed professionals are not required to undergo such high levels of supervision as they have incurred large amounts pre-licensure. While in a sense there can never be too much supervision as this further increases competency, a potential downside of this requirement is difficulty and arduousness of soliciting and obtaining supervision. This would be more challenging for independent

private practitioners than those who work for a company with numerous professional staff available to supervise.

The Adult Associate Level requires: 1. A baccalaureate degree or above in a behavioral science with training or experience in counseling/ therapy.

Evaluation Team Comment

This is a common and recommended requirement for providers of sexual offender treatment/evaluation.

2. A professional mental health license or registered psychotherapist and not currently under disciplinary action.

Evaluation Team Comment

This is a common and recommended requirement for providers of sexual offender treatment/evaluation.

3. A minimum of one hundred direct face to face co therapy hours with adult sexual offenders co provided with a Full Operating or Associate Level treatment provider.

Evaluation Team Comment

This is considered within the common range and recommended requirements for new providers of sexual offender treatment/evaluation.

4. Within the past five years must have a minimum of 50 hours training including 28 hours of sex offense specific training; 8 hours of victim issues training; 10 hours specific to the treatment of adult sexual offenders; and four hours specific to female sex offenders.

Evaluation Team Comment

This is considered within the common range and recommended requirements for providers of sexual offender treatment/evaluation. The availability and affordability of such training is an important factor that should be maximally facilitated. Providers in Focus Groups report training is too costly and often inaccessible (i.e. if one misses the yearly conference they need to go out of state for training; geographically prohibitive for rural providers; can't get/afford the time off). On line and other forms of distance training should be considered.

5. Demonstrated competency according to the respective professional ethics and standards consistent with the accepted standards of sexual offense specific treatment practice.

Evaluation Team Comment

This is a common and recommended requirement for providers of sexual offender treatment/evaluation.

It is noted that listing this requirement is duplicative to the preamble of this standard and that the requirement is not so specified in the requirements for subsequent levels. It is unclear whether this is an error. It is recommended the SOMB either remove this from this section or add it to the other application level requirements.

6. Professional references from current work.

Evaluation Team Comment

This is a common and recommended requirement for providers of sexual offender treatment/evaluation.

7. Never been convicted of a crime that is related to the applicant's ability to practice under the standards; background investigation; statement of any conflicts of interest.

Evaluation Team Comment

A criminal background investigation that is thorough and reasonably flexible in terms of what disqualifies a provider is a necessary feature of assuring therapist competency and reducing potential harm to offender clients. Face to face supervision, co-therapy with senior colleagues and working under the license of a supervisor are common requirements for professional disciplines for pre-licensed providers.

8. Demonstrate compliance with the Standards and other SOMB requirements.

Evaluation Team Comment

This is considered within the common range and recommended requirements for providers of sexual offender treatment/evaluation.

Reapplication to the Associate Level:

Must be submitted every three years and include having completed at least 600 hours of clinical experience every three years, 300 of which must be direct with sexual offenders; along with the same supervision requirement; 40 hours continuing education every 3 years including 8 in the area of victimology and 10 in adult sexual offender treatment; and numbers 6, 7 and 8 from above list.

Evaluation Team Comment

The re-application period, three years, is considered within the common range and recommended requirements for certified providers of sexual offender treatment/evaluation. Regarding the number of clinical service hours required, the minimum is an average of about 17 general/8 sexual offender specific hours yearly, some have reported this is excessive for some whose treatment/evaluation of sexual offenders is a small component of their practice. Regarding the remaining criteria, the same comments rendered in the preceding section apply.

3. Full Operating Level

Applying to advance from the Associate to the Full Operating Level Treatment Provider:

Requires a letter from the supervisor substantiating readiness to advance completion and submission of all the following requirements:

1. Approved and in good standing or meeting the requirements of the Associate Level.
2. Must be licensed or certified as a psychiatrist, psychologist, clinical social worker, marriage and family therapist, clinical psychiatric nurse specialist, or licensed addiction counselor and not currently under disciplinary action.

Evaluation Team Comment

This is considered within the common range and recommended requirements for providers of sexual offender treatment/evaluation.

3. Within the past 5 years, a minimum of 1000 hours of adult sexual offender clinical experience including at least 500 hours direct face to face clinical contact.

Evaluation Team Comment

A significant number of treatment providers/evaluators report this minimum requirement of sexual offender treatment/evaluation, an average of 17 hours per month, exceeds what can be reasonably expected in some practices and it is prohibitive.

4. At least 60 hours co therapy with a Full Operating Level provider (in addition to the 100 required for the Associate level).

5. Face to face supervision of 2 to 4 hours per month depending on the number of clinical contact hours.

Evaluation Team Comment

Regarding 5 and 6, co-therapy and supervision, in most settings licensed professionals are not required to undergo such high levels of supervision as they have incurred large amounts pre-licensure. While there can never be too much supervision as this further increases competency, a potential downside of this requirement is difficulty and arduousness of soliciting and obtaining supervision. This would be more challenging for independent private practitioners than those who work for a company with numerous professional staff available to supervise. Focus group results indicate a significant number of providers/evaluators perceive these requirements as excessive and too difficult to achieve.

6. Within the past 5 years at least 100 hours training with a minimum 65 sex offense specific; 15 victim issues; 20 specific to treatment of adult sex offenders and meet requirements numbers 5, 6, 7, 8 as listed in the Associate level.

Evaluation Team Comment

These are considered within the common range and recommended requirements for providers of sexual offender treatment/evaluation.

Those who are Full Operating Level for juveniles who want to provide services to adults must apply at the Associate's Level.

Reapplication to the Full Operating Level:

Re-application for Full Operating must be completed every three years.

Evaluation Team Comment

The re-application period, three years, is considered within the common range and recommended requirements for certified providers of sexual offender treatment/evaluation.

First Re-Application of Full Operating Level:

Requirements are the same licensure requirement as the initial for Full Operating Level (number 2 above); a minimum of 600 hours of clinical experience including 300 direct clinical contact per three year application cycle; a minimum of 40 continuing education hours years per three year cycle including at least 8 hours in victimology and 10 in adult sexual offender treatment and numbers 6,7,8 as listed in the Associate level.

Evaluation Team Comment

The same comments as the preceding section apply to all requirements listed above for First Re-Application of Full Operating Level.

Second and subsequent Re-Applications of Full Operating Level:

Requirements are the same licensure requirement as the initial for Full Operating Level (number 2); stay active in the field through clinical experience, supervision, administration, research, training, teaching, consultation, and/or policy development; the same continuing education hours years per three year cycle as the initial reapplication to Full Operating Level and numbers 6,7,8 as listed in the Associate level.

Evaluation Team Comment

These are considered within the common range and recommended requirements for providers of sexual offender treatment/evaluation. They appropriately simplify the reapplication process.

A listed provider/evaluator re-applicant is afforded up to 1-yr to achieve compliance with any Standards revisions. New applicants must be in compliance with the Standards when they apply.

The SOMB Standards and Guidelines sub-specify further mandates for providers and evaluators from out of state and for developmentally disabled sexual offenders.

Standard 8.000 Denial of Placement on Provider List

This standard indicates the SOMB reserves the right to deny any provider/evaluator placement on the Provider List. As summarized below, the reasons for denial include, but are not limited to, the following:

The SOMB determines the applicant does not meet the qualifications or is not in compliance with the specified Standards; the applicant does not provide the necessary application materials; the applicant has been convicted of a crime; the applicant has been found to engage in unethical behavior by a licensing/certifying body or has had an adverse action by a professional oversight body; the applicant has a serious substance abuse problem; the applicant has a physical or mental disability that renders them unable to treat clients skillfully and safely; the SOMB determines the results of the background investigation or other aspects of the application are unsatisfactory.

Evaluation Team Comment

These are considered within the common range and recommended requirements for providers of sexual offender treatment/evaluation.

The SOMB Procedures for handling complaints and grievances.

A salient result of the Focus Groups Survey was uniform agreement across stakeholder groups that treatment providers incur unfair and prohibitive amounts of grievances and liability for adhering to SOMB Standards and Guidelines. Provider liability appears to be compounded by the fact that the supervision officer holds decision-making power in individual cases and that treatment providers and evaluators are the only CST members mandated under purview of the Standards and Guidelines. It appears that providers incur complaints due to following through with the decisions of the supervision officers and that in so following through, they are positioned to compromise professional ethics. Offender clients are prone to file complaints against therapists when they are dissatisfied with any part of the SOMB Standards and Guidelines as no other members of the CST are managed by state licenses. As one offender advocate described it, "There is no other member of the CST to hang a grievance on."

Evaluation Team Comment

Indeed, since Offender advocacates are the most common complainants, SOMB will benefit from taking specific measures to interact, educate and respond to this group. Further, the SOMB staff have reported the Department of Regulatory Agencies appears to have somewhat helped to slow down the complaint process but stronger efforts and direct actions by the SOMB are necessary.

Because providers are state licensed professionals (supervision officers do not operate under licenses) held by both professional ethical standards and the SOMB Standards and Guidelines, it is necessary that they can maintain a commitment to both and that they are offered clear advisement on how to proceed when this is not possible.

If it is the case that Supervision Officers dictate treatment plans, when this is inconsistent with the professional judgment of therapists this would present a serious challenge to therapists' professional ethical mandate to utilize their professional judgment.

Evaluation Team Comment

The results of the current review suggest that therapist liability is a significant barrier to the implementation of the Standards and Guidelines of the SOMB and that the SOMB inadequately supports its therapists against grievances and lawsuits and in their duty to maintain professional ethics.

The SOMB Standards and Guidelines do allow for a complaint process against Treatment Providers, Evaluators and Polygraphers. This is described in Appendix F, Sex Offender Management Board Administrative Policies. There is also a link on the CO SOMB website that describes Information and Instructions about the Complaint Process and provides the Complaint Form. The SOMB offers no method of filing a complaint against a CST member other than those listed above.

In the Instructions and Information about the Complaint Process is stated, "...the SOMB also ensures that the services being provided comply with the Standards and Guidelines that the SOMB was statutorily required to create." However, the instructions allow that a complaint can only be levied when a Standard is alleged to have not been met. There is no means of filing a complaint when a guiding principle is alleged to have not been met.

Evaluation Team Comment

There appears to be a barrier to efficacy of the Standards and Guidelines created by the narrow complaint opportunity. A significant result of the Focus Groups Survey was that the stakeholders involved in individual cases, such as the offender participant, the offender's family members, the defense attorney, the treatment provider, and the victim advocate, or the supervision officer identify that a guiding principle is not met by the individual application of the standard in the particular case, or that an implementation problem has occurred that is not the direct result of the provider or evaluator. Examples of this are when the supervision officer appears to be dictating treatment conditions that do not support the rehabilitation of the offender, when polygraph is utilized in a manner that does not facilitate treatment, or when the application of the no contact with minors policies are contraindicated. The SOMB

system of standardizing and guiding services for offenders could be improved by allowing a legitimate avenue for stakeholders to submit complaints regarding the application of the Standards and Guidelines that are more broad than what is currently permitted by the Complaint Process. A portion of this barrier could be alleviated allowing variances from the Standards in well-supported cases and addressing the power differential between supervision officers and treatment providers in regard to decisions about treatment and external controls.

The Instructions in the current SOMB complaint process require the complainant to complete the Complaint Form which includes providing their name, address, and phone number; describing the nature of the complain; citing the specific Standard(s) alleged to have been violate, and a proposed solution. There is no assurance of confidentiality.

Evaluation Team Comment

Given complainants are likely to be offenders and their advocates and the power differential between offenders and therapists there could be reasonable concern that filing a complaint may result in adverse consequences to the offender.

After the SOMB receives the Complaint Form, the forward it to the Department of Regulatory Agencies if it is against a treatment provider or evaluator. Complaints against polygraphers are not forwarded to any external regulatory body and are handled entirely internally by the SOMB, Application Review Committee (ARC). SOMB staff report that utilization of DORA has partially alleviated a heavy burden upon SOMB of handling large numbers of complaints.

The Vice Chair of SOMB and the ARC review all complaints, the outcome of which is either that further action is required resulting in requiring a written response from the provider/evaluator within 20 days or no further action. The complainant and

the provider/evaluator are informed of the results and have a 30-day right to appeal.

Evaluation Team Comment

It is recommended that the SOMB maintain detailed data on complaints received and conduct regular, at minimum yearly, analyses. Even when complaints are not substantiated thematic trends will allow systemic improvements.

Appendix N: Victim Perspectives, including contact with past victims and family reunification

The SOMB Standards and Guidelines include two sections where victim perspectives are specifically addressed. These are the sections: The Role of Victims/Survivors in Sex Offender Treatment (p.8) and Appendix E: Guidance Regarding Victim/Family Member Readiness for Contact, Clarification, or Reunification (p. 176-178).

In the Role of Victims/Survivors in Sex Offender Treatment the Standards and Guidelines recognize the damage to victims caused by sexual offenders' behavior then goes on to make three bulleted points.

First, it describes a premise of the Standards that victims should determine their level of involvement in the offender's criminal justice process after he has been convicted and sentenced.

Evaluation Team Comment

This is a reasonable premise that is consistent with victim oriented sexual offender treatment and the opinion of victim advocates who participated in the Focus Groups Survey. However, it was noted by these stakeholders that this premise is reported to not achieve uniform full implementation. It has been reported that some victims desire contact or reunification with the offender as in the case when the offender and victim are in the same family, however, they are prevented from such contact by the offender's prohibitions.

The next bullet discusses Colorado's Constitutional Amendment for Crime Victims that indicates victims have a right to be notified about changes to the offender's status in the criminal justice system. It notes that the Standards allow that victims may request notification about compliance with treatment and changes that might pose a risk to the victim. In certain situations there may be communication with the

victim's therapist/advocate. Further, if willing a victim may provide information during the presentencing investigation.

Evaluation Team Comment

The victim rights described in this bullet are reasonable and consistent with a victim-oriented model of sexual offender treatment and the opinion of victim advocates who participated in the Focus Groups Survey. However, it was noted by these stakeholders that this premise is reported inconsistently implemented. In some cases victims desired to never have contact with the perpetrator and felt they were not adequately provided information about the offender's whereabouts and supervision conditions. This problem was described as more prevalent after the offender is released from community supervision. In addition, a barrier was described to occur when the victim chooses not to undergo personal therapy and desires direct contact to learn about the offender. It has been reported that members of the CST are not permitted to discuss the issues delineated in the above bullet directly with victims but only through the victim's therapist/advocate.

The third bullet instructs that professionals involved in offender cases should contact victims through appropriate channels. It describes the value of risk related offender information provided by victims.

Evaluation Team Comment

The victim rights described in this bullet are reasonable and consistent with a victim-oriented model of sexual offender treatment and the opinion of victim advocates who participated in the Focus Groups Survey.

Appendix E: Guidance Regarding Victim/Family Member Readiness for Contact, Clarification, or Reunification is the second document within the SOMB Standards and Guidelines that directly addresses victims' perspectives.

This document provides guidelines for the CST when the victim desires contact, clarification or reunification as well as readiness for other parents/children in the home. It is divided into three sections:

1. Victim Readiness

For contact and clarification the victim should be able, based on age and development, to acknowledge and talk about the abuse and its impact without minimizing the scope; accurately identify the offender's responsibility for the abuse and not blame self; place responsibility on the offender and not minimize responsibility based on fear of repercussions; avoid perceiving as destroyer or protector of the family; demonstrate assertiveness skills and will disclose further abuse/violations of the safety plan; demonstrate reduction of symptoms and no active PTSD; express feeling safe, supported and protected and in control but not controlling; positive supportive relationships with supports; demonstrate healthy boundaries, self-respect and empowerment.

Evaluation Team Comment

The victim readiness features described in this section are generally reasonable and consistent with best practices involving contact and clarification between offenders and victims. They are consistent with the opinion of victim advocates who participated in the Focus Groups Survey with exception of a complaint that they are applied too rigidly in cases where early contact and contact prior to affirmative evidence that all above are met is therapeutically indicated for the victim. It is recommended that these features be expected to a reasonable and flexible degree. There are circumstances when contact between the offender and the victim is therapeutically indicated at early stages of intervention for both the offender and the victim. Application of guidelines regarding contact should consider the attachment needs of the victim. For example, in some cases early contact between offenders who had pre-offense positive relationships with the victim and the victim can prevent victim feelings of abandonment and shame.

For reunification, which is distinguished from contact and clarification as occurring without high levels of external structure, the SOMB offers the following guidelines to be considered in addition to the prior. The person is able to demonstrate and awareness of the grooming tactics of the offender; recognize ongoing grooming patterns; exercise assertiveness skills and confront the offender as needed; identify and seek out external support when needed.

Evaluation Team Comment

The reunification features described in this section are generally reasonable and consistent with best practices involving contact and clarification between offenders and victims. They are generally consistent with the opinion of victim advocates who participated in the Focus Groups Survey with exception that they are applied too rigidly in cases where early contact and contact prior to affirmative evidence that all guidelines are met is therapeutically indicated for the victim. It is recommended that these features be expected to a reasonable and flexible degree.

2. Non-Offending Parent/Guardian Readiness

The guideline describes the conditions that should be met by the non-offending parent/guardian but it does not describe for what kind of contact, -contact, clarification and/or reunification: believes the victim's report of the abuse; recognizes without minimizing the impact of the abuse upon the victim; holds the offender solely without blaming the victim in any way; has received appropriate education regarding their role as a non-offending parent; supportive and protective of the victim; more concerned with victim impact than consequences to the offender; has received appropriate education regarding sexual offender behavior; has received full disclosure of the offender's sexual abusive behavior; is aware of the grooming tactics used by the offender against the victim and other family members; supports and implements the family safety plan; demonstrates the ability to recognize and react properly to signs of high risk or offending behavior;

demonstrate assertiveness skills that would confront the offender and is willing to disclose high risk or offending behavior.

Evaluation Team Comment

The guideline should be clarified to indicate the type of contact it guides. Further, if the guidance is intended to apply to all contact between offenders and non-offending parent of victim, rather than reunification it may be overly rigid. There are circumstances when contact between the offender and the parent/guardian of the victim is therapeutically indicated at early stages of intervention for both the offender and the victim.

3. Secondary Victim, Sibling or Other Children in the Home Readiness

The guideline describes the conditions that should be met by the secondary victim but it does not describe for what kind of contact, -contact, clarification and/or reunification. It states that the individual: has an understanding of the nature of abuse and the victim impact; does not blame the victim or minimize the abuse; has received information about offender treatment, and high risk and grooming behaviors; can express the ways the abuse has affected and impacted his/her life; demonstrates healthy boundaries, including ability to identify and set limits regarding personal space and privacy; is aware of the family safety plan.

Evaluation Team Comment

The guideline should be clarified to indicate the type of contact it guides. Further, if the guidance is intended to apply to all contact between offenders and non-offending parent of victim, rather than reunification it may be overly rigid. There are circumstances when contact between the offender and siblings of the victim, secondary victim, or other children in the home is therapeutically indicated at early stages of intervention for both these individuals and the offender.

Appendix O: Results of Focus Groups Surveys of the SOMB Standards and Guidelines Stakeholders

Introduction

An important feature of any codification of rules and aspirations is how they impact the functioning of those targeted. Therefore, in addition to identifying how the SOMB Standards and Guidelines as written comport with RNR Principles, the evaluation team assessed the experience and opinions of members from the various stakeholder groups impacted. These groups were identified with assistance from the SOMB staff. The purpose of soliciting stakeholder feedback was to acquire current representative information on how the Standards and Guidelines as implemented comport with RNR on the ground level of experience of those individuals whose work or personal life they most deeply affect. In this sense, the focus group data speaks to the Risk, Need, Responsivity and Integrity Principles of effective correctional programming.

It is important to note that the intention of a Focus Group driven analysis is to provide a summary of the *perceptions* of a group of focus rather than to investigate the *accuracy* of the perceptions. Even inaccurate perceptions, if widely shared, become significant barriers to effective treatment.

The Focus Groups were asked to reply to the following primary questions:

1. How do the CO SOMB Standards and Guidelines impact you?
2. What are the ways that the Standards and Guidelines work well, enhance you/your work, its strengths?

3. What are the ways that the Standards and Guidelines do not work well, negatively impact you/your ability to do your work well, the ways it can be improved?
4. How well does the SOMB solicit and respond to your feedback?

Method

With assistance from the SOMB staff, the following stakeholder groups were identified and solicited to participate in face-to-face, or telephonic focus groups: Supervision Officers (Probation, Parole and Community Corrections), Listed Treatment Providers and Evaluators, Victim Advocates and Victim Therapists; Offender Advocates and Defense Attorneys, and Stakeholders not Mentioned in Other Categories (aka “Other Stakeholders”). After the initial invitation for focus groups was distributed, it was identified that the initial categories did not include prosecutors, judges and polygraphers who are also relevant stakeholders and efforts were made to include these specific groups in addition to the “Stakeholders Not Mentioned” group. Three SOMB staff members were also invited and participated. For the purpose of summarizing results, prosecutor data is included in the Victim Advocates and Victim Therapists group. Polygraphers are included in the “Other Stakeholders” category. No judges participated.

Stakeholders were solicited via email notification distributed by the SOMB staff. Face-to-face focus groups were prescheduled and occurred on November 14 and 15th, 2013 in Denver. Telephonic Focus Groups were held from November 18 through November 29. The size of focus groups ranged from 21 people in attendance to 1. Efforts were made to provide a focus group for every interested party. We know of no specific individuals who desired but were unable to participate in either a written, telephonic or face-to-face focus group. In total, over 32 hours of face-to-face or telephonic focus groups were conducted. All in focus group attendance were invited to provide further written or telephonic feedback in

the case that they had further feedback that could not be presented in the time allowed for the group.

Participants were briefly explained the nature and purpose of the SOMB evaluation, the evaluation team and the Focus Group. The Participant Information and Consent Form was read by each participant and each consenting participant was asked to sign the form accordingly and submit it to a member of the evaluation team. Regarding the format of the focus group, an evaluator from the research team asked pre-set questions to the group as listed on the SOMB Focus Group Survey (aka SOMB Survey), facilitating a semi-structured group discussion while the evaluator took notes. Some focus groups were audio-recorded to assist the evaluator with accurate write-up. These audio recordings were not available to any party outside the evaluation team and were subsequently destroyed. Participants were also encouraged to complete the written SOMB Survey; approximately 70% of participants completed the survey in addition to providing verbal responses. In a small number of cases, 9, participants chose to provide information solely via written completion of the SOMB Survey Form.

Table 1: Participation in Focus Groups

Stakeholder Group	Number of Participants	Percent of Total
Supervision Officers	52	29%
Treatment Providers and Evaluators	29	16%
Victim Advocates & Victim Therapists (incl. Pros)	33	18%
Offender Advocates (incl. Def. Attys)	36	20%
Polygraphers	2	1%

SOMB Staff	3	2%
Other or Unspecified	27	15%
TOTAL	182	100%

* percentages are rounded to the nearest whole unit

Results

The analysis of focus group data from the current study is summarized in this section. These results were supplemented by the Statewide Outreach Focus Groups data of 136 surveyed by SOMB staff, and presented by staff members Jesse Hansen, Cathy Rodriguez, and Raechel Alderete at the SOMB board meeting on November 15, 2013 resulting from a SOMB staff conducted statewide outreach project involving eight focus groups that were held from August to October, 2013. These staff conducted SOMB focus groups included all the stakeholder groups of the current external evaluation and additionally included judges.

Below are a ranking of the most recurrent themes in the responses to the questions asked to participants in the Focus Groups. The format below includes the enumerated topics of questions asked to Focus Group participants followed by alphabetized lists of the most endorsed response themes followed by the names(s) of the group(s) most strongly endorsing. Alphabetized lists are not rank ordered. A group listed as endorsing means that numerous, but not necessarily all, endorse. Subsequent bullet points provide further details and examples. When the themes found in the current study matched those found by the SOMB staff in their Statewide Outreach Focus Groups, they are considered highly significant and this is considered in summarizing results. It is important to note that unlike the current evaluation, the SOMB staff conducted focus groups did not survey for positive feedback but rather areas of concern.

1. Describe ways that SOMB Standards and Guidelines work well, enhance you/your work, its strengths.

A. Standards and Guidelines are indispensable; the quality of our work would be reduced if they were altogether eliminated (supervision officers, victim advocates, polygraphers, treatment providers and evaluators, SOMB Board Members and Staff).

- The majority of stakeholders surveyed in all groups except the offender advocates generally reported this.
- The groups endorsing this were each able to identify specific standards and guidelines or broad areas warranting improvement but generally agreed that Colorado's response to sexual offenders is improved by the presence of Standards and Guidelines.

B. The Standards and Guidelines provide a map for working with sexual offenders that eases decision-making (supervision officers, SOMB Board Members and Staff).

- The Standards and Guidelines provide a continuum of care for intervening with sexual offenders in CO.
- The supervision officers in particular generally perceive that the Standards and Guidelines define rules for working with sexual offenders that makes their job much easier by reducing discretionary decision-making by themselves and treatment providers.
- Responding to challenges about decision-making is made easier by citing the Standards and Guidelines.
- There are two widely opposite opinions on how specific and rule based the Standards and Guidelines should be versus more flexible and discretionary; allowing for clinical judgment.

C. The Standards and Guidelines are research based and therefore provide confidence in decision-making (supervising officers, victim advocates, SOMB Board Members and Staff).

- Standards and Guidelines create a consistent and clear language for communication among stakeholders however the desired degree of standardization strongly varies. Most appreciate that Standards and Guidelines “reigns in” problematic idiosyncratic decision-making.
- Many perceive the Board as highly motivated to have research supported Standards and Guidelines.
- The groups surveyed vary widely in opinion of how well the Standards and Guidelines have “kept up” with contemporary research on sexual offender treatment efficacy.
- Several noted a concern that many voting Board members are not experts in subject matter content and may be misinformed or politically biased in their voting which lead to Standards and Guidelines that reflect political value systems rather than treatment efficiency and community safety.
- Some also note that the Standards and Guidelines over focus on group sample research, problematically disregarding learning and decision-making informed by the individual case at hand.

D. Having SOMB Standards and Guidelines assures the community that offenders are made accountable (supervision officers, victim advocates, polygraphers, SOMB Board Members and Staff).

- Victims deserve to know that those who offended against them do not “get off easy” and will not be tolerated by the community unless they take accountability and get treatment so that they never create another victim.

- Assuring that offender treatment is conducted by high quality and specialized providers makes victim's feel that the state deeply cares about their victimization, -"Victims want to know the perpetrator is being treated and won't do it again."
 - A significant portion of those surveyed communicated a belief that the Standards and Guidelines could never be "too harsh" upon sexual offenders.
 - The polygraph helps make sure offenders take accountability. I.e., "Victims must know that the offender admits it in order for them to heal."
- E. The SOMB provides free (or greatly discounted) training (supervision officers, treatment providers and evaluators, victim advocates, offender advocates, polygraphers, SOMB Board Members and Staff).
- This assists therapists in developing/maintaining expertise.

2. Describe ways that SOMB Standards and Guidelines do not work well, negatively affect you/your work, the ways they can be improved.

- A. The SOMB Standards and Guidelines do not adequately adhere to the Risk, Need, Responsivity Principles (all groups).
- Supervision and treatment decision-making are often not risk based i.e. Lifetime Supervision, SVP, contact with minors.
 - In practice, the parole board determines when an inmate has sufficiently completed inpatient treatment; the parole board's decisions about readiness for release are not adequately influenced by the offender's risk and needs and are often inconsistent with the treatment program's opinions. This further causes lack of clarity about program expectations and undermines the motivation of inmates.

- Treatment and supervision are not adequately titrated in response to proven management of risk factors/treatment needs. I.e. For some offenders it is therapeutically indicated for them to transfer from prison to community treatment settings; difficulty gaining permission to work, have an intimate relationship, reduced polygraph testing, treatment requirements, etc. The time it takes to complete treatment and get off parole is too long.
- Need better clarification, communication, transparency of treatment program requirements. Program should offer written completion criteria and provide regular reviews and feedback so that participants know clearly what is needed to complete treatment and get off parole.
- The treatment does not adequately target relevant criminogenic needs; treatment is not adequately individualized.
- The treatment environment, therapist and supervision officer style do not strive to maximize offender participants' responsivity. There is a significant negative attitude toward sexual offenders in Standards and Guidelines tone and practice. The SOMB supported system replicates the offender victim abuse dynamics, with the "system" tending toward "abusiveness" of sexual offenders (i.e. power, shaming, humiliation, retaliatory).
- The verbiage of the Standards and Guidelines does not promote responsivity of participants nor that treatment can be effective; it does not anchor in RNR principles. Many offenders regress back to prison in response to unwelcoming attitudes and behaviors by treatment/supervision.
- Financial motivated decision-making often trumps RNR influenced decisions. I.e. Sometimes the victim is removed from the home because the offender cannot afford alternate housing.
- The Standards and Guidelines do not provide a realistic procedure for offender participants to submit grievances.

- Putting a 90-day limit on how long an offender can be in “denial” is not appropriate for every case.
- Resource efficiencies can be made through a more flexible and RNR focused implementation of Standards and Guidelines. i.e. Some offenders are over-treated or over-evaluated (e.g. historical offenders; excessive polygraph).
- Some offenders intentionally violate the conditions of parole in order to serve the remainder of their sentence in prison as a means of avoiding what they perceive as unachievable expectations, impossible financial costs, and mishandling by the CST.
- The next less restrictive alternative to prison treatment in CO is community corrections housing, however this is not viable for most sexual offender inmates.
- Those who do not have life sentences are placed after those with life sentences on prison treatment waitlists and often cannot get into the treatment program; this not completing inpatient treatment then prevents their parole.
- Parole revocations often occur for minor, non-sexual related violations. The duration of time revoked to prison is excessive (greater than 120 days). Paroled inpatient treatment completers are required to “re-complete” treatment upon release to the community. This is seen as redundant, unnecessary and intentionally prolonging sentences; participants would like to receive reciprocal credit for treatment completed in the community and inpatient when they have not lapsed to sexual abuse.

B. Standards and Guidelines result in therapists having inadequate influence over treatment related decisions (treatment providers and evaluators, offender advocates, SOMB Board Members).

- Treatment providers describe often having to deliver treatment when they believe it is no longer needed or needed with less intensity. i.e. “We

are afraid to advocate for low risk offenders deserving reduced restrictions and treatment intensity.”

- Providers are reluctant to share their opinions on cases with supervision officers.
 - Treatment providers often sacrifice their clinical judgment in order to carry out the decisions of supervision officers, “The PO directs the work of the provider and there is no real way for the provider to disagree”.
 - The Standards and Guidelines are overly rigid and do not sufficiently allow for the CST to make exceptions. The variance process is not adequate.
- C. There is significant disagreement and tension between supervision officers and treatment providers; this undermines the efficacy of treatment delivery (all groups).
- Of those who intervene with sexual offenders, the Standards and Guidelines only mandate the work of therapists and polygraphers. Within court-imposed limits, supervision officers have discretionary and ultimate authoritative influence over the treatment intensity, duration, restrictions and permissions in individual cases, which can usurp best treatment practices and cause power issues between the stakeholders. The disagreement between the provider and the supervision officer is often perceived by offender participants.
 - There are economic sanctions for treatment providers exercising their clinical judgment when it is inconsistent with that of the supervision officers. Therapists are penalized by being “black-balled” from referrals by supervision officers. These issues appear in large part caused by the fact that supervision officers control treatment referrals.
- D. Standards and Guidelines do not adequately promote the strengths, healthy functioning, and protective factors of offender participants (All groups).

- Primary utilization of the containment model as applied seems to conceptualizes all offenders as equally, highly and perpetually dangerous and fails to acknowledge improvement and protective factors.
- The Standards and Guidelines are experienced as failing to instill hope in offender participants and their families.
- The Standards and Guidelines over-focus on external control over internal change of offender participants.
- The Standards and Guidelines and their implementation do not include appropriate focus on the motivation of offender participants.
- The Standards and Guidelines do not adequately incentivize and reinforce offender client progress.
- The verbiage, content and implementation of the Standards and Guidelines fails to define and acknowledge healthy functioning, healthy sexuality. They over-focus on deviancy over healthy functioning.
- The SOMB Standards and Guidelines do not value the family unit. They are particularly insensitive to the importance of offender clients living with their children and minor siblings. There are many cases where the offender's return to the home (with minor children) is in the best interest for the entire family but Standards and Guidelines prohibit this. Child contact assessments should be made a regular part of assessment prior to community release but are delayed and put on the onus of the offender to acquire and pay for them. Offenders are often prevented from developing/maintaining intimate relationships with adults. The wife/family members are inadequately involved in the offender's supervision and treatment plan.
- Offenders with no history of victimizing a child are prohibited from any contact with minors including working anywhere where it is possible to have contact with minors.
- The Standards and Guidelines are overly stringent and inflexible in defining what constitutes a support person.

- Treatment is at times terminated when the offender can't afford to pay for it and the state cannot/will not provide funding.
 - Standards and Guidelines disallow use of pornography while on parole but in some cases non-deviant pornography may be treatment indicated.
- E. The Standards and Guidelines require or promote a one-size-fits all approach to intervening with sexual offenders that is in many instances problematically insensitive to important individual case factors (all groups).
- Lack of individualization. Standards and Guidelines require or compel regimented decision- making that is contraindicated to treatment needs and reduces offender response to treatment delivery.
 - All sex offenders are treated the same; participants and their support systems feel the treatment program does not really know, acknowledge or value their unique features.
 - There is no quality control of treatment material, treatment delivery, or treatment planning. Treatment is not adequately specific to participant's unique crimes, culture, religious values, family circumstance or lifestyle.
 - There is a lack of flexibility in adjusting intensity and duration of treatment. I.e. "They are cumbersome and impractical to implement and do not facilitate treatment. They would be perfect if all the "shalls" were replaced with "shoulds.""
- F. Therapists incur unfair and prohibitive amounts of liability for adhering to SOMB Standards and Guidelines (all groups).
- The SOMB inadequately supports its therapists against grievances and lawsuits.
 - It is perceived that because supervision officers do not operate under a professional license offender clients are prone to file complaints against

therapists when they are dissatisfied with any part of the SOMB Standards and Guidelines.

- The SOMB's "DORA" committee has somewhat helped to slow down the complaint process but stronger efforts are necessary.
- Offender advocacy groups are the most common complainants; SOMB needs to take specific measures to interact, educate and respond to this group.

G. There is an absence of much needed quality control among the various stakeholder groups (all groups).

- The large number of treatment providers/programs are not required to undergo any kind of quality assessment by SOMB.
- The SOMB does not but should assess treatment outcome.
- The quality of polygraph, penile plethysmograph and offender evaluations (i.e. reunification) are widely variable and in need of quality assurances.
- The SOMB should provide examples of what is considered good quality, i.e. therapy, treatment plan, child contact assessment look like.

H. The Standards and Guidelines are implemented with problematic variability in consistency (all groups).

- Given that they are not under the mandated purview of the SOMB, there is marked inconsistency in the degree to which supervision officers are guided by the Standards and Guidelines.
- There is marked implementation inconsistency among treatment providers in their adherence to the Standards and Guidelines.
- Polygraphers vary widely in style and conclusion rates.

I. Two important stakeholder groups, Judges and the Parole Board are not adequately educated about the Standards and Guidelines and they are variably supportive (all groups).

- Judges are not considered part of the CST and operate independent of the Standards and Guidelines. This often frustrates the other stakeholders who are all at least guided by the SOMB Standards and Guidelines.
- Because the judges make the ultimate decisions in a case and to a lesser but significant degree so also does the parole board, judges and parole board members who are uneducated, ambivalent or hostile toward the SOMB Standards and Guidelines often make decisions inconsistent with the Standards and Guidelines; when this happens it devalues the Standards and Guidelines and leads to treatment of sexual offenders that is contraindicated by the RNR principles.

J. Victim advocates and victims are not adequately solicited to be part of the CST's decision-making (victim advocates, offender advocates).

- Victims of offender participants report they have no idea of the case status; they would like to be considered a necessary part of the CST.
- Victims of offender participants who have/had a relationship with the offender at times feel reunification/reparation is unnecessarily prohibited.
- Particularly when a victim chooses not to engage in their own therapy, it is perceived contact with the offender is unnecessarily prohibited.

K. The manner of utilization of the polygraph undermines treatment efficacy (treatment providers and evaluators, offender advocates).

- Polygraph use is perceived as excessive and implemented coercively, punitively and rigidly rather than as a treatment tool.
- The polygraph takes up too large a space in offenders' treatment, it has become the center of the treatment instead of a useful tool to facilitate treatment.

- Inconclusive polygraph results influence decision making in the same manner as deceptive results.
 - Treatment is often terminated by the officer due to a failed polygraph, which is viewed as indicative of a lack of progress. i.e. Cases where after many years of passing polygraphs, one failure leads to revocation back to prison where there is a long wait list to enter the prison treatment program which does not acknowledge any of the progress made in prior treatment
 - There are not enough polygraphers; only a few are used and they tend to over-fail participants; those who pass too many get “blackballed” from the referral list.
 - There is no flexibility to amend polygraph requirements for offenders with comorbid issues rendering them unable to reliably participate (i.e. PTSD, psychotic, cultural paranoia, medications/serious health problems).
 - The quality control of polygraphers is inadequate.
- L. Standards and Guidelines do not adequately address certain offender groups (all groups).
- Developmentally Delayed and Significantly Cognitively Impaired Offenders
 - Geriatric offenders
 - Offenders with severe psychiatric or medical disorders
 - Offenders with significant personal trauma histories
 - Offenders transferring from the DOC to community supervision and treatment
 - Offenders with an absence of social supports and/or a place to live
 - Adults whose only sex offense(s) was as a juvenile
 - Offenders with very high levels of psychopathy.

- Low risk sexual offenders. i.e. Concerns about iatrogenic effects resulting from excessive supervision and treatment requirements.
- The Standards and Guidelines are designed more for non-familial offenders and fail to adequately address the treatment needs of familial offenders.

3. Briefly describe how well the SOMB solicits and responds to your feedback.

A. The SOMB does not solicit or respond to feedback/questions from individual stakeholders at an ideal level (all groups generally shared this opinion, with SOMB Board Members and Staff least likely to endorse).

- Stakeholders did not know to whom to submit questions.
- Questions submitted are not answered or not adequately/timely answered.
- There is a lack of much desired consumer satisfaction survey (of all stakeholder groups).

B. The SOMB appears committed to improving (all groups).

- There are many committees examining how specific Standards and Guidelines can be improved.
- Many are unclear how they can be involved in the committees.

C. The SOMB does not adequately educate its various stakeholders or the community at large about its Standards and Guidelines (all groups).

- There is wide variability in how much people know about the Standards and Guidelines.
- Some victim groups did not even know the Standards and Guidelines existed and reported “a desperate desire” to be a part of SOMB.

- Rural stakeholders in particular feel the SOMB does not adequately reach out to them.
- The details of specific Standards are not adequately understood nor is how individual stakeholders can involve themselves in influencing updates.
- There is a particular distinction in knowledge of and motivation to adhere to the Standards and Guidelines between parole versus probation officers.
- The SOMB email distribution list does not adequately reach stakeholders.

D. The SOMB does not adequately solicit treatment providers (all groups).

- The certification process is too arduous.
- The certification process fails to select for therapist style and quality.
- There are not enough treatment providers to do the work.
- The SOMB does not adequately consider the impact and opinions of treatment providers in its decision-making, -too many decisions about what providers must do are being made by non-treatment providers.
- The number of treatment provider representatives on the SOMB and on its committee is insufficient.
- Whereas the majority of SOMB members are from state agencies and get paid for their SOMB involvement, treatment providers are mostly private practitioners and lose billable hours to participate or attend. This is perceived as intentionally dissuading provider involvement.

E. The SOMB is not appropriately resourced/board composition concerns (all groups).

- More funding is needed for SOMB staff to conduct research, outreach, education, quality review.
- The number on the SOMB has become too great.

- The SOMB voting members are not appropriately influenced by research and best practice standards and over influenced by political motivations.
- Many opined to increase the number of treatment providers on the board and to add a DOC seat to the board.
- The number of SOMB seats should be balanced according to the representative proportion of the vote desired.

F. The SOMB should expand its purview to include victim services (victim advocates).

- Victim advocacy groups believe too much of the state's resources go toward offender services and not enough toward victim services.
- The state should prioritize its victims getting treatment over its offenders getting treatment.

Discussion

The various stakeholders of the CO SOMB Standards and Guidelines were surveyed via focus groups for the purpose of this external evaluation. The aim was to solicit candid feedback on what works and does not work from the various stakeholder groups' perspectives. Semi-structured group and individual format interviews were administered to obtain a clear picture of the psychological reality of the SOMB's stakeholders. The purpose was not to investigate whether stakeholder experience represents objective truth. Perceptions strongly endorsed by the groups surveyed are detailed above along with bulleted examples.

The results of the focus group surveys provide valuable information about how the CO SOMB and its Standards and Guidelines are perceived to adhere to the Risk, Need, Responsivity and Integrity Principles of effective correctional programming. Several perceived strengths and weaknesses were identified. The strengths include their being considered indispensable; providing a pragmatic road map and common

language that eases decision making in working with sexual offenders; providing research informed recommendations; assuring accountability of sexual offenders and accessible and quality training for treatment providers and evaluators. It is recommended that the SOMB undergo serious efforts to understand and amplify the aspects of the Standards and Guidelines perceived as strengths. Acknowledging the salience of these facts and striving to consistently implement them across the jurisdictions in Colorado will facilitate treatment engagement and outcome. The implementation of Standards and Guidelines that have positive and engaging features that result in the provision of services and mandates that offender participants experience as therapeutic and responsive to their needs will lead to a greater willingness to meaningfully engage with treatment and supervision activities and mandates.

From this analysis also emerged several perceived barriers to the efficacy of the SOMB and its Standards and Guidelines. These largely fall into areas of inadequate adherence to the Risk, Need, Responsivity Principles. There appears a specific and significant barrier to effective treatment involving treatment providers' ability to adequately influence treatment related decisions as well as the relationship between treatment providers and supervision officers and the amount of liability incurred by treatment providers. Further, it is perceived that the Standards and Guidelines are applied too rigidly and in a one size fits all approach that does not adequately promote strengths, protective factors and healthy functioning of offender participants. Barriers to efficacy due to an absence of quality control, variable consistency in implementation, variable support by judges and the parole board, under involvement by victim advocates, and lack of good fit to certain offender subgroups are also perceived. Finally, similar to the CO DOC external evaluation, the polygraph emerged in the current evaluation as utilized problematically.

In response to how well the SOMB solicits and responds to stakeholder feedback, several areas of strength and opportunities to improve emerged. The SOMB is

perceived as committed to improving and providing research supported Standards and Guidelines but in need of more resources to do so. It has much opportunity to improve its communication, education and outreach efforts and its responsiveness to individual questions. In particular, the SOMB is perceived as inadequately soliciting the involvement of treatment providers. Lastly, many perceive the scope of the SOMB should be widened to include victim services.

The SOMB will benefit from careful consideration and action to each of the primary focus group themes as summarized in the above paragraphs and detailed in the Results section. It is recommended the SOMB invest itself in learning the perception of the SOMB and its Standards and Guidelines from the vantage of its stakeholder groups through this analysis as well as ongoing periodic review. When the SOMB determines a main theme is based on inaccurate information, it is advised to proactively adapt the Standards and Guidelines or communication thereof to include credible clarifying relevant information. In cases where negative perceptions are credible, the SOMB should seek to improve, maximally removing to as much degree as possible, these barriers.

Limitations

Three shortcomings in terms of focus group participant demographics are noted: no judges participated; treatment providers were underrepresented; and rural providers were under-represented (many from distances remote from Denver were geographically prohibited from attending the face-to-face focus group). These barriers were partially resolved by supplementing results with the data from the Statewide Outreach Focus Groups project of the SOMB, through telephonic focus groups and the solicitation of written surveys. Further, a small number of participants complained about SOMB members or SOMB staff being in attendance at the focus groups, which may have led to disinclination of candid responding by some focus group attendees. In addition, some victim advocates complained that the

“open to all (Other/Unspecified)” focus group was compromised due to the mixed attendance of offenders and offender advocates and to the shortened duration of the focus group.

Participant Information and Consent Form

INFORMATION

Evaluation of the Colorado SOMB Standards and Guidelines

The State of Colorado has commissioned an independent evaluation of the SOMB Standards and Guidelines which is being conducted by Central Coast Clinical and Forensic Psychology Services. The purpose of the evaluation is to determine ways in which the SOMB adheres to best practice standards and can be improved. Recommendations from the evaluation might speak to ways the SOMB can accomplish its goals more quickly at less cost or ways it can better meet the needs of those under its purview.

The evaluation team are Drs. D’Orazio, Thornton, and Beech from who come from California, England and Wisconsin. It is completely independent of Colorado. The evaluators are experienced doctors who are very familiar with the subject of sexual offending. Questions may be directed to Dr. D’Orazio at drdorazio@cccfpsych.com.

If you agree to participate in a focus group you will be asked to verbally and/or in writing provide your opinions on the SOMB Standards and Guidelines. The verbal focus groups will occur in person or telephonically and take up to 1.5 hrs. You will also be asked to fill in a brief questionnaire that asks you to identify your role with the SOMB and your opinions about how it works well and how it can be improved. This questionnaire should take about 15 minutes to complete.

All of the information that you provide at interview or on any of the questionnaires will be kept confidential within the evaluator team. No names or specific identifying information will be in the final report.

We hope you will take advantage of this opportunity to contribute to improving Colorado’s SOMB.

CONSENT

By signing below I agree to the following statements:

- I confirm that I have read and understood the information provided above for the current evaluation.
- I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.
- I understand participation is voluntary, and that I am free to withdraw at any time, without giving any reason, without my rights to treatment being affected.
- I agree to take part in the evaluation

_____	_____	_____
Name of participant & agency/role	date	signature

_____	_____	_____
Researcher name	date	signature

FOCUS GROUP SURVEY

1. **POSITION TITLE/RELATIONSHIP TO SOMB:** _____

2. **NAME (OPTIONAL):** _____

3. **BRIEFLY DESCRIBE HOW THE SOMB STANDARDS AND GUIDELINES IMPACT YOU, I.E. WHICH STANDARDS INFLUENCE YOUR WORK OR PERSONAL LIFE:**

4. **BRIEFLY DESCRIBE THE WAYS THAT SOMB STANDARDS AND GUIDELINES WORK WELL, ENHANCE YOU/YOUR WORK, ITS STRENGTHS (CONTINUE ANSWER ON BACK IF NECESSARY).**

5. **BRIEFLY DESCRIBE THE WAYS THAT THE SOMB STANDARDS AND GUIDELINES DO NOT WORK WELL, NEGATIVELY AFFECT YOU/YOUR WORK, THE WAYS IT CAN BE IMPROVED (CONTINUE ON BACK IF NECESSARY).**

6. **BRIEFLY DESCRIBE HOW WELL THE SOMB SOLICITS AND RESPONDS TO YOUR FEEDBACK.**

Appendix P: Sexual Offender Management Boards in the United States

State	SOMB?
Alabama	No
Alaska	Sex Offender Treatment Committee with Approved Provider process and Standards of Care
Arizona	No
Arkansas	Board for Purposes of Notification only
California	Yes
Connecticut	No
Delaware	Yes – developed standards similar in scope to CO and appears to be closely modeled on them
Florida	No
Georgia	No
Hawaii	No
Idaho	Yes
Illinois	Yes – moderately developed standards which appear to be significantly modeled on CO
Indiana	No
Iowa	No SOMB but do have treatment provider certification standards and a board to administer them
Kansas	No
Kentucky	No
Louisiana	No
Maine	No
Maryland	Yes – Developed standards; marriage of statistical instruments and Comprehensive approach including multiple technologies e.g GPS; in some parts clearly reflecting the influence of the CO SOMB
Massachusetts	No
Michigan	No
Minnesota	No (but are proposed standards)
Mississippi	No
Missouri	No
Montana	No
Nebraska	No
Nevada	No
New Hampshire	Yes
New Jersey	No
New Mexico	Yes but we were unable to locate their Standards
New York	No but do have Treatment Provider Standards
North Carolina	No

North Dakota	No
Ohio	No
Oklahoma	No
Oregon	Yes – adopted ATSA national standards
Pennsylvania	Sex Offenders Assessment Board which sets treatment standards for SVPs
Rhode Island	SO Management Task Force which recommends standards and guidelines for treatment of adult sex offenders – strongly modeled after CO SOMB
South Carolina	No
South Dakota	No
Tennessee	Yes – Sex Offender Treatment Board – less elaborate standards
Texas	Council on Sex Offender Treatment - ad
Utah	No SOMB but standards for sex offender treatment
Vermont	No
Virginia	No but have certification standards
Washington	SO Policy Board but no standards for programs or for providers
West Virginia	No
Wisconsin	No
Wyoming	No

Commentary

Of necessity our examination of approximations to Sex Offender Management Boards in other states was limited to information easily available on relevant websites. As indicated in the above table, few states have SOMBs comparable to the Colorado SOMB. A number of states have standards or guidelines of more limited scope, for example a standards and process to become an approved sex offender treatment provider. The states that have SOMBs more closely resembling the Colorado SOMB either had deliberately largely replicated Colorado (including verbatim sharing of language from the CO Standards and Guidelines) or opted to employ the Association for the Treatment of Sexual Abuser’s national guidelines. The Standards and Guidelines of some of the states seem to notably languish behind contemporary research. For example, there is a dated quality to some of the state sponsored prescriptions for the assessment of sexual offenders, i.e. use of the SONAR instrument was recommended in several places despite it becoming out of date in 2000 when it was replaced by what is now called STABLE-2000, an instrument which has since been replaced by STABLE-2007. Although a thorough analysis was not possible given the scope and duration of the current project, none of the SOMBs of the other states reviewed appear more developed than the Colorado SOMB.

References

Abel, G. G., Becker, J. V., Mittelman, M., Cunningham-Rathner, J., Rouleau, J. L., & Murphy, W. D. (1987). Self-reported sex crimes of nonincarcerated paraphiliacs. *Journal of Interpersonal Violence*, 2, 3-25.

Ahlmeyer, S., Heil, P., McKee, B., & English, K. (2000). The impact of polygraphy on admissions of victims and offenses in adult sexual offenders. *Sexual Abuse: A Journal of Research and Treatment*, 12, 123-138.

Colorado Sex Offender Management Board (CSOMB). (2011). *Standards and Guidelines for the Evaluation, Assessment, Treatment, and Supervision of Juveniles who have Committed Sexual Offenses*. Colorado Department of Public Safety, Division of Criminal Justice. Available at http://dcj.state.co.us/odvsom/sex_offender/SO_Pdfs/2012%20ADULT%20STANDARD%20FINAL%20C.pdf

Cowley (2013). "Let's get drunk and have sex": the complex relationship of alcohol, gender and sexual victimization. *Journal of Interpersonal Violence*, Online-First, downloaded December 26th 2013.

D'Orazio, D., Thornton, D, & Beech, A. (2013). A Program Evaluation of In Prison Components: The Colorado Department of Corrections Sex Offender Treatment and Monitoring Program. Colorado Department of Corrections. Available at http://www.doc.state.co.us/sites/default/files/CO_SOTMPPProgramEvaluationJan20.pdf

English, K. (1998). The containment approach: an aggressive strategy for the community management of adult sex offenders. *Public, Policy and Law*, 14, 218-235.

English, K. (2004). The containment approach to managing sex offenders. *Seton Hall Law Review*, 989, 1255-1272.

Gylys, J. A., & McNamara, J. R. (1996). A further examination of the sexual experiences survey. *Behavioral Sciences and the Law*, 14, 245-260.

Groth, A.N., Longo, R.E., & McFadin, J.B. (1982). Undetected recidivism in rapists and child-molesters. *Journal of Research in Crime and Delinquency*, 28, 450-458.

Freeman-Longo, R.E. (1985). Incidence of self-reported sex crimes among incarcerated rapists and child-molesters. Unpublished manuscript. Correctional Treatment Program, Oregon State Hospital.

Finkelhor, D. & Jones, L. (2006). Why have child maltreatment and child victimization declined. *Journal of Social Issues*, 62, 685-716.

Hanson, R.K., Harris, A.J.R., Helmus, L. & Thornton, D. (in press). High Risk Sex Offenders May Not Be High Risk Forever. *Journal of Interpersonal Violence*.

Harkins, L., Beech, A.R. & Goodwill, A.M. (2010). Examining the influence of denial, motivation, and risk on sexual recidivism. *Sexual Abuse: A Journal of Research and Treatment*, 22, 78-94.

Heil, P., Ahlmeyer, S., & Simons, D. (2003) Crossover sexual offenses. *Sexual Abuse: A Journal of Research and Treatment*, 15, 221 - 236.

Kokish, R., Levenson, J.S., & Blasingame, G.D. (2005). Post-conviction Sex Offender Polygraph Examination: Client-Reported Perceptions of Utility and Accuracy. *Sexual Abuse: A Journal of Research and Treatment*, 17, 211-221.

Koss, M. P., Gidycz, C. A., & Wisniewski, N. (1987). The Scope of rape: Incidence and prevalence of sexual aggression and victimization in a national sample of higher education students. *Journal of Consulting and Clinical Psychology*, 55, 162–170.

Langan, P. A., Schmitt, E. L., & Durose, M. R. (2003). Recidivism of sex offenders released from prison in 1994. Washington, DC: U.S. Department of Justice, Bureau of Justice Statistics.

Lisak, D. & Miller, P.M. (2002). Repeat rape and multiple offending among undetected rapists. *Violence and Victims*, 17, 73-84.

Mann, R. E., Hanson, R. K., & Thornton, D. (2010). Assessing risk for sexual recidivism: Some proposals on the nature of psychologically meaningful risk factors. *Sexual Abuse: A Journal of Research and Treatment*, 22, 191-217.

McGrath, R. J., Lasher, M. P., & Cumming, G. F. (2012). The Sex Offender Treatment Intervention and Progress Scale (SOTIPS): Psychometric properties and incremental predictive validity with Static-99R. *Sexual Abuse: A Journal of Research and Treatment*, 24, 431-458. doi:10.1177/1079063211432475

Minnesota Department of Corrections (2007). Sexual offender recidivism in Minnesota.

Nunes, K. L., Hanson, R. K., Firestone, P., Moulden, H. M., Greenberg, D. M., & Bradford, J. M. (2007). Denial predicts recidivism for some sexual offenders. *Sexual Abuse: A Journal of Research and Treatment*, 19, 91-105.

Thornton, D., & Knight, R. (2007, November). *Is denial always bad?* Paper presented at the 26th annual conference of the Association for the Treatment of Sexual Abusers, San Diego, CA.

Ward, T., Gannon, T.A., & Birgden, A. (2007). Human rights and the treatment of sex offenders. *Sexual Abuse: A Journal of Research and Treatment*, 19, 195-216.

Ward, T., Mann, R., & Gannon, T.A. (2007). The good lives model of rehabilitation: Clinical implications. *Aggression and Violent Behavior*. 12, 87-107.

Weinrott, M. R., & Saylor, M. (1991). Self-report of crimes committed by sex offenders. *Journal of Interpersonal Violence*, 6, 286-300.

Willis, G. M., Yates, P. M., Gannon, T. A., & Ward, T. (2013). How to integrate the Good Lives Model into treatment programs for sexual offending: An introduction and overview. *Sexual Abuse: A Journal of Research and Treatment*, 25, 123-142.

Zgoba, K. M., Miner, M., Knight, R., Letourneau, E., Levenson, J., & Thornton, D. (2012). *A multi-site recidivism study using Static-99R and Static-2002 risk scores and tier guidelines from the Adam Walsh Act*. Report submitted to the US National Institute of Justice. <https://www.ncjrs.gov/pdffiles1/nij/grants/240099.pdf>