SEX OFFENDER MANAGEMENT BOARD

ANNUAL LEGISLATIVE REPORT

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

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

January 2025

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Executive Summary

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

The Sex Offender Management Program (SOMB) is statutorily mandated in § 16-11.7-101(2), C.R.S., to create evidence-based standards for the evaluation, treatment, management, and monitoring of adults convicted of sex offenses and juveniles adjudicated of sex offenses. The primary aim of the Standards and Guidelines for the Assessment, Evaluation, Treatment and Behavioral Monitoring of Adult Sex Offenders (henceforth the *Adult Standards and Guidelines*) and the Standards and Guidelines for the Evaluation, Assessment, Treatment and Supervision of Juveniles Who Have Committed Sexual Offenses (henceforth the *Juvenile Standards and Guidelines*) are to prevent reoffending and to enhance the protection of victims and potential victims.

To ensure the *Adult Standards and Guidelines* and *Juvenile Standards and Guidelines* reflect evidence-based best practices, the SOMB reviews relevant research literature and conducts research projects using SOMB data in support of ongoing committee work and the development of this report.

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

Section 1: Research and Evidence-Based Practices

Treatment programs for sexual offending are designed to address the complex psychological, behavioral, and social factors contributing to sexually abusive and criminal behavior. A critical measure of their effectiveness is recidivism—the rate at which individuals reoffend with a new sexual or violent offense. Lower recidivism rates signify successful rehabilitation, enhanced community safety, and support greater public confidence in the justice system. Monitoring these outcomes, while prioritizing victim safety, is essential for evaluating treatment efficacy and guiding future practices.

Sexual and Violent Recidivism: Summary of Literature and Research

A literature review was conducted that examined recidivism rates for adults convicted of and juveniles adjudicated of sex offenses. Highlights of critical findings include:

- Sexual recidivism among adult males in routine parole and probation samples ranges from 3.5% to 10% over follow-up periods of 3 to 10 years. Recidivism is most pronounced in the initial years following release, declining significantly over time, as evidenced by a long-term study indicating cumulative rates of 9.1% at 5 years and 18.5% at 25 years.

- Juveniles with sex offense adjudications show lower sexual recidivism rates than adults convicted of sex offenses but have relatively high general recidivism due to non-sexual crimes.

- Females comprise a small proportion of the individuals convicted or adjudicated of sex offenses and demonstrate low rates of sexual recidivism.

- Factors such as younger age, prior arrests, and higher assessed risk levels correlate with higher rates of sexual recidivism.

- Cognitive-behavioral and tailored treatment programs have been shown to reduce recidivism rates, with meta-analyses reporting treated individuals showing rates of 9–10%, compared to 13–14% for untreated control groups, over follow-up periods of 6 to 7 years.

- Sexual recidivism rates are best understood as estimates of the true rate due to underreporting, differences in detection methods, varying justice outcomes, and factors such as follow-up duration and the timing of reoffending. Broader social and policy factors also influence recidivism trends, underscoring the need for adaptive policies and continuous program evaluation to enhance their effectiveness and ensure public safety.

SOMB Integration of Evidence-Based Policy and Practices

The SOMB has evolved its *Adult Standards and Guidelines and Juvenile Standards and Guidelines* over the past 30 years, incorporating emerging research to meet legislative directives. Key milestones include studies showing reduced recidivism among adults and juveniles following SOMB treatment, adopting Risk, Need, and Responsivity (RNR) principles, and ongoing adjustments based on audits and legislative reviews.

SOMB Recidivism and Desistance Outcomes Project

Mandated by House Bill 16-1345, the SOMB implemented the Provider Data Management System (PDMS) in 2020 to track client-level service data, using deidentified client information and optional consent for criminal recidivism matching. Since 2021, a summary of the service data has been presented in the SOMB annual legislative reports, with the next phase of the project being an analysis of recidivism and desistance outcomes.

The recidivism and desistance project involves a significant amount of preparatory work and data analysis, so it has been approached in stages. The first stage has focused on:

- Creating the SOMB recidivism and desistance outcomes dataset

- Describing the proportion of clients who have sexual, violent, and general recidivism post-treatment for those who successfully completed sex offense-specific treatment and those who were unsuccessfully discharged from sex offense-specific treatment

- Describing the types of recidivism evident in the charge and conviction data

- Describing recidivism and desistance outcomes by client demographics

The final sample included 1,004 individuals discharged from sex offense-specific treatment between October 2019 and January 2024 who consented to have their criminal recidivism data tracked for research. Key findings from this study include:

- A comprehensive dataset was developed to track recidivism outcomes for clients treated under the purview of the SOMB. This dataset was created in collaboration with the Office of Research and Statistics, focusing on charge and conviction recidivism outcomes for sexual, violent, and general offenses. The dataset appears representative of the larger client population in terms of key client demographics, risk level, and discharge types.

- Clients who successfully completed treatment exhibited low rates of sexual and violent recidivism, while higher rates were observed among those who were unsuccessfully discharged. For example, 1.1% of adult community clients who successfully completed treatment had a new sex offense charge within three years of discharge, and none had a new sex offense conviction. In comparison, 3.3% of those who were unsuccessfully discharged had a new sex offense charge, and 2.6% had a new sex offense conviction within the same timeframe.

- The recidivism rates for adult clients with unsuccessful discharges were comparable to state parole and probation samples, whereas clients who successfully completed treatment demonstrated much lower rates of recidivism.

- For adult clients in the Department of Corrections (DOC), sexual and violent recidivism after successful treatment completion reflected the reoffending of just one individual. Juvenile clients who successfully completed treatment showed no instances of sexual recidivism in either charges or convictions across the follow-up periods.

- Following treatment discharge, sexual recidivism among clients included many non-contact sex crimes like invasion of privacy and indecent exposure but also contact sex crimes including sexual assault and unlawful sexual contact. Many cases involved child sexual exploitation material (CSEM). Violent recidivism included serious offenses and numerous misdemeanors, with over a third of violent charges linked to a small number of individuals. A wider range of general recidivism encompassed property crimes, drug offenses, driving violations, breaches of protection orders, and sex offender registration failures, with most non-violent offenses resulting in misdemeanor charges.

- A review of recidivism patterns following treatment discharge showed that about two-thirds of reoffending by adult community clients occurred within the first year. The sole instance of sexual reoffending by an adult DOC client also took place in the first year post-discharge, with half of all reoffending occurring within this time frame. For juvenile clients, about one-quarter of violent reoffending occurred within the first year, and approximately one-third of all reoffending took place in the first year after discharge.

Progress toward desistance from sexual and violent recidivism remained high following treatment discharge. Key trends included:

- Females showed no sexual recidivism and minimal violent recidivism, indicating most were on a desistance trajectory.

- Race and ethnicity did not significantly differ among those who recidivated sexually, with American Indian/Alaska Native individuals showing no sexual recidivism and Hispanic or Latino individuals having fewer sexual offense convictions. Although the incidence of violent recidivism was higher among Black/African American and Asian or Pacific Islander individuals, these groups represented a small proportion of violent recidivists, and most were on a

desistance path by the end of the first year. American Indian/Alaska Native individuals had a higher rate of recidivism for charges only, though they made up a small percentage of recidivists.

- Recidivists were often younger, in keeping with the well-established age-crime curve. The findings also indicated lower educational levels and developmental or intellectual disabilities are treatment responsivity factors.

The current study faced several key limitations that may influence its findings:

- *Impact of Subgroup Size*: Smaller subgroups, namely adult DOC and juvenile data, were analyzed separately to avoid obscuring their outcomes within the larger adult community sample. However, this also increased the influence of individual cases on recidivism percentages and limited the feasibility of certain analyses for juvenile clients.

- *Parole and Discharge Interactions*: Successful discharge from treatment for adult DOC clients directly impacts parole decisions and recidivism opportunities. Recidivism analyses were not seen as valid for clients who did not successfully complete treatment, as they were unlikely to be released.

- *Interpretation of Unsuccessful Discharges*: While many individuals with unsuccessful discharges did not recidivate, interpreting this outcome is complex due to potential revocation hearings, temporary community removal, or redirection to alternative treatments also potentially influencing their recidivism rate.

- *Follow-up Accuracy*: Follow-up durations may be slightly inflated, as the length of follow-up data did not account for time spent in prison or other non-community periods, including time in jails. Future phases of the study aim to address some of these limitations.

- *Short Recidivism Study Period*: The study's average follow-up period was under three years, limiting the analysis of long-term sexual recidivism. Recidivism rates over two and three years were based on smaller, non-cumulative samples, potentially reducing their stability compared to one-year estimates.

Future stages of the project will extend analysis to recidivism during the treatment period and compare observed recidivism to risk-based estimates where possible. Analyses will incorporate evaluation and polygraph examination data to determine the impact of these interventions. Insights from this research will be used to refine the *Adult and Juvenile Standards and Guidelines*, improve treatment and monitoring outcomes, and potentially inform sentencing, policy, and legislation to uphold evidence-based practices and fulfill the SOMB's statutory mandate.

Section 2: Relevant Policy Issues and Recommendations

Modifications to Adult Treatment Standards

Historically, adults assessed as posing a very low risk of future sexual or violent recidivism and exhibiting minimal treatment needs have been recommended for alternative interventions outside the SOMB’s purview. In general terms, these alternative approaches emphasize psychoeducational

interventions focused on promoting healthy interpersonal boundaries, sexuality, and relationships. These differ in breadth and length from more standard sex offense-specific treatment. Proponents of this practice contend that standard treatment may be unnecessary for these individuals and inadvertently increase risk and undermine protective factors.

However, the SOMB and the Colorado Attorney General's Office have clarified that all individuals convicted of a sexual offense must adhere to SOMB-established *Adult Standards and Guidelines* and *Juvenile Standards and Guidelines*. Treatment services that deviate from these *Standards and Guidelines* constitute a violation and may potentially result in formal complaints against the Approved Treatment Provider.

With a broader legal purview that now includes cases previously directed toward alternative interventions, the SOMB is examining how this impacts the current *Adult Standards and Guidelines*. While the *Adult Standards and Guidelines* already allow for substantial treatment individualization and flexibility, there is a need to consider whether further modifications are warranted and possible, without jeopardizing victim safety considerations or the integrity of the standards. Distinctions between the *Adult* and *Juvenile Standards and Guidelines* and the differing client populations they serve make accommodating alternative treatment cases a greater challenge for the *Adult Standards and Guidelines*.

The SOMB Adult Standards Revision Committee convened a Treatment Modifications Workgroup in 2024 to examine the issues and propose potential evidence-informed strategies to address these cases better while preserving community safety and victim rights. Initial efforts have included discussions about the characteristics of alternative treatment cases and the apparent conflict with the existing adult standards, a literature review on research to inform treatment modifications, and a SOMB PDMS data analysis project to explore adjunct treatment approaches. The workgroup will continue to meet in 2025 to address the issues raised by alternative treatment cases. It will also consider potential recommendations to enhance guidelines around best practices for higher-risk cases as a function across the continuum of risk.

Reduction in Crime Victim Services Funding

Federal Victim of Crimes Act (VOCA) funding has declined sharply, from $56 million in 2018 to $13 million projected for 2024. This reduction significantly impacts over 200 victim service organizations statewide, including those addressing sexual violence recovery. Key services, such as post-conviction advocacy and therapy, face significant cutbacks, directly affecting the inclusion of Victim Representatives on sex offense-specific treatment Community Supervision Teams (CSTs) and Multidisciplinary Teams (MDTs). Inclusion of Victim Representatives is a requirement of the *Adult and Juvenile Standards and Guidelines*. Proposition KK, passed in Colorado in November 2024, introduces an excise tax to replenish crime victim service funding, with a maximum annual allocation of $30 million. This funding adjustment may offer some relief to victim service organizations, although immediate challenges remain due to the current funding shortfalls.

Section 3: Milestones and Achievements

In 2024, the SOMB made significant progress in fulfilling the mandates outlined in the SOMB reauthorization bill, Senate Bill 23-164, while also continuing to effectively manage its ongoing responsibilities. Notable accomplishments include:

- Presented the SOMB/DOC Treatment Solutions Report to the Joint Judiciary Committee and collaborated with the DOC Sex Offender Treatment and Management Program (SOTMP) to enhance accessibility to the SOTMP to the extent possible.

- Updated language to the *Adult Standards and Guidelines and Juvenile Standards and Guidelines* to comply with changes made in SB 23-164. Continuing to progress changes to the policy and processes related to supervising agencies providing adult clients access to a complete list of Approved Providers with the expertise to work with their specific risks and needs.

- Established a Determinate Sentence Workgroup to update the release guidelines for adult parole.

- Developed the additional administrative and technical resources to adhere to the requirement to conduct compliance reviews on a minimum of 10% of Approved Providers every two years, beginning September 1, 2024.

- Continued priority was given to supporting culturally responsive care by the SOMB provider community.

- Undertaken the second phase of the ODVSOM recruitment and retention project involving the development of outreach strategies and materials by Orange Consulting, ensuring these are appealing and reach upcoming professionals from diverse groups.

- Engaged in multiple outreach strategies to connect with providers, stakeholders, and the community.

- Managed 13 SOMB committees and workgroups.

- Conducted multiple research reviews and data analysis projects to support the work of the SOMB committees and inform the provider community.

- Managed 273 applications for placement or continued placement on the SOMB Approved Provider List.

- As of November 2024, there are 231 adult treatment providers and 158 juvenile treatment providers approved by the SOMB in Colorado. There are 25 adult polygraph examiners and 13 juvenile polygraph examiners.

- Every Colorado county has an SOMB Approved Provider for adult evaluation, treatment, and polygraph examination. All judicial districts have an SOMB Approved Provider for juvenile evaluation, treatment, and polygraph examination.

- Continued to optimize the ODVSOM shared services model, including development of the Implementation Specialist roles with specialized training and certification.

- Prioritized ongoing implementation of the *Adult Standards and Guidelines and Juvenile Standards and Guidelines* through the SOMB training hub, staff positions as Implementation Specialists, a range of communication strategies, training, and research.

- Hosted the Annual Office of Domestic Violence and Sex Offender Management (ODVSOM) conference in July 2024, which was fully subscribed with over 500 in-person attendees.

- Conducted 33 training events with over 1,400 attendees from across Colorado.

Together, these efforts underscore the SOMB's steadfast commitment to advancing public and victim safety through effective treatment, education, and collaborative partnerships across the state.

Introduction

Purpose

This annual report presents findings from an examination by the Sex Offender Management Board (SOMB) of best practices for the treatment and management of adults and juveniles who have committed sexual offenses.

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

This report fulfills the statutory mandate by providing:

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

This report also documents the 2024 achievements and current efforts being undertaken by the SOMB.

Background of the Sex Offender Management Board

In 1992, the Colorado General Assembly passed legislation (§ 16-11.7-101 through § 16-11.7-109, C.R.S.) establishing a Sex Offender Treatment Board. As per the legislative mandate, the Board developed the *Standards and Guidelines for the Assessment, Evaluation, Treatment and Behavioral Monitoring of Adult Sex Offenders* (henceforth the *Adult Standards and Guidelines*). In 1998, the General Assembly changed the name to the SOMB as it better reflected the duties assigned to the Board.

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

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

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

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

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

The following is a list of the SOMB committees:

1. Executive Committee

2. Best Practices Committee

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

Report Organization

The annual legislative report is divided into four sections. The first section gives an overview of key research and evidence-based practices that are informing updates to the *Adult Standards and Guidelines* and *Juveniles Standards and Guidelines*. The second section focuses on relevant policy issues that may be of interest to the legislature. The third section highlights the accomplishments of the SOMB in the year 2024. The fourth and final section briefly highlights the future goals and directions of the SOMB.

Section 1: Research and Evidence-Based Practices

The Sex Offender Management Program (SOMB) is statutorily mandated in § 16-11.7-101(2), C.R.S., to create evidence-based standards for the evaluation, treatment, management, and monitoring of adults convicted of sex offenses and juveniles adjudicated of sex offenses. The primary aim of the Standards and Guidelines for the Assessment, Evaluation, Treatment and Behavioral Monitoring of Adult Sex Offenders (henceforth the *Adult Standards and Guidelines*) and the Standards and Guidelines for the Evaluation, Assessment, Treatment and Supervision of Juveniles Who Have Committed Sexual Offenses (henceforth the *Juvenile Standards and Guidelines*) is to prevent reoffending and to enhance the protection of victims and potential victims. To ensure the *Adult Standards and Guidelines* and *Juvenile Standards and Guidelines* reflect evidence-based best practices, the SOMB reviews relevant research literature and conducts research projects using SOMB data.

The following sections highlight significant work undertaken by the SOMB in 2024 to fulfill its statutory mandates to evaluate the effectiveness of the standards and guidelines. First, research on sexual recidivism for male adults, juveniles, and females is summarized. Understanding these rates for individuals convicted or adjudicated of sex offenses provides important context for the SOMB's efforts and establishes points of reference for comparing service-related outcomes. Second, the initial phase of the SOMB recidivism and desistance outcomes project is described, which involves tracking the recidivism outcomes for individuals who received treatment services under the purview of the SOMB. The related accessible data tables are provided in **Appendix A**, while supplementary tables are provided in **Appendix B**.

In prior SOMB annual reports, Section One presented the critical data collected through the SOMB Provider Data Management System (PDMS) regarding evaluations, treatment, and polygraph examinations. For brevity, **Appendix C** presents the critical information for individuals discharged during 2024. **Appendix D** provides the related accessible data tables, and **Appendix E** includes supplementary tables.

Sexual and Violent Recidivism

Treatment programs for sexual offending are designed to address the complex psychological, behavioral, and social factors contributing to sexually abusive and criminal behaviors. Primary outcomes sought from these programs include reducing the risk of reoffending, enhancing participants' understanding of their behaviors, and promoting healthy interpersonal relationships. An essential focus of these programs is the protection of potential victims and the support of healing processes for those who were the victims of the sexual offending. By equipping the offending individuals with coping strategies, cognitive-behavioral techniques, and insights into their motivations, these programs aim to foster long-term behavioral change, reintegration into society, and a commitment to preventing future harm.

Among the various outcomes evaluated in the context of sex offending treatment, recidivism stands out as a critical indicator of program effectiveness. Recidivism refers to whether previously convicted

individuals reoffend, and its measurement provides valuable insights into the long-term impact of treatment interventions (NIJ, 2024). A reduction in recidivism rates not only indicates effective rehabilitation and sentence management but also enhances community safety and supports public confidence in the criminal justice system. Consequently, monitoring and analyzing recidivism outcomes, alongside the commitment to victim protection and support, is essential for assessing the efficacy of treatment programs and informing future practices in the field.

Summary of Literature and Research

A significant body of research has been conducted on the recidivism rates and patterns of individuals who have been previously convicted of offenses. Recidivism refers to reoffending after a formal sanction or intervention for a prior crime (NIJ, 2024). Researchers typically measure recidivism by examining a specific time frame, ranging from a conviction or release date to a particular follow-up point, such as three years later or until criminal justice records are pulled. The definition of a recidivist event varies across studies and can include a new arrest, charge (filing), conviction, or return to prison (Alper et al., 2018). Some studies concentrate on specific types of recidivism, such as sexual or violent recidivism, while others focus on any new offense.

Recidivism contrasts with desistance, which describes the process by which criminal behavior, or the risk of future criminal behavior, decreases as individuals mature during adulthood (Rocque, 2021). Desistance is characterized by significantly fewer or no further arrests, charges, or convictions over time (Alper et al., 2018). There has been less research on desistance, and discussions regarding the best methods to measure or study it within criminal justice populations are still evolving. Researchers have noted that understanding desistance in sexual offending as a process presents challenges because even a small residual risk is concerning, as it can lead to the severe consequences of sexual victimization. Some researchers have suggested that a reasonable threshold for desistance is when the risk of sexual recidivism becomes equal to or lower than the risk posed by individuals with no prior history of sex offenses (Hanson et al., 2018).

When evaluating recidivism rates across studies, several factors to recognize include:

- **Detection rates.** The observed sexual recidivism rate is a significant underestimate of the true sexual recidivism rate, as sexual offenses are frequently not reported to law enforcement, or cases do not proceed through the criminal justice system to conviction (Abbott, 2020; Drury et al., 2020; Scurich & John, 2019). While the overall rate of undetected sexual offending is estimated to be up to twenty times greater than the arrest rate, little is known about the undetected recidivism rate amongst persons previously detected for sex offending (Bourke et al., 2015; Drury et al., 2020; Kelley et al., 2024; Lisak & Miller, 2002; Weinrott & Saylor, 1991).[1] The nature of sexual victimization also fundamentally differs from other crimes,

[1] Most studies that explore undetected sex offending do not differentiate between offenses committed before the first arrest and recidivist offending. These two rates may differ as arrest may be more likely when a suspected individual is known to authorities, has a criminal record, and is subject to community notification or registration (Helmus, 2021; Lave et al., 2021). In a recent US study of individuals under Sexual Violent Predator (SVP) statute there were more undetected victims prior to first conviction than at reconviction (Kelley et al., 2024). About one-third of the recidivists had no undetected victims, while a small proportion had an extraordinary number of undetected victims.

leading to some types of sex offenses having higher reporting rates than others (Drury et al., 2020; Chen & Ullman, 2010).

- **Recidivism measure.** The way recidivism is measured significantly impacts reported rates. Arrest rates are generally higher than charges (filings) since not all arrests lead to charges being brought. However, this difference may not be as pronounced in cases of sexual recidivism where the suspected individual is known to authorities (Helmus, 2009; Lave et al., 2021). Conviction rates are usually lower than charges (filings) because some charges may be amended or dropped, and not all cases result in conviction.

- **Length of follow-up.** More extended follow-up periods increase the likelihood of detecting reoffending and capturing later occurring relapses of sex offending. The increased detection of an individual as a recidivist over longer follow-ups may reflect the higher chance of at least one reoffense being reported or detected if repeat reoffending is occurring. A more extended timeframe also accounts for the time the criminal justice system takes to process filings and convictions.

- **Speed of recidivism.** Research shows that the rate of sexual recidivism is highest in the first few years in the community and decreases the longer an individual remains offense-free. For example, a comprehensive long-term study that analyzed data from multiple countries found the sexual recidivism rate was 9.1% at 5 years, 13.3% at 10 years, 16.2% at 15 years, 18.2% at 20 years, and 18.5% at 25 years (Hanson et al., 2018). This study shows that while the cumulative recidivism rate increased over time, a greater proportion of reoffending occurred within the initial five years of follow-up.

- **Policy and period effects.** Research increasingly indicates that broader macro-level factors play a role in the recidivism rates reported across different follow-up periods. For example, social and policy changes, technological advances, and the evolution of preferred research methodologies may all impact recidivism rates over time (Lussier et al., 2024).

Review of Recidivism Studies Focused on Adult Male Offenders

Several studies have examined the rate of recidivism for prisoners released across multiple states within the United States. In the most comprehensive survey, Antenangeli and Durose (2021) examined the rearrest rate of state prisoners released across 24 states in 2008 over a ten-year follow-up period.[2] The study estimated recidivism rates for a representative sample of 400,000 released prisoners, representing 69% of all persons released from state prisons in 2008 nationwide. The prisoners were 40% Non-Hispanic White, 37% Black, 21% Hispanic, 1% American Indian/Alaska Native, and less than 1% Asian/Native Hawaiian/Other Pacific Islander. Approximately 90% were male. In this large sample, 4% were incarcerated for rape or sexual assault of an adult or child.[3] For that group, 6% were rearrested

[2] The study included prisoners released from Colorado.

[3] Rape or sexual assault included forcible sexual acts and nonforcible sexual acts such as statutory rape, incest with a minor, or where someone was unable to give legal or factual consent due to intellectual or physical disability or intoxication. It did not include the possession, production, or distribution of child sexual exploitation materials (CSEM).

with a new rape or sexual assault offense during the ten-year follow-up, while their rate of violent recidivism was 26% and any recidivism 63%.[4]

In a related study, Alper and Durose (2019) examined the recidivism rates of released prisoners whose most serious offense was rape or sexual assault, comparing them to all other released prisoners. The data was from 30 state prisons and tracked outcomes from 2005 to 2014. The sample was 53% White, 27% Black, 17% Hispanic/Latino, and 3.5% from other race-ethnicities. Approximately 90% were male. During the nine-year follow-up, 7.7% of those originally incarcerated for sexual offenses were rearrested for a new sex crime. The cumulative rearrest rate steadily increased from 1.9% at one year, 3.5% at two years, 4.4% at three years, 5.1% at four years, and 5.9% at five years. Younger individuals were more likely to be rearrested for sex offenses than their older counterparts. The rate of violent recidivism was 28%, while any recidivism was 67%. About half were rearrested for any new offense within the first three years of release, with 28% reconvicted.

An older study by Langan et al. (2003) analyzed the recidivism rates of individuals convicted of a sex offense released across 15 state prisons in 1994, with a follow-up period of three years. The study included 9,691 men, representing approximately two-thirds of all men with sex offense convictions released from state prisons that year. Nearly half (44%) of the men were imprisoned for sex offenses against children. The demographic breakdown was 67% White, 32% Black, and 1% from other racial and ethnic backgrounds, with 20% Hispanic and 80% non-Hispanic. Over the three years, 5.3% were rearrested for a new sex crime, while 3.5% were reconvicted for a new sex crime.[5] Among the men who had been released after serving time for sex offenses against children, 3.3% were subsequently rearrested for another sex offense against a child, with most victims being 13 years or younger.[6]

Factors associated with sexual recidivism included a greater number of prior arrests for any crime, as well as more prior arrests for sexual offenses.[7] The oldest age group had a lower rate of sexual recidivism compared to all younger age groups. No clear connection was observed between the length of time served in prison and sexual recidivism. The sexual recidivism rates were similar between Black and White released prisoners while marginally lower for Hispanic prisoners.[8] Men imprisoned for sexual offenses were about four times more likely to commit a new sex crime during the follow-up period than men who had been incarcerated for non-sexual convictions. In contrast, the rate of general recidivism was lower for those with sexual convictions (43%) compared to those with non-sexual convictions (68%).

Some studies have focused on the recidivism rates associated with child sexual exploitation materials (CSEM). Cohen and Spidell (2016) studied 7,416 men with sex offense convictions released from federal prison and placed on supervision. The study spanned 94 federal judicial districts between 2007 and

[4] The rate of any new rearrest reported for each year of the follow-up period for individuals incarcerated for a sex offense was 28% at one year, 46% at three years, 54% at five years, and 63% at ten years.

[5] The first year following release accounted for 40% of the new arrests for sex crimes committed, while the second year accounted for 75%.

[6] This does not mean all the new sex offenses against children were committed by men with similar previous convictions; there were instances committed by men with different prior sex offenses.

[7] Men released who had two prior arrests for a sex crime (i.e., the one leading to the current period of imprisonment and an earlier arrest) were about twice as likely to be rearrested for another sex crime than those who were serving their imprisonment for a first sex crime.

[8] It was noted that some Hispanic men were deported following their release which may have influenced the recidivism rate.

2013. The sample contained 60% with a CSEM conviction and 14% with a sexual abuse or assault conviction. Notably, 95% of the men with CSEM convictions were White. Over three years of supervision, the rate of rearrest for a sexual offense was 2.6% for those with a CSEM conviction and 2.2% for those with a sexual abuse or assault conviction.[9] Additionally, the probation revocation rate was 11.6% for individuals with CSEM convictions compared to 38.5% for those with sexual abuse or assault convictions.

Many individuals convicted of a sexual offense receive community sentences instead of prison, or also serve parole in the community following incarceration. A study by Lee et al. (2016) examined the recidivism rates of individuals convicted of a sex offense who began parole or community probation in California between 2009 and 2010. The study contained 1,626 men, with 74% being parolees and 26% probationers. Approximately 38% of the men were White, 22% were Black, 34% were Hispanic, and 6% belonged to other racial or ethnic groups.[10] Over the five-year follow-up period, 5.1% of the sample were rearrested for a new sex offense. Probationers had a sexual recidivism rate of 7.0%, while parolees had a rate of 4%. The study found that the rates of sexual recidivism increased with higher assessed risk, with a 1.1% sexual recidivism for individuals evaluated as low-risk and a 21.1% rate for those evaluated as high-risk. In a similar study of parolees released between 2006 and 2007, the five-year sexual recidivism rate was 6.2%, while the ten-year rate was 10.4% (Lee et al., 2018). The five-year recidivism rates steadily increased by assessed risk level, ranging from 0% for the lowest risk group to 1.4%, 2.2%, 10.8%, and 30.3% for progressively higher-risk groups.

The Office of Research and Statistics at the Colorado Department of Public Safety conducted a study examining sexual recidivism among a cohort of 4,698 adults who had either a conviction or a deferred judgment for a sex offense between 1999 and 2008 (English et al., 2023). This group consisted of first-time offenders in Colorado who were sentenced for crimes that made them eligible to be designated as Sexually Violent Predators (SVPs) according to § 18-3-414.5, C.R.S. The sample excluded individuals who were prequalified for an SVP application due to prior sexual offenses, likely omitting the highest-risk subgroup. The sample was predominantly male (97%) and White (74%). Over an eight-year follow-up period in the community, the rate of new charges related to sexual offenses was 4%, while the rate for either sexual or violent offenses was 10%.

Another area of study that receives attention is the impact of treatment programs on sexual recidivism. Holper et al. (2024) conducted a meta-analysis of 35 evaluations of treatment programs for males convicted of sexual offending that included a treatment and a control group. The average sexual recidivism rate associated with the treatment programs was 9.3% over 6.7 years, compared to 13.6% for the control comparisons. Gannon and colleagues (2019) conducted a meta-analysis of 44 treatment evaluations, finding that the average sexual recidivism rate for treatment programs was 9.5% over 6.3 years and for control groups was 14.1%.[11] Both meta-analyses found significant heterogeneity among the included studies. The studies covered a span of several years (1988–2021), which means some of the programs may differ from current approaches. Since the studies were also conducted in various countries, the recidivism rates may be influenced by differences in criminal justice systems and contextual factors specific to each time period.

[9] Sexual recidivism was any new arrest for a violent or non-violent sexual offense over three years. It excluded technical violations of the conditions of supervision.

[10] The race-ethnicity was provided for a subsequent study group that contained an additional 475 men.

[11] Both meta-analyses were conducted independently, though some studies overlapped.

Table 1. Summary of Reviewed Adult Male Recidivism Studies.

Authors	Study	Recidivism Rates
Antenangeli & Durose (2021)	• All state prisoners released across 24 states in 2008 • 10-year follow-up	• 6% sexual recidivism (arrest) • 26% violent recidivism (arrest) • 63% any recidivism (arrest)
Alper & Durose (2019)	• All state prisoners convicted of a sexual offense, compared to all other prisoners, released across 30 states in 2005 • 9-year follow-up	• 7.7% sexual recidivism (arrest) • 28% violent recidivism (arrest) • 67% any recidivism (arrest)
Langan et al. (2013)	• All state prisoners convicted of a sexual offense released across 15 states in 1994 • 3-year follow-up	• 5.3% sexual recidivism (arrest) • 3.5% sexual recidivism (conviction) • 43% any recidivism (new arrest)
Cohen & Spidell (2016)	• Federal prisoners released between 2007-2013 and serving three or more years federal supervision • 60% convicted for CSEM	• 2.6% sexual recidivism (arrest) when prior CSEM conviction; 11.6% revocation • 2.2% sexual recidivism (arrest) when prior sexual assault conviction; 38.5% revocation
Lee et al. (2016)	• California parolees and probationers released or sentenced between 2009-2010 • 5-year follow-up	• 5.1% sexual recidivism (arrest) • Parolees 4% sexual recidivism • Probationers 7% sexual recidivism
Lee et al. (2018)	• California parolees released between 2006-2007 • 5 and 10-year follow-up	• 6.2% sexual recidivism (arrest) over an average 5 years • 10.4% sexual recidivism (arrest) over an average 10 years
English et al. (2023)	• Colorado parolees and probationers sentenced between 1998–2008 • Excluded subgroup with prior sex offense conviction who automatically eligible for SVP application • 8-year follow-up	• 4% sexual recidivism (charge) • 10% violent and sexual recidivism (charge)
Holper et al. (2024)	• Meta-analysis of sex offending treatment outcome studies published 1983-2021 • Variable study years, follow-up periods, and recidivism measures • Average 6.7 years follow-up	• Average 9.3% sexual recidivism for treatment groups • Average 13.6% sexual recidivism for control groups
Gannon et al. (2019)	• Meta-analysis of sex offending treatment outcome studies published 1986–2018 • Variable study years, follow-up periods, and recidivism measures • Average 6.3 years follow-up	• Average 9.5% sexual recidivism for treatment groups • Average 14.1% sexual recidivism for control groups

Summary

Table 1 summarizes the key findings from the studies on adult male recidivism in this review. As can be seen, there is no single benchmark for sexual recidivism rates. The sexual recidivism rates in routine state parole and probation studies in the United States ranged from 3.5% to 10% over follow-up periods of three to ten years. The rate of sexual recidivism in a federal population predominantly convicted of CSEM offenses was 2.6% over three years. Routine samples are generally representative of the broader population of individuals convicted of sexual crimes. Although many individuals in the routine samples may have participated in treatment programs, those studies do not explicitly identify the impact on risk reduction. Routine samples differ from preselected treatment samples, which examine risk reduction effects but may be biased toward higher-risk individuals due to treatment prioritization. Recent meta-analyses showed that the overall sexual recidivism rate for adult men in treatment samples was between 9% and 10%, with an average follow-up period of six to seven years.

Review of Recidivism Studies Focused on Juvenile and Female Offenders

Juveniles adjudicated for sexual offenses are subject to separate SOMB *Juvenile Standards and Guidelines*. These recognize adolescents' distinct developmental and life circumstances, considering variations in motivations, behavior patterns, and offending trajectories for juveniles. Research indicates that many juveniles who commit sexual offenses are adolescent-limited, while a smaller group continues to sexually offend in adulthood (Lussier, 2017). Research also indicates that many juveniles who commit sexual offenses also engage in other criminal activities as part of adolescent-limited and adult persistent trajectories (Lussier et al., 2012, 2015; Ozkan et al., 2020).

In an extensive meta-analysis by Lussier et al. (2024) on the sexual recidivism rate of juveniles (Count 25,765), the average rate was 8% over a follow-up period of 5.3 years. Of note, the meta-analysis drew primarily from studies conducted in the United States. For those studies with follow-ups that began between 2000 and 2009 (Count 6,784), the rate was 5% over 5.4 years.[12] The cumulative recidivism rate increased during the first four years of follow-up, after which it remained stable. The average rate of general recidivism was 42%, indicating that a significantly larger proportion of juveniles reentered the criminal justice system for non-sexual offenses rather than for sexual crimes. In a similar meta-analysis, Caldwell (2016) reported that the average sexual recidivism rate for juveniles was 2.75% over an average of 3.7 years, based on follow-up periods that started between 2000 and 2015. In that meta-analysis, the middle 75% of studies published from 1928 to 2015 showed sexual recidivism rates ranging between 3% and 9.5% over an average follow-up of 5.2 years.

Kettrey and Lipsey (2018) examined the impact of specialized treatment programs on recidivism rates among predominantly male juveniles who had committed sex offenses. The study focused on evaluations that included matched control groups. The rates of sexual recidivism for the juveniles in the treatment groups ranged from 0% to 12.7%, while the control groups showed rates between 3.7% and 75%. The follow-up periods varied from 1 to 6.3 years. Regarding general recidivism, the treatment groups had rates ranging from 19% to 54%, whereas the control groups exhibited rates from 17% to 75%.

Females convicted or adjudicated for sexual offenses represent a small subgroup, making up approximately 3% of clients seen by treatment providers under the purview of the SOMB (Collie et al.,

[12] The reason to consider recidivism rates by different time periods is that research indicates rates can vary due to policy changes affecting the functioning and response of the criminal justice system (such as treatment and supervision approaches) and social changes.

2023, 2024). Females are subject to the same *Adult Standards and Guidelines* and *Juveniles Standards and Guidelines* as their male counterparts. However, services must be individualized and consider variations in the pathways to offending and associated risks and needs that often differ between males and females who commit sex offenses. In the only meta-analysis on sexual recidivism rates for females, Cortoni et al. (2010) found the rates ranged from 0–11%. On average, the rate was 2% over a mean follow-up period of 6.5 years based on ten studies. When an outlier was excluded, the average rate was 1% across the remaining nine studies (Count 2,416).[13]

More recent research by Epperson et al. (2018) examined the sexual recidivism rates among all 1,699 females on the California Sex Offender Registry up until June 2016. The overall sexual recidivism rate was 4.5%. Specifically, the rate for the 717 women sentenced to probation was 6%, while it was 2.5% for the 982 on parole. For the cohort registered between 2000 and 2009, the recidivism rate was 3.6% with a follow-up period of 7 to 16 years. For the cohort registered between 2010 and 2016, the recidivism rate was 2.1%, with a follow-up period of 0 to 6 years. In a similar study, Ghossoub and El Harake (2023) examined the sexual recidivism rate of all 532 females registered on the Missouri Sex Offender Registry. The sexual recidivism rate was 0.6% (3 females), with two cases of recidivism after eight years on the registry and one case after 16 years.[14] A study that examined 243 women who were released from Texas State Prison between 2008 and 2014 found the sexual recidivism rate was 0.4% over an average follow-up of 5.7 years (Marshall et al., 2022). In that study, about one-third of the women were rearrested for any new offense.[15]

Table 2a summarizes the key findings from the studies on juvenile male sexual recidivism in this review. As can be seen, the rate ranges widely between different studies and cohorts. Findings concerning more recent study periods estimate the rate to be between 3% and 5% over three to five years of follow-up.

Table 2b summarizes the key findings from the studies on female sexual recidivism in this review. As can be seen, the rate of sexual recidivism is low for females with a sexual offense conviction. Findings estimate the rate to be between 1% and 4% over seven or more years of follow-up.

[13] One study reported a sexual recidivism rate of 11%, which was an outlier from the other studies, in part due to including a broad range of prostitution related offending that is not typically included within recidivism studies of either male or female offenders. When included, the average sexual recidivism rate was 2%; when excluded, it was 1%.

[14] The study did not report the average follow-up time across the sample. However, the sexual offenses leading to registration were between 1979 and 2020 indicating follow-up varied over 30 years.

[15] In a separate but overlapping study, women convicted of a sexual offense and released between 2000 and 2014 had a sexual recidivism rate of 3.5% (Count 739) over an average 7-year follow-up (Marshall et al., 2021). Differences between these overlapping studies that may affect the reported recidivism rates are that the Marshall et al. (2022) study included a more recent cohort of releases (i.e., from 2008 to 2014), and the women had a greater proportion of index offenses committed against a child than an adult.

Table 2a. Summary of Reviewed Juvenile Recidivism Studies.

Authors	Juvenile Studies	Recidivism Rates
Lussier et al. (2024)	• Meta-analysis of longitudinal juvenile recidivism studies between 1949 and 2019 • Analyzed by cohorts • About two-thirds from United States	• 8% sexual recidivism over 5.3 years • Sexual recidivism rate increased up to 4 years and then stable • 2000-2009 cohort: 5% sexual recidivism over 5.4 years
Caldwell (2016)	• Meta-analysis of juvenile recidivism studies between 1928 and 2015	• 75% of studies reported sexual recidivism between 3% and 9.5% over an average 5.2 years • 2000-2015 cohort: 2.75% sexual recidivism over average 3.7 years
Kettrey & Lipsey (2018)	• Reviewed higher quality evaluations of specialized treatment for juveniles who sexually offended • Follow-up ranged from 1 to 6.3 years	• 0% to 12.7% sexual recidivism among juveniles in treatment programs • 3.7% to 75% sexual recidivism among juveniles in the control groups

Table 2b. Summary of Reviewed Female Recidivism Studies

Authors	Female Studies	Recidivism Rates
Cortoni et al. (2010)	• Meta-analysis of female sexual recidivism	• 1-2% sexual recidivism over average 6.5 years follow-up • Range 0-11% sexual recidivism
Epperson et al. (2018)	• All females on the California Sex Offender Registry up until June 2016	• 4.5% sexual recidivism; 6% probationers, 2.5% parolees • 2000-2009 cohort: 3.6% sexual recidivism (follow-up 7-16 years) • 2010-2016 cohort: 2.1% sexual recidivism (follow-up 0-6 years)
Ghossoub & El Harake (2023)	• All females on the Missouri Sex Offender Registry	• 0.6% sexual recidivism • Reoffenses committed at 8 and 16 years
Marshall et al. (2022)	• Females released from Texas State Prison between 2008 and 2014 with an LSI-R	• 0.4% sexual recidivism over average follow-up 5.7 years • Approximately one-third any recidivism

SOMB Integration of Evidence-Based Policy and Practices

The current *Adult Standards and Guidelines* and *Juvenile Standards and Guidelines* represent a significant evolution from earlier directives and policies established by the SOMB over its thirty-year tenure. Each set of *Standards and Guidelines* are progressively revised each year based on the emerging literature and research in this specialized field. This enacts the Colorado Legislature directive that "The board shall revise the guidelines and standards for evaluation, identification, and treatment, as appropriate, based upon the results of the board's research and analysis." The latest versions of these *Standards and Guidelines* demonstrate a continued commitment to fulfilling this legislative requirement.

Significant milestones in the evolution of these *Standards and Guidelines* include:

- A 2011 evaluation of recidivism rates among adults with sexual offense convictions who were successfully discharged from their probation or parole sentence between July 1, 2005, and June 30, 2007. This evaluation tentatively supported the notion that treatment provided under the *Adult Standards and Guidelines* contributed to low rates of sexual recidivism.

- An evaluation conducted in 2013 that assessed the recidivism rates of juveniles adjudicated for sexual offenses before and after the introduction of the *Juvenile Standards and Guidelines*. The evaluation found a significant reduction in sexual, violent, and other types of recidivism following the implementation of these guidelines.

- Completion of an external evaluation in 2013 of the Adult *Standards and Guidelines and Juvenile Standards and Guidelines*, as directed by the Colorado Legislature. The major outcome was a comprehensive review of the *Adult Standards and Guidelines* and *Juvenile Standards and Guidelines* to align them with the Risk, Need, and Responsivity (RNR) principles as substantiated by empirical literature. The shift toward the RNR principles has resulted in the consistent use of validated risk assessments, a greater focus on dynamic risk factors related to sexual recidivism, and improved individualization of treatment.

- A series of Sunset Reports conducted by the Department of Regulatory Agencies in 2011, 2016, and 2022 have each prompted modification of the *Adult Standards and Guidelines* and *Juvenile Standards and Guidelines* based on input from stakeholders.

- A legislative audit conducted by the Office of the State Auditor in 2020 led to additional modifications to Board processes and procedures.

The confluence of these events has fundamentally influenced the policy landscape and has resulted in the current framework for the evaluation, assessment, treatment, and behavioral monitoring of individuals who are sentenced under the SOMB *Standards and Guidelines*. As part of the continued commitment to enacting evidence-based policies, the SOMB is invested in collecting pertinent information about the services offered to individuals seen under its purview and evaluating longer-term outcomes including recidivism.

SOMB Recidivism Outcomes Project

Background

In 2016, during the sunset report process, the General Assembly and other stakeholders recognized the importance of collecting client-level service data to assess the effectiveness of SOMB policies, in keeping with the SOMB's statutory requirement that *Adult Standards and Guidelines* and *Juvenile Standards and Guidelines* be evidence-based (see § 16-11.7-103 (4)(e), C.R.S.). The General Assembly passed House Bill 16-1345, which required the SOMB to develop a plan for collecting data from SOMB Approved Providers who offer services to adults convicted and juveniles adjudicated for sex offenses. Data collection was set to commence once funding became available. The 2017 SOMB Annual Legislative Report discussed the data collection plan.

Based on the receipt of funding, the Colorado Department of Public Safety developed the SOMB PDMS, which was officially implemented on January 1, 2020.[16] Per the plan, each Approved Provider submits service information on evaluation, treatment, and polygraph examinations at the time of service completion, regardless of the outcome of the service.[17] Approved Providers enter client information in a deidentified format, meaning that no names or birth dates are recorded. Approved Providers are requested to seek a release of information consent from clients to allow the criminal recidivism data to be matched in the future. If the client grants consent, a unique court case identifier is linked to the client record. If consent is not given, the provider can still enter the service information without adding the unique linking identifier.

A description of the evaluation, treatment, and polygraph examination services provided by Approved Providers from data recorded in the PDMS has been included in the annual legislative reports since 2021.[18] These legislative reports highlight the quantity of data entered and services offered, client demographics, RNR characteristics of services and clients, and the types of discharges from services clients receive. The SOMB's longer-term outcome project represents the next phase in the data collection plan, focusing on recidivism and desistance outcomes for individuals who received evaluation, treatment, and polygraph examination services from SOMB Approved Providers.

Project Objectives

The overall objective of this project is to provide a comprehensive analysis of recidivism and desistance outcomes for both adults convicted of sex offenses and juveniles adjudicated for sex offenses seen under the purview of the SOMB *Adult Standards* and *Guidelines and Juvenile Standards*

[16] Of note, Approved Providers had the option to enter data from October 1, 2019, although it was not required as part of the Adult Standards and Guidelines or Juveniles Standards and Guidelines until January 1, 2020. Data entered before the official start date has been retained in the database.

[17] Each type of service arises from a separate referral of the client and is entered as its own unique record.

[18] Provider compliance with data entry requirements has increased significantly over the years since the introduction of the PDMS in conjunction with the implementation support undertaken by SOMB staff. As indicated in the 2024 SOMB Annual Legislative Report, less than 20 Providers (6%) had yet to enter data. The SOMB has identified that one reason is that some providers are currently not seeing clients in their practice.

and Guidelines. A related objective is to evaluate and refine the process to develop a robust research methodology that will enable these analyses to be conducted at regular intervals in the future.

The project involves a significant amount of preparatory work and data analysis, so it has been approached in stages. In this first stage, the focus is on:

- Creating the SOMB recidivism and desistance outcomes dataset.
- Describing the proportion of clients who have sexual, violent, and general recidivism post-treatment for those who successfully completed sex offense-specific treatment and those who were unsuccessfully discharged from sex offense-specific treatment.[19]
- Describing the types of recidivism evident in the charge and conviction data.
- Describing recidivism and desistance outcomes by client demographics.

Future stages of the project will include analysis of recidivism committed during the treatment period, comparing the observed recidivism rates against expected rates based on risk level where possible, and examining the impact of evaluation and polygraph examination interventions. Knowledge gained from this project will inform further refinement of the *Adult and Juvenile Standards and Guidelines* to increase the effectiveness of evaluation, treatment, polygraph examinations, and behavioral monitoring.

Method

Number of Clients in Analysis

The sample used in the analyses contained 1,004 individuals who were discharged from sex offense-specific treatment and recorded in the PDMS between October 2019 and January 1, 2024.[20] Of those, 45 were juveniles under 18 years, while the remainder were adults.

As shown in **Figure 1**, the data cleaning process began with an initial number of 2,527 client treatment records extracted from the PDMS. All client data was entered in a deidentified manner, and only cases that had granted a release of information consent had a unique linking court identifier that could be used to match criminal recidivism records. Removing duplicate records and those without a unique linking identifier reduced the number to 1,156 records.[21] Three additional records were excluded as they were missing a treatment discharge date. From those records, 1,004 were successfully matched to a Colorado criminal record.

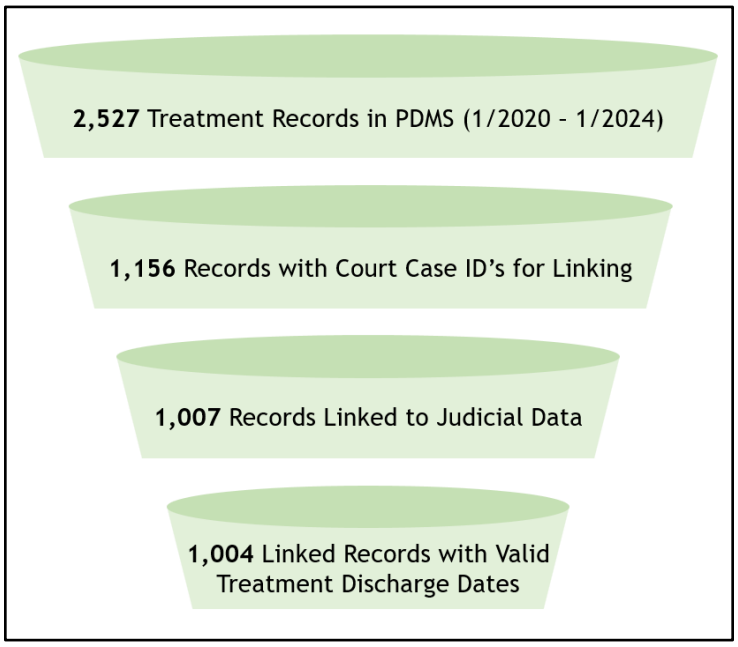
[19] Focusing on post-treatment outcome is consistent with the proposed standardized definition of recidivism pursuant to § 24-33.5-536, C.R.S.

[20] The PDMS officially launched on January 1, 2020. However, some Approved Providers began entering data in October 2019 as part of the rollout and this data has been retained in the PDMS.

[21] The uptake of clients providing consent to release information for the purposes of recidivism follow-up has increased over the time the PDMS has been operational, from less than half in the first two years to over half in these last two years. Approved Providers have responsibility for covering this consent request in their own service contracts with clients. Implementation support for this process is provided by SOMB staff.

The reduction in client records between initial data extraction and the final sample necessitated examining key demographic and risk characteristics of the final sample and the initial total sample, as shown in **Table 3** and **Table 4**. The final sample resembled the total sample in gender, race/ethnicity, and developmental or intellectual disability, although it was marginally older and better educated. The final and initial samples did not differ significantly on risk level or treatment discharge types.

Figure 1. Number of Treatment Records Extracted from the PDMS and Included in the Analyses. For Data Table See Appendix A.F1.



Client Subtypes: Treatment Setting and Adult or Juvenile Status

The data are presented by the subtypes of adults who received treatment in the community, adult who received treatment in a DOC facility, and juveniles.[22] Adults received treatment under the purview of the SOMB *Adult Standards and Guidelines*, whereas juvenile clients were under the age of 18 at the time of their offense and received treatment under the purview of the SOMB *Juvenile Standards and Guidelines*. Of note, about a quarter of the juveniles were 18 years at the time of discharge from treatment. These different treatment subtypes reflect the significantly different settings, program types, and sentence management practices that influence treatment delivery and time in the community.

[22] The DOC clients were identified in the PDMS from a treatment setting field. The juvenile clients received treatment in either a Department of Human Services facility or the community. However, given their smaller number, their results are presented as a single group to avoid any juvenile with a recidivist event being identified.

Table 3. Demographic Characteristics of the Final Sample Used in the Analyses and the Total Sample Extracted from the PDMS. For Screenreader Accessible Table, see Appendix A.T3.

Client Characteristic	Final Sample Count 1,004	Initial Sample Count 2,527	Statistical Significance*
Gender			n.s
Male	958 (95%)	2,316 (96%)	
Female	36 (3.6%)	83 (3.4%)	
Other	10 (1.0%)	24 (1.0%)	
Missing	0	104	
Race/Ethnicity			n.s
White	607 (60%)	1,434 (59%)	
Hispanic or Latino	244 (24%)	638 (26%)	
Black or African American	103 (10%)	240 (9.9%)	
Native American or American Indian	22 (2.2%)	43 (1.8%)	
Asian or Pacific Islander	11 (1.1%)	25 (1.0%)	
Other	8 (0.8%)	22 (0.9%)	
Unknown	9 (0.9%)	18 (0.7%)	
Missing	0	107	
Age (At Time of Offense)			p<.05
Mean (Range)	42 (13 - 84)	41 (11 - 92)	
Missing	1	163	
Developmental or Intellectual Disability			n.s
No	955 (95%)	2,260 (94%)	
Yes	49 (4.9%)	141 (5.9%)	
Missing	0	126	
Education			p<.01
High school degree or equivalent (e.g., GED)	566 (56%)	1,272 (53%)	
Less than high school degree	144 (14%)	453 (19%)	
Some college but no degree	183 (18%)	413 (17%)	
Bachelor degree	47 (4.7%)	149 (6.2%)	
Associate degree	43 (4.3%)	82 (3.4%)	
Graduate degree	21 (2.1%)	36 (1.5%)	
Missing	0	122	

* n.s = not significantly different to each other using Chi Square test of association for all categorical variables and t-test for the continuous age variable.

Table 4. Risk Levels and Discharge Types of the Final Sample Used in the Recidivism Analyses and the Total Sample Extracted from the PDMS. For Screenreader Accessible Table, see Appendix A.T4.

Client Characteristic	Final Sample Count 1,004	Initial Sample Count 2,527	Statistical Significance *
Beginning Risk Level			n.s
Low	284 (28%)	625 (27%)	
Low-moderate	188 (19%)	482 (21%)	
Moderate	268 (27%)	625 (27%)	
Moderate-high	130 (13%)	270 (12%)	
High	132 (13%)	304 (13%)	
Missing	2	221	
Ending Risk Level			n.s
Low	414 (41%)	1,008 (44%)	
Low-moderate	128 (13%)	329 (14%)	
Moderate	122 (12%)	265 (12%)	
Moderate-high	127 (13%)	260 (11%)	
High	211 (21%)	441 (19%)	
Missing	2	224	
Outcome Type			n.s
Successful	427 (43%)	1,097 (46%)	
Unsuccessful	404 (40%)	920 (38%)	
Administrative	173 (17%)	378 (16%)	
Missing	0	132	

* n.s = not significantly different to each other using Chi Square test of association for all categorical variables and t-test for the continuous age variable.

Recidivism Measurement

Defining and Categorizing Recidivism Outcomes

Recidivism was operationalized as any new misdemeanor or felony charge or conviction for an offense that occurred after the initial conviction for a sexual offense. The findings for charges and convictions are presented separately, as each has a different meaning. Charges are formal accusations by law enforcement and prosecutors, indicating that a person is suspected of committing a crime without knowledge of guilt or innocence. Convictions are formal determinations by a court that a person has committed a crime and contain only the subset of specific charges for which individuals were found guilty.

Recidivism is categorized into three types:

- Sexual recidivism: Any new sex offense that places the individual within the purview of the SOMB as listed in § 16-11.7-102(3), C.R.S.[23] These offenses include sexual assault, unlawful sexual contact, sexual assault on a child, enticement of a child, incest, sexual exploitation of children, indecent exposure, and soliciting for child prostitution.

- Violent recidivism (including sexual recidivism): Any new violent offense that involves the threat of force or results in injury against a person as listed in § 18-1.3-406(2) C.R.S. These offenses include murder, non-negligent manslaughter, robbery, aggravated assault, and sexual assault.

- Any recidivism: Any new offense as listed in Colorado criminal statutes as per § 18-1-104, excluding petty and misdemeanor traffic offenses.[24] Failure to register as a sex offender is included within any recidivism as it reflects an administrative violation rather than a sexually motivated offense per se. Failure to register as a sex offender is separated in the results section in places due to its relevance for individuals seen under the purview of the SOMB Approved Providers.

Accessing and Matching Criminal Justice Records

The primary source for the recidivism data was the Colorado Judicial Branch's information management system (ICON). This system contains statewide county and district court adult and juvenile filings and case dispositions, excluding Denver County Court. Denver County Court filings and dispositions were obtained separately and combined with the ICON data to create the recidivism dataset. The Division of Criminal Justice Office of Research and Statistics (CDPS) accessed the criminal recidivism data and provided the support to SOMB to match cases. The Colorado criminal justice records were searched to identify if any recidivism was committed by each unique case in the final data set. The data was most recently matched on September 23, 2024.

Recidivism is reported separately for new charges and new convictions. New charges are a more inclusive recidivism measure and are frequently used in studies of sexual reoffending. New charges are most similar to rearrest rates. In contrast, reconvictions are a more conservative measure of recidivism as they involve the reoffense being confirmed by the admission of guilt or being found beyond reasonable doubt by the criminal justice system. The decision to report reconvictions, as well as charges, was to align the types of reported outcomes with the proposed standardized recidivism definition pursuant to § 24-33.5-536, C.R.S.

[23] C.R.S. Sections 18-3-305, 18-3-402, 18-3-403, 18-3-404, 18-3-405, 18-3-418, 18-6-301, 18-6-302, 18-3-504(2), 18-6-403, 18-6-404, 18-7-302, 18-7-402, 18-7-403, 18-7-404, 18-7-405, 18-7-406, 19-2-517, 19-2-518, 19-2.5-801, 19-2.5-802, 38-157.1 (Denver Muni Code), 18-3-306(3), 18-3-504(2), 18-7-301(2)(b).

[24] Petty offenses were those identified by law class “PO” and “DPO,” while misdemeanor traffic offenses were those identified by law class “T.” Other offense types that were not included were sentence enhancers (i.e., “SE”) that provide additional information to the formal offense and the Denver County Court code “UC,” unclassified offense.

Measuring Recidivism Timeframes

The recidivism follow-up timeframe began on the discharge date from sex offense-specific treatment for each client, regardless of the treatment discharge outcome. Any new offense or conviction that had an offense date after the treatment discharge date was counted as a recidivism event. The number of days from the treatment discharge date to the latest criminal record pull date (September 23, 2024) was recorded as the follow-up period for each client.

The follow-up period does not include any days removed from the community following treatment discharge and incarceration due to revocation, reconviction, or any other reason. The follow-up period also excludes any days spent in prison between the end of treatment and parole for clients who received treatment in a Department of Corrections (DOC) facility. Adjusting the follow-up timeframes for any time spent in prison after treatment discharge requires access to data maintained by the DOC. This adjustment is expected to be included in the future phases of the project. Consequently, the current follow-up timeframes used in the analyses may be slightly inflated.

As stated, the timeframe for following recidivism begins at treatment discharge, so it does not include recidivism committed during treatment participation. However, most individuals who recidivated during treatment participation will be recorded as having an unsuccessful discharge as reoffending is a significant violation of the treatment contract.[25] To accurately represent the proportion of clients who recidivated after treatment discharge, rather than before, an additional category was created for clients who recidivated during treatment.

The analyses used a series of fixed follow-up periods. Fixed follow-up periods are advantageous because they remove variability in the duration of time individuals spend in the community, which arises from their variable discharge dates. This approach facilitates more accurate reporting of recidivism rates and allows for better comparisons across studies. For each specific follow-up period, the treatment discharge date marked the beginning of follow-up. Only charges or convictions recorded during the fixed time period were then counted as recidivist events. Multiple follow-up samples were employed to examine outcomes over progressively longer durations while maximizing data retention. For this reason, individuals included in each subsequent fixed time period are also counted in the earlier period.[26]

Table 5 shows the length of follow-up across the sample as a whole (see first two columns) and the sample size for a series of fixed follow-up timeframes (see last four columns). The average time between discharge from treatment and the recidivism follow-up period was between 2.4 and 2.9 years. The range was from less than one year to just over six years. As noted above, the follow-up periods may be slightly inflated as they do not account for any days not in the community following treatment discharge. As the discharge date for the sample was between 2019 and 2024, much of the follow-up period occurred during the COVID-19 pandemic.

[25] When reoffending occurs during treatment but is not detected until after treatment has concluded, it is possible for individuals to have received other types of treatment discharge.

[26] For example, the 570 adult community treatment clients in the two-year follow-up group are also included among the 817 in the one-year follow-up group.

Table 5. Number of Individuals with Various Lengths of Follow-up in the PDMS Recidivism Follow-Up Dataset.

PDMS Recidivism Follow-Up Dataset	Range in Follow-Up Years	Average Follow-Up Length	1 Year Follow-Up Sample Size	2 Year Follow-Up Sample Size	3 Year Follow-Up Sample Size	4 Year Follow-Up Sample Size
Adult Community Clients (Count 858)	0.75 - 6.3	2.6 years	817	570	308	109
Adult DOC Clients (Count 101)	0.78 - 4.3	2.4 years	94	59	35	4
Juvenile Clients (Count 45)	0.82 - 4.6	2.9 years	42	31	24	12

* The PDMS client data were matched to judicial criminal records up until 9/23/24

Treatment Discharge Categories

In the current *Adult Standards and Guidelines* and *Juveniles Standards and Guidelines*, clients receive one of three discharge types. A successful discharge is when the client completes all treatment goals and achieves the requirements stipulated in these *Standards and Guidelines*. An unsuccessful discharge is when there is significant non-compliance with the treatment contract. Reasons for a non-compliance discharge can include new sexual or non-sexual offending, violation of supervision or treatment conditions, and lack of consistent engagement in treatment and failure to progress with treatment goals. An administrative discharge is used when a change in circumstances interferes with the client continuing in treatment with the provider. It contains a variety of potential reasons including significant medical issues, incompetency or incapacity to complete treatment, significant instability within the community, deportation, conflict of interest, death, therapeutic transfer, and sentence completion.

All client treatment discharge records were categorized according to the treatment discharge types listed in the current *Adult Standards and Guidelines* and *Juvenile Standards and Guidelines*.

Results

Recidivism Rates Over Fixed Follow-Up Periods: Successful Treatment Discharge

Table 6. presents the proportion of individuals who recidivated following successful discharge for adult community clients, adult DOC clients, and clients adjudicated as juveniles.[27] The rates are shown for the subsamples in the one-, two-, and three-year fixed follow-up periods.

[27] As described in the method section above, about a quarter of the clients who were initially adjudicated as juveniles were 18 at the time of discharge.

Table 6. Proportion of Clients Who Recidivated Following Successful Treatment Discharge from Adult Community, Adult DOC, and Juvenile Subgroups at One-Year, Two-Year, and Three-Year Follow-Up Periods. For Screenreader Accessible Table, see Appendix A.T6.

One-Year Follow-Up Subsamples						
	Adult Community (Count 299)		Adult DOC (Count 67)		Juvenile (Count 33)	
Recidivism	Charges	Convictions	Charges	Convictions	Charges	Convictions
Sexual	0.3%	0%	1.5%	1.5%	0%	0%
Violent*	2.7%	2.0%	1.5%	1.5%	3.0%	0%
Any	11.0%	6.0%	3.0%	3.0%	12.1%	0%
Failure to register**	3.7%	2.7%	1.5%	1.5%	3.0%	0%
Two-Year Follow-Up Subsamples						
	Adult Community (Count 192)		Adult DOC (Count 41)		Juvenile (Count 24)	
Recidivism	Charges	Convictions	Charges	Convictions	Charges	Convictions
Sexual	0.5%	0%	2.4%	2.4%	0%	0%
Violent*	3.1%	2.6%	2.4%	2.4%	8.3%	4.2%
Any	10.9%	7.3%	9.8%%	7.3%	25.0%	4.2%
Failure to register**	3.6%	2.6%	2.4%	2.4%	4.2%	0%
Three-Year Follow-Up Subsamples						
	Adult Community (Count 92)		Adult DOC (Count 27)		Juvenile (Count 18)	
Recidivism	Charges	Convictions	Charges	Convictions	Charges	Convictions
Sexual	1.1%	0%	3.7%	3.7%	0%	0%
Violent*	4.3%	3.3%	3.7%	3.7%	11.1%	11.1%
Any	13.0%	9.8%	16.7%	7.4%	27.8%	11.1%
Failure to register**	6.5%	4.3%	0%	0%	5.6%	0%

* Violent recidivism was inclusive of sexual recidivism.

** Failure to register offenses are also counted in the any recidivism category.

To examine outcomes over longer time frames whilst maximizing data retention, individuals included in each subsequent fixed time period are also counted in the earlier period. For example, the 192 adult community treatment clients in the two-year follow-up group are also included among the 299 in the one-year follow-up group. The proportion of recidivists is also provided separately for new charges and new convictions. New charges are a more inclusive measure and are frequently used in studies of sexual reoffending. New charges are similar to rearrest rates. Reconviction rates are a more conservative measure as they require that the charge was confirmed through the criminal justice process. Using reconvictions or new adjudications also aligns with the definition of recidivism in § 24-4.2-302(1) C.R.S.

Appendix B Supplementary Table 1 provides a similar table presenting the proportion of individuals who recidivated following any type of discharge from treatment.

Table 6 indicates that:

- the proportion of adult community clients who sexually recidivated after successful completion of treatment remained low over the one-, two-, and three-year follow-up periods.
- the adult DOC clients' sexual and violent recidivism after successful completion of treatment reflected the reoffending of one individual. Due to the decreasing number of individuals in the two- and three-year follow-up subgroups, that one recidivist represents a greater proportion of each subgroup.
- juvenile clients who successfully completed treatment had no instances of sexual recidivism detected across the follow-up time periods.
- the discrepancy between charges and convictions may reflect the failure of charges to result in convictions or the lag time between the filing of charges and the resolution of cases.

Recidivism Rates Over Fixed Follow-Up Periods: Unsuccessful Treatment Discharge

Table 7 presents the proportion of adult community clients who recidivated following unsuccessful discharge from treatment. The DOC client subgroup was not presented because successful discharge plays a significant factor in parole considerations, and as a consequence, many of the adult DOC clients with an unsuccessful discharge had significant delays or were not paroled to the community.[28] However, it is noted that no sexual recidivism was detected for adult DOC clients with unsuccessful discharge. The juvenile subgroup with an unsuccessful discharge was also not presented as the sample size was very small, dropping below five cases.[29] However, it is also noted that no sexual recidivism was detected for juvenile clients with an unsuccessful discharge.

[28] Parole date data and return to prison data is being obtained for the dataset to allow this information to be incorporated into the longer-term tracking of the samples.

[29] The SOMB follows a high standard of research ethics that cautions against reporting data on very small samples. This helps prevent the identification of individuals and ensures that the findings are reliable, as small samples can be heavily influenced by one or two cases.

Table 7. Proportion of Adult Community Clients Who Recidivated Following Unsuccessful Treatment Discharge in the One-Year, Two-Year, and Three-Year Follow-Up Subgroups for Screenreader Accessible Table, see Appendix A.T7.

One-Year Follow-Up Subsamples		
	Adult Community (Count 365)	
Recidivism	Charges	Convictions
Sexual	2.5%	1.9%
Violent*	12.6%	6.3%
Any	33.4%	21.9%
Failure to register**	15.9%	8.5%
Two-Year Follow-Up Subsamples		
	Adult Community (Count 267)	
Recidivism	Charges	Convictions
Sexual	3.4%	2.6%
Violent*	13.9%	7.9%
Any	38.2%	27.0%
Failure to register**	18.7%	10.9%
Three-Year Follow-Up Subsamples		
	Adult Community (Count 151)	
Recidivism	Charges	Convictions
Sexual	3.3%	2.6%
Violent*	17.2%	9.9%
Any	43.7%	31.8%
Failure to register**	24.5%	14.6%

* Violent recidivism was inclusive of sexual recidivism.

** Failure to register offenses are also counted in the any recidivism category

Table 7 shows that a greater proportion of adult community clients recidivated after unsuccessful discharge from treatment than successful discharge, although the absolute number remains small.[30] For example, 2.5% of the adult community clients with an unsuccessful discharge had a new sex offense charge in the first year following treatment discharge, compared to 0.3% for the adult community clients who successfully completed treatment.

Among the clients with an unsuccessful discharge, some will have been discharged due to recidivism that occurred during their treatment period, as recidivism is a reason that leads to an unsuccessful discharge. As the current study is focused on recidivism that occurred following treatment discharge, some of those recidivists are not reflected in the recidivism rates presented in **Table 7**. **Table 8** presents the proportion of adult community clients with an unsuccessful discharge and at least a one-year follow-up timeframe who recidivated either during treatment or following treatment.[31] As shown, these rates increased and indicate a substantial proportion of clients with unsuccessful discharges had recidivated in some manner.

Table 8. Proportion of Adult Community Clients with Unsuccessful Discharge and at Least One Year of Follow-Up Who Recidivated During Treatment or Following Treatment (Count 365).

Recidivism Type	% of Clients with New Charges	% of Clients with New Convictions
Sexual	5.8%	3.8%
Violent*	17.3%	9.9%
Any	44.9%	30.7%

* Violent recidivism was inclusive of sexual recidivism.

Proportion of Recidivism Committed According to Treatment Discharge Type

Figure 2a and **2b** show the proportion of post-treatment adult community treatment recidivists by treatment discharge type.[32] **Figure 2a** shows for new charges, while **Figure 2b** shows for new convictions. The recidivists were predominantly individuals who were unsuccessfully discharged from treatment. Statistical analyses indicated that successful discharge was associated with lower rates of recidivism and unsuccessful discharge was associated with higher rates of recidivism. Although a small number of individuals with administrative discharge did recidivate, that discharge category showed no statistical association with recidivism.

[30] Statistical analyses are not reported here but confirmed that the differences were significant.

[31] A proportion of these recidivists had recidivism both during treatment and following discharge, and thus were reflected in the post-treatment discharge data.

[32] Only those clients with at least a one-year follow-up period were included in these rate calculations.

Figure 2.a. Treatment Discharge Outcomes of Adult Community Clients by the Presence of New Charges. For Data Table, see Appendix A.F2.a.

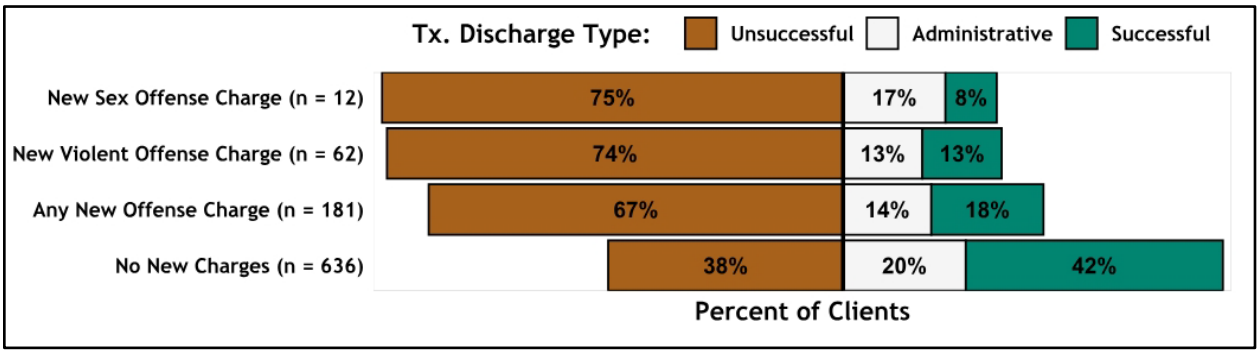
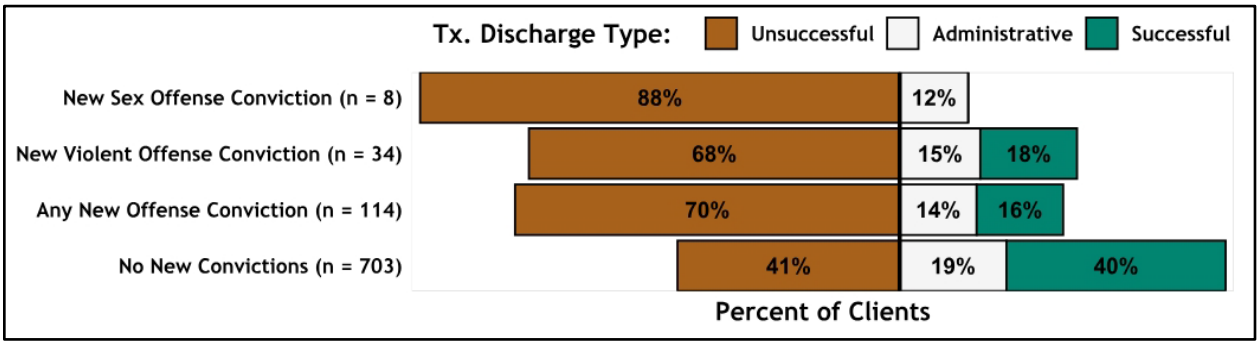


Figure 2.b. Treatment Discharge Outcomes of Adult Community Clients by the Presence of New Convictions. For Data Table, see Appendix A.F2.b.



Cumulative Recidivism Across All Discharge Types

Cumulative recidivism rates indicate the increase in proportion of individuals who reoffended over time. They show how quickly recidivism occurs and quantify the annual increase in recidivists from one assessment period to the next. Given the low proportion of recidivists among individuals who successfully completed treatment programs, the cumulative proportion is discussed for all post-treatment recidivists across the three different discharge categories.

Figure 3 illustrates the cumulative proportion of recidivists for adults in the community treatment sample with a three-year follow-up period across all discharge types.[33] The figure illustrates that the cumulative proportion of recidivists with new charges and new convictions rises significantly in the first year, while the increase becomes less pronounced over subsequent years.

[33] As described above, these individuals had a treatment discharge date that was at least three years before the date the criminal justice record was extracted.

Figure 3: Cumulative Recidivism Rates for Sexual, Violent, and Any Recidivism Among Adult Community Clients with 3-Year Follow-Up Time Frames (Count 308). For Data Table, see Appendix A.F3.

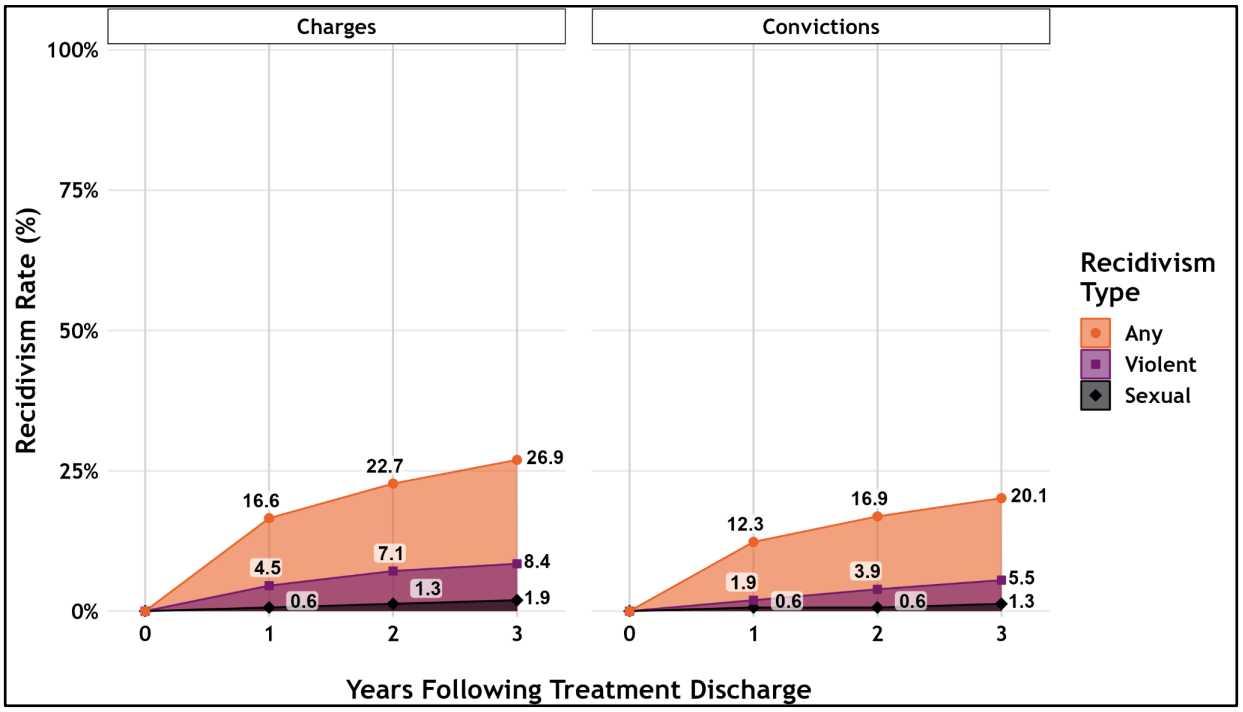


Table 9 shows the cumulative proportion of recidivists for adults in the DOC sample with a three-year follow-up period across all discharge types. The data show that the incident of sexual reoffending occurred in the first year and was the only counted offense among violent reoffending.

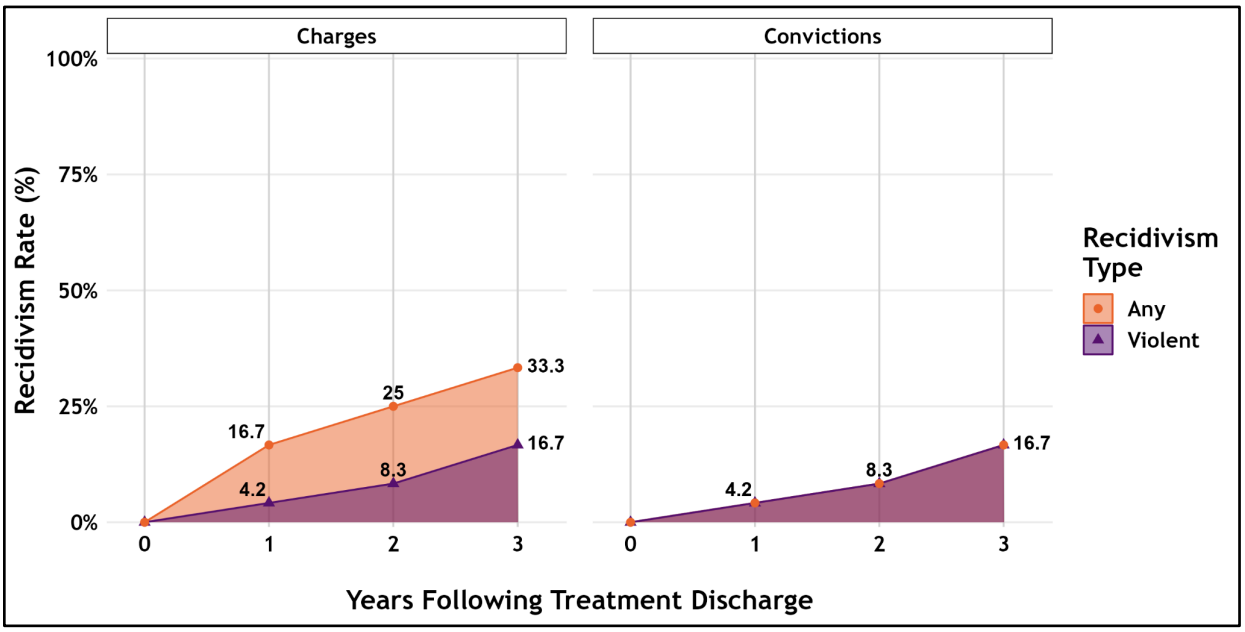
Table 9. Cumulative Recidivism Rates (%) for Violent and Any Recidivism Among Adult DOC Clients with 3-Year Follow-Up Time Frames (Count 35).

Recidivism Type	% of Clients with Year 1 Charges	% of Clients with Year 2 Charges	% of Clients with Year 3 Charges	% of Clients with Year 1 Convictions	% of Clients with Year 2 Convictions	% of Clients with Year 3 Convictions
Sexual	0.3%	0.3%	0.3%	0.3%	0.3%	0.3%
Violent*	0.3%	0.3%	0.3%	0.3%	0.3%	0.3%
Any	0.3%	1.0%	1.3%	0.3%	0.6%	0.6%

* Violent recidivism was inclusive of sexual recidivism.

Figure 4 illustrates the cumulative proportion of recidivists for the juvenile sample with a three-year follow-up period. The figure shows that the cumulative proportion of juveniles with violent reoffending rises significantly across the three years. Although new charges for any reoffending rise steadily over the three years, these are not resulting in convictions. As stated above, the small sample size of juveniles is a limitation of these analyses.

Figure 4: Cumulative Recidivism Rates for Violent and Any Recidivism Among Juvenile Clients with Three-Year Follow-Up Time Frames (Count 24). For the Data Table see Appendix A.F4.



Review of the recidivists and their type of reoffending that occurred following discharge from treatment indicated:

- about two-thirds of all reoffending committed by adult community clients occurred in the first year after treatment discharge. See **Figure 3**.
- the one instance of sexual reoffending committed by an adult DOC client occurred in the first year of discharge, while about half of all reoffending occurred within the first year after discharge. See **Table 9**.
- about a quarter of the violent reoffending committed by juvenile clients occurred within the first year of discharge, while about one-third of all reoffending occurred within the first year. See **Figure 4**.

Characteristics of the Recidivist Charges and Convictions

Sexual Recidivism

During the follow-up period, a total of 12 sex crime charges resulted in convictions for adult clients. Among the individuals convicted, two-thirds were found guilty of a single charge, while one-third were convicted of two charges. All but one charge involved felonies. The greatest number of charges related to CSEMs, while other charges involved online solicitation of a child and sexual assaults on victims

under 15 years old. There were charges for sexual assault or unlawful sexual contact with an adult victim, indecent exposure, and invasion of privacy for sexual gratification.[34]

In addition, a total of 26 charges did not result in convictions. Among those charges, most involved felonies and more than half related to invasion of privacy for sexual gratification or indecent exposure. Other charges included offenses involving CSEMs, soliciting and patronizing a child for prostitution, and sexual assault or unlawful sexual contact with an adult victim. Overall, the charges and convictions reflect a wide range of sexual crimes, varying in severity from felony to misdemeanor. Over two-thirds of all the charges pertained to non-contact offenses, while just under a third involved contact sex offenses.

Violent Recidivism

In addition to the charges for sex offenses, 41 charges for other violent crimes resulted in convictions for adult and juvenile clients. Half of those charges involved felony violent offending or robbery, while the remainder involved misdemeanor assault. A further 194 charges for other violent crimes did not result in convictions. About two-thirds involved serious violent offending, while about a third involved misdemeanor assault. Over a third of all of the violent offense charges were attributed to four individuals.

Any Recidivism

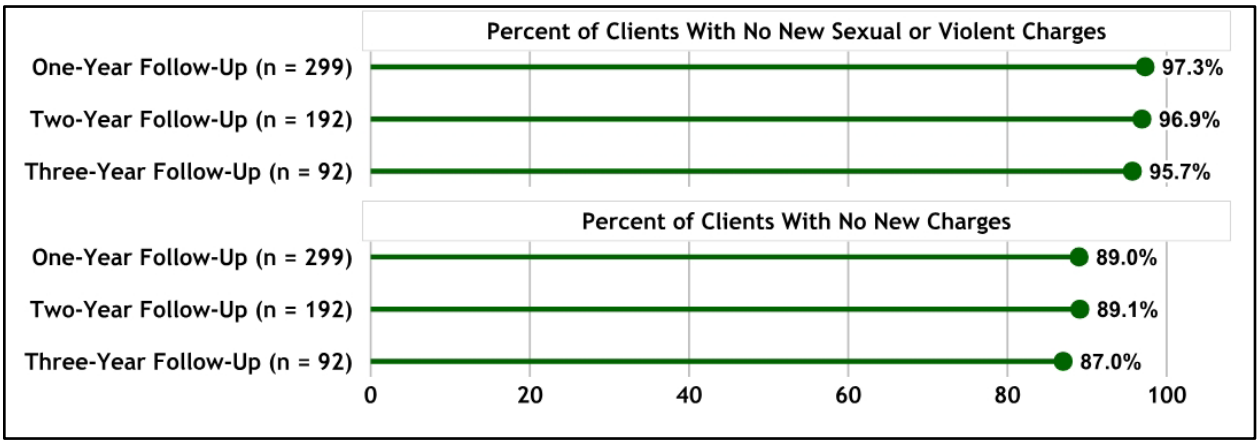
In addition, 164 charges for non-violent crimes resulted in convictions for the adults and juveniles. These included property crimes, drug crimes, driving offenses, violation of a protection order, and failing to register as a sex offender. A further 603 charges did not result in convictions, most involving misdemeanor crimes. About a third of all non-violent offense charges were attributed to six individuals, with one individual accounting for 21%.

Recidivism and Desistance Outcomes by Client Demographics

Figure 5 shows the progress toward desistance for adult community treatment clients who achieved successful discharge. Progress toward desistance from sexual and violent recidivism remained high following treatment discharge.

[34] Sexual assault is often interchangeably referred to as rape as it involves non-consensual acts involving penetration or intrusion. In contrast, unlawful sexual contact typically involves non-consensual touching or groping. It was not possible from the indecent exposure or invasion of privacy charges to determine if these were against adult or child victims.

Figure 5. Progress Toward Desistance for Adult Community Treatment Clients Who Successfully Completed Treatment. For the Data Table, see Appendix A.F5.



The demographic characteristics of the adult community treatment sample with and without recidivism were compared for the one-year follow-up group. The data were combined across discharge types. **Appendix B Supplementary Tables 2–4** display information for new charges and new convictions for sex, violent, and any offenses.

Trends in the demographic data for the adult community treatment group include:

- Females had no sexual recidivism and little violent recidivism, indicating most were on a desistance trajectory.
- The race and ethnicity of individuals who recidivated sexually were similar across groups, except that American Indian/Alaska Native individuals had no observable sexual recidivism, while Hispanic or Latino individuals had relatively fewer recidivists based on convictions for sexual offenses. Statistical analyses found no significant differences based on race or ethnicity, indicating similar progress toward desistance across groups.
- The incidence of violent recidivism was relatively higher among Black or African American and Asian or Pacific Islanders. However, these groups made up a relatively small proportion of all recidivists and most clients with this racial identity were on a pathway toward desistance at the end of the first year of follow-up. American Indian/Alaska Native individuals had a relatively higher rate of recidivism for charges only, but made up a small percentage of the recidivists. Statistical analyses found no significant differences based on race or ethnicity.
- Recidivists appeared younger, on average, than non-recidivists, which is consistent with age-crime curves that show desistance increases in general over the lifecourse. A significant difference in age was found for violence charges, while violence convictions approached significance levels.[35]
- Individuals with a developmental or intellectual disability appeared to have relatively higher rates of sexual and violent recidivism. In the follow-up sample, 44 (5%) of the clients were recorded as having such a disability. Statistical tests did not find significant differences in

[35] For violence charges, $t(815)=6.587$, $p<.05$. For violence convictions, $t(815)=3.394$, $p=.066$, $\varphi=.095$.

sexual recidivism rates, but they did find significant differences in violent recidivism.[36] It is important to emphasize that most of the recidivists had neither an intellectual nor developmental disability. This raises the possibility that these disabilities can be a treatment responsivity barrier that impacts treatment success and desistance.

- Having less than a high school degree was associated with higher rates of sexual and violent recidivism.[37] This is consistent with research that shows lower educational levels are a risk factor for recidivism.

- Any recidivism had a significant association with having less than a high school diploma, developmental or intellectual disability, and being younger. Although Hispanic Latino individuals had a higher rate of any charges and White individuals had a lower rate, there were no significant differences related to race or ethnicity for convictions. **See Appendix B Supplementary Table 4** for demographic data for any recidivism.

Due to the small number of recidivists in the adult DOC subgroup and small number of individuals in the juvenile sample, conducting similar comparisons for those subgroups was deemed inappropriate.

Limitations

Several limitations present in the current study include:

- The adult DOC and juvenile data represented smaller subgroups within the overall dataset. Reporting these subgroups separately ensured that their outcomes were not obscured by the larger adult community treatment group but it also meant that individual cases could have a more significant influence on the recidivism percentages. As a consequence, it was deemed inappropriate to present certain analyses for juvenile clients.

- For the adult DOC clients, successful discharge from treatment is a key factor in parole considerations. Therefore, successful discharges are directly linked to the opportunity for recidivism. As a result, analyses of recidivism among clients who did not successfully complete treatment were not valid as many of those individuals were not released.

- Although a significant proportion of individuals with an unsuccessful discharge were not found to have recidivated, interpreting this result is complicated. Unsuccessful discharges can lead to revocation hearings and temporary removal from the community. Moreover, clients who experience unsuccessful discharges may be redirected to alternative treatment interventions to address their risks and needs, or referred on to another SOMB Approved Provider. These post-treatment risk management strategies may have contained and supported clients who had an unsuccessful discharge and should be considered when interpreting the recidivism rate.

- The follow-up timeframes may be slightly overestimated because they did not include any additional days removed from the community either to prison, jails, or time spent in prison

[36] For charges, $\chi2(1) = 9.485$, $p<.01$ (2-sided). For convictions, $\chi2(1) = 6.048$, $p<.05$ (2-sided), $\varphi=.086$.

[37] The overall chi-squared tests of association were not significant; however, further analysis of specific categories using z-scores identified significant difference in rates of recidivism for those with less than a high school degree for new sex offense charges, new violent offense charges, and new violent offense convictions ($p<.05$).

before parole for adult DOC clients. Future stages of the project aim to include this additional information.

- The follow-up period was relatively short for studying sexual recidivism. The average timeframe was less than three years. As a result, multiple follow-up groups were used to examine outcomes over progressively longer durations to maximize data retention. However, the two- and three-year recidivism rates may be less stable estimates of recidivism as they have smaller sample sizes than the one-year recidivism rate. It also means the one-, two-, and three-year recidivism rates are not true cumulative recidivism rates as each follow-up period does not have the same sample.

Summary and Discussion

The overall objective of this project is to provide a comprehensive analysis of the recidivism and desistance outcomes for adults convicted of sexual offenses and juveniles adjudicated for sexual offenses seen under the purview of the SOMB *Standards and Guidelines*. A related objective is to develop a robust research methodology that will enable these analyses to be conducted at regular intervals in the future. As the project involves a significant amount of preparatory work and data analysis, it is being approached in stages. In this first stage, the focus is on (i) developing the SOMB recidivism and desistance outcomes dataset; (ii) describing the proportion of clients who have sexual, violent, and general recidivism post-treatment; (iii) describing the types of recidivism evident in the charge and conviction data; and (iv) describing recidivism and desistance outcomes by client demographics.

Developing the Dataset

A comprehensive recidivism dataset has been developed that is representative of clients seen for treatment under the SOMB. The dataset contains 1,004 treatment clients discharged between October 2019 and January 1, 2024, who gave consent to have their criminal recidivism data followed up and matched to their record. The creation of this dataset required extensive preparatory work and significant collaboration between the SOMB and Office of Research and Statistics, as well as with Denver County Court. Further outreach and collaboration are occurring with the DOC to ensure the follow-up timeframes include any time spent in prison during the follow-up period. In the development of this database, coding rules have been carefully considered and documented to create a reliable and robust methodology that can be repeated in future years. This process has also provided an opportunity for learning and improvements that are being incorporated into the SOMB PDMS moving forward.

Proportion of Clients Who Recidivated Post-Treatment

Key findings for *sexual recidivism* include:

- Clients who successfully completed treatment had low sexual recidivism. Among the adult community treatment clients, 0.3% had a new sex offense charge after one year follow-up, increasing to 1.1% at three years. None had a new sex offense conviction. One adult DOC client reoffended sexually and no juvenile clients reoffended sexually.

- Clients who were unsuccessfully discharged from treatment had higher rates of sexual recidivism than clients who successfully completed treatment. Among adult community clients, 2.5% had a new sex offense charge within one year of discharge, which increased to 3.3% by

the three-year follow-up. Of these clients, 2.6% received a new sex offense conviction by the three-year mark. When including reoffending that occurred during treatment, it was found that 5.8% had a new sex offense charge, while 3.8% received a new conviction within a year of unsuccessful discharge from treatment. No sexual recidivism was recorded for adult DOC or juvenile clients.

- The rates of sexual recidivism compared favorably to findings from the research review on adult males and juveniles. The research review found that the sexual recidivism rates in routine state parole and probation samples ranged from 3.5% to 10% over three to ten-year follow-up periods, while for juveniles it ranged from 3% to 9.5% over five years. Notably, the rate for clients who successfully completed treatment was substantially lower than these figures. In contrast, the rate for adult community clients with unsuccessful discharges was similar but still more favorable than the average 9% to 10% sexual recidivism rate over six years reported in meta-analyses of sex offense treatment outcome. That there was no sexual recidivism recorded for adult DOC and juvenile clients compares favorably with other research.

- Most individuals who reoffended sexually had unsuccessful treatment discharges, with the majority of sexual recidivism occurring during the first year after treatment or while still undergoing treatment. The recidivism seen after treatment included incidents of serious contact sex crimes as well as a large number of non-contact sex crimes.

Key findings for *violent recidivism* include:

- Clients who successfully completed treatment had low violent recidivism inclusive of sexual recidivism, while the rate for clients who were unsuccessfully discharged were significantly higher. Among adult community clients successfully discharged, the proportion with a new violent offense charge was 4.3% over three years follow-up, while for those unsuccessfully discharged it was 17.2%. These compare with rearrest rates of 26% to 28% reported in routine state parole and probation samples of released prisoners with a sex offense conviction over ten-year follow-ups.

- Including reoffending that occurred during treatment by adult community clients who were unsuccessfully discharged from treatment increased the proportion of recidivists by the end of the first year of follow-up from 12.6% to 17.3%.

Key findings for *any recidivism* include:

- Among adult community clients successfully discharged, the proportion with any new offense charge was 13.0% over three years follow-up, while for those unsuccessfully discharged it was 43.7%. Among the adult DOC clients successfully discharged, the proportion with any new offense was 16.7% over three years follow-up. These compare with rearrest for any recidivism of 63% to 67% reported in routine state parole and probation samples of released prisoners with a sex offense conviction over ten-year follow-ups.

- For juvenile clients who were successfully discharged, the proportion of those with any new offense charge was higher, but this did not lead to increased conviction rates.

- Including reoffending that occurred during treatment by adult community clients who were unsuccessfully discharged from treatment increased the proportion of recidivists by the end of the first year of follow-up from 33.4% to 44.9%.

Recidivism and Desistance by Client Demographics

Key findings include:

- During the three-year follow-up period, all but one adult community client showed no observed instances of sexual recidivism, and 96% remained free of the broader category of sexual and violent recidivism.

- Females were observed to have no sexual recidivism and minimal violent recidivism, which compares favorably with research indicating females generally desist from sexual offending after criminal justice intervention. The race and ethnicity of individuals who recidivated sexually or violently were similar across groups, indicating similar access to desistance trajectories at one year follow-up.

- Recidivists, on average, tended to be younger than non-recidivists and had an educational level below a high school degree. Individuals with developmental or intellectual disability were also overrepresented among those that had violent reoffending. This indicates these factors may reflect criminogenic needs or treatment responsivity barriers. However, it is also important to note that while many recidivists had low educational levels most did not have either an intellectual or developmental disability.

Future Project Stages

The current study represents the initial stage of a larger research project that examines recidivism and desistance outcomes among clients seen for evaluation, treatment, and polygraph examination under the purview of the SOMB. The main limitations of this study are the small subgroups of DOC and juvenile clients within the overall dataset and the relatively short follow-up period after treatment discharge. This limitation will be addressed when the project is updated in subsequent iterations, such as in three years' time. Additionally, the dataset lacks information on any days clients spent removed from the community during the follow-up periods or remained incarcerated after completing DOC offense-specific treatment. This limitation is being addressed currently with DOC data being gathered and integrated into the dataset. As well, any removals from the community to jails cannot be accounted for within individuals time-at-risk, due to lack of a unified dataset of people jailed in Colorado.

Future stages of the project will involve a more comprehensive analysis of recidivism that occurred during the treatment period. It will also involve comparing observed recidivism rates to expected rates based on risk assessment data when possible. This approach will enable a clearer understanding of overall recidivism among all clients and assess whether treatment has effectively reduced the expected recidivism based on pre- and post-treatment risk levels. Analyses will seek to determine which combination of client, risk, and treatment factors interact to influence outcomes. Additionally, the analysis will incorporate evaluation data and polygraph examination results to determine the impact of these interventions.

The insights obtained from this project will serve as a critical resource for the refinement of the *Adult Standards and Guidelines* and *Juvenile Standards and Guidelines*. The insights will be used for the objective of improving the outcomes from evaluation, treatment, polygraph examinations, and behavioral monitoring. Furthermore, the findings may provide valuable recommendations that could influence sentence management strategies, policy development, and legislation initiatives where appropriate. By integrating these insights, the SOMB will continue to implement policies and processes to enact evidence-based standards and meet its statutory mandate to "revise the guidelines and standards for evaluation, identification, and treatment, as appropriate, based upon the results of the board's research and analysis."

Section 2: Relevant Policy Issues and Recommendations

Starting in 2011, as part of the SOMB Sunset renewal, the SOMB was required to make policy recommendations in addition to implementing *Adult* and *Juvenile Standards and Guidelines* based on evidence and research. Each year, in the annual legislative report, the SOMB makes policy recommendations formulated from research, highlights recent court cases that affect the SOMB, and discusses research trends on pertinent or emerging topics that may interest the legislature.

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

Modification to Adult Treatment Standards

Individuals convicted or adjudicated for sexual offenses, whether as adults or juveniles, fall under the statutory jurisdiction of the Colorado Sex Offender Management Board (SOMB), as defined by Colorado Revised Statutes (C.R.S.) § 16-11.7-102. Accordingly, all such individuals are required to participate in treatment (§ 16-11.7-105), where treatment is defined as "therapy, monitoring, and supervision of any sex offender that conforms to the standards created by the board" (§ 16-11.7-102(4)).

Historically, adults assessed as posing a very low risk of future sexual or violent recidivism and exhibiting minimal treatment needs have been recommended for alternative interventions that were viewed by certain stakeholders as being outside the SOMB's purview. This practice, referred to as **"boundary treatment"** or **"healthy sexuality curriculum**," has prompted significant discussion, particularly within the adult treatment field, due to its implications.

The SOMB, in collaboration with the Colorado Attorney General's Office, has clarified that all individuals convicted of a sexual offense must adhere to SOMB-established treatment requirements in the applicable *Adult Standards and Guidelines* or *Juvenile Standards and Guidelines*, regardless of the type of recommended treatment. As a result, treatment services that deviate from these constitute a violation and may potentially result in formal complaints against the Approved Provider. With this context of a broader legal purview that now includes adult cases referred for alternative interventions, the SOMB is examining how the inclusion of these cases may impact the current *Adult Standards and Guidelines* and how sex offense-specific treatment can be further modified without jeopardizing victim safety considerations or the integrity of the standards.

The *Adult Standards and Guidelines* define sex offense-specific treatment as the application of evidence-based approaches designed to prevent recurring sexually abusive and aggressive behaviors. This is achieved by helping clients at risk of sexually reoffending to:

- Effectively manage individual factors contributing to sexually abusive behaviors.

- Develop strengths and competencies to address criminogenic risks.
- Identify and change thoughts, feelings, and actions that may contribute to sexual offending.
- Establish and maintain stable, meaningful, and prosocial lives.

Key objectives of sex-offense specific adult treatment include reducing recidivism, fostering client success, the safety of victims and potential victims, and enhancing community safety. The focus is on replacing harmful behaviors with those conducive to healthy, consensual relationships. The *Adult Standards and Guidelines* mandate comprehensive interventions to include:

- Assignment of a risk level to align treatment intensity with individual treatment needs.
- Core treatment concepts:
    - Acceptance of responsibility for offending and abusive behavior.
    - Identification of the cognitive-behavioral triggers for offending.
    - Restructuring cognitive distortions.
    - Establishing adaptive prosocial functioning.
    - Promoting healthy sexuality and relationship skills.
    - Understanding victim impact and developing empathy.
    - Creating a prosocial living plan.
- Comprehensive sex history disclosure and polygraph examinations.
- Victim clarification processes.
- Group therapy as the preferred modality, with alternatives used when clinically appropriate.

Alternative Treatments

Although the SOMB standards allow flexibility to tailor treatment to individual risks and needs, concerns have been raised about their applicability to adults with very low Risk-Need-Responsivity (RNR) factors who are being recommended for alternative interventions that are contrary to sex offense-specific treatment as defined in the *Adult Standards and Guidelines*. In general terms, **boundary or healthy sexuality treatment** emphasizes psychoeducational methods focused on promoting healthy interpersonal boundaries, sexuality, and relationships rather than the broader focus found in standard sex offense-specific adult treatment. It is typically a time-limited curriculum (e.g., weekly sessions for 12–15 weeks) that provides basic knowledge and competence about relationship issues and facilitates some insight and education toward the goal of preventing future sexual offending.

Anecdotally, alternative treatments have been ordered and applied as a sentence condition in cases where “boundary violations” were identified as the significant contributor to the sex offense in the absence of other established criminogenic factors. Established criminogenic risk factors associated with sexual recidivism risk are included in the *Adult Standards and Guidelines: Section 2.000 Standards for Sex Offense-Specific Evaluations*. These include the domains of atypical or deviant sexual interests and behavior patterns (e.g., sexual preoccupations and paraphilic sexual interests), antisocial attitudes and cognitions (e.g., offense-supportive attitudes and beliefs, hostile masculinity), self-regulation/management problems (e.g., impulsivity, lifestyle instability, emotional regulation deficits,

and problem-solving deficits), and relationship problems (e.g., intimacy deficits, emotional congruence with children, and negative social influences) (Seto et al., 2023).

Proponents contend that sex offense-specific treatment, as defined by the *Adult Standards and Guidelines*, may not only be unnecessary for these alternative treatment cases but could inadvertently increase risk and undermine protective factors. The concerns expressed include stigmatizing individuals with a "sex offender" label inconsistent with their risk factors or the characteristics of the offense, exposing them to negative influences through associating with higher-risk individuals in group settings, and undermining protective factors by being subject to unnecessary restrictions required as part of offense-specific treatment and supervision.

Existing Policy Approaches

A significant degree of treatment individualization and flexibility already exists within the *Juvenile Standards and Guidelines* and within aspects of the *Adult Standards and Guidelines*. However, the *Juvenile Standards and Guidelines* have traditionally had greater flexibility as this is consistent in meeting the treatment and risk management needs of adolescents and young adults, which can differ from those of adults.

The *Juvenile Standards and Guidelines* emphasize individualized treatment tailored to the developmental and ecological context of adolescents. The standards focus on preventing sexual offending, general delinquency, and abusive behavior while enhancing understanding of the harm caused to victims and communities and fostering healthy prosocial functioning. Therapists, in collaboration with the Multidisciplinary Team (MDT), choose treatment content that is appropriate for the specific needs and circumstances of each case. There is no requirement for a comprehensive sex history disclosure or polygraph examinations, as these may not be developmentally appropriate unless a specific clinical need exists.[38] Moreover, there is an emphasis on utilizing a broader range of treatment modalities as clinically indicated, including group, individual, and family therapy, with the understanding that group therapy may not be appropriate for all youth.

The *Young Adult Modification Protocol* applies to individuals aged 18–25 under the *Adult Standards and Guidelines*, following specific inclusion and exclusion criteria. The protocol offers additional flexibility that empowers treatment providers, in collaboration with the Community Supervision Team (CST), to make exceptions to certain requirements. This creates an individualized treatment approach for young adults more similar to the flexibility found in the *Juvenile Standards and Guidelines*, when developmentally appropriate. Another significant distinction between the application of *Juvenile Standards and Guidelines* and the *Adult Standards and Guidelines* lies in the number of clients and treatment providers involved. Data from the Provider Data Management System (PDMS) indicates that juvenile clients constitute a significantly smaller group than adult clients, and there is a correspondingly lower number of juvenile treatment providers compared to their adult counterparts. Consequently, achieving consistent implementation of the *Adult Standards and Guidelines* presents greater challenges for the adult field.

Both the *Adult Standards and Guidelines* and *Juveniles Standards and Guidelines* also include a mechanism called a variance process, which enables exceptions to specific requirements in unique cases. The process is formal and requires that the provider make a request to the SOMB Application

[38] As well, most research on polygraph examinations has been conducted with adult populations.

Review Committee (ARC), which can provide initial approval for the variance in some instances before a formal review from the Board is conducted. The Board reviews and either approves or denies the requested deviation from the required standard. However, this variance option is rarely utilized by providers at present. The possible reasons for under-utilization include a lack of familiarity with the process by treatment providers, the formality of the process, and the time commitment involved in a variance request.

Treatment Modifications Workgroup

The gap between the existing *Adult Standards and Guidelines* and the flexibility needed to accommodate boundary cases underscores the necessity of further considering refinements to the *Adult Standards and Guidelines*. In 2024, the SOMB Adult Standards Revision Committee convened a Treatment Modifications Workgroup to examine this issue and propose potential solutions. Initial efforts have included:

- Discussions about the characteristics of boundary cases and conflicts with the existing *Adult Standards and Guidelines*.
- A literature review on research to inform treatment modifications.
- A PDMS data analysis project to explore alternative and adjunct treatment approaches being recommended and used.

The PDMS data analysis found that boundary treatment was occasionally referenced as a treatment recommendation in the comment sections of client evaluation records. Although this observation aligns with the understanding that such alternative treatments are applicable in a limited number of cases, it underscores a gap in systematic or comprehensive data collection concerning these cases. As alternative treatments recommended from evaluations may have been occurring outside the purview of SOMB, the treatment specifics and outcomes are not reported within the PDMS treatment case record. As a result, there is insufficient data to track the usage of these alternative approaches or their effectiveness.

The workgroup is tasked with developing evidence-informed strategies for managing very low-risk cases and ensuring alignment with statutory mandates to regulate the treatment and with SOMB guiding principles. Proposed solutions must prioritize community safety, consider victims' rights and interests, and deliver individualized, evidence-based interventions that are consistently and appropriately implemented across treatment providers and cases. The workgroup's scope has also extended to potential recommendations to enhance guidelines around best practices for higher-risk cases as a function across the continuum of risk. The workgroup will continue to meet in 2025 and report on proposed solutions to ensure the adult treatment standards allow for sufficiently individualized approaches aligned with clients' risk, criminogenic needs, and treatment responsivity.

Reduction in Crime Victim Services Funding

A substantial reduction in federal funding via the Victim of Crimes Act (VOCA) is expected to significantly impact the availability of victim services across Colorado (Colorado Division of Criminal Justice, 2024a). This funding supports more than 200 victim service organizations statewide, providing essential resources to individuals recovering from various crimes, including sex offenses. As a result, many agencies are scaling back their services, making it more challenging for victims, particularly

survivors of sexual violence, to access the support necessary for recovery (Colorado Division of Criminal Justice, 2024b). For example, The Blue Bench, a comprehensive sexual assault prevention and survivor support center in the Denver Metro area, will reduce its therapy staff and services. Starting January 1, 2025, it will also discontinue its post-conviction advocacy service, which plays a vital role in supporting victims after criminal convictions (Swick, 2024).

Victim post-conviction services directly impact the availability of victim representatives on adult CSTs and juvenile MDTs. CSTs and MDTs must include a victim representative, per the *Adult Standards and Guidelines* Section 5.025 and the *Juvenile Standards and Guidelines* Section 5.110. These representatives ensure victims and their families have opportunities to be informed and heard during the offending adult or juvenile's treatment process. They also contribute to maintaining a victim-centered approach within CSTs and MDTs that emphasizes victim safety, which helps achieve the SOMB's statutory mandate to enhance the protection of victims and potential victims (per § 16-11.7-101(2), C.R.S.).

Victim assistance programs depend on funding from both local and federal sources. Local funding primarily comes from fees imposed on offenders convicted of felony, misdemeanor, and traffic crimes. However, the 2023 Colorado Crime Victim Compensation report highlights that this revenue stream has declined by an average of 12% per fiscal year since FY 2018. At the federal level, funding is provided through VOCA, which collects money from criminal fines, forfeited bail bonds, penalty fees, and special assessments. These funds are managed through the Office of Victims of Crime (OVC) within the U.S. Department of Justice (DOJ). In 2018, Colorado received approximately $56 million in VOCA funds but this amount has decreased significantly in recent years. It dropped to $25 million in 2022, $23 million in 2023, and an estimated $13 million projected for 2024.

The Office for Victims Programs, part of the Division of Criminal Justice within the Colorado Department of Public Safety, is responsible for distributing VOCA funds. These funds are allocated using a formula that considers each judicial district's target fund balance. Once allocated, they are subsequently passed through to local programs. The availability of VOCA funds fluctuates, depending on the expenditures of the local judicial districts.

Future Prospects

The recent passage of Proposition KK: Firearms and Ammunition Excise Tax in the November 2024 election is expected to help replenish some of the funding for crime victim services over time. Revenue from this excise tax will support grants for crime victim support services, veteran mental health services, youth behavioral health services, and school safety. The maximum annual allocation to crime victim services is $30 million, adjusted for inflation. The tax takes effect on April 1, 2025, but the funds will unlikely be distributed to local programs until the following year's fiscal cycle.

This funding adjustment may offer some relief to victim service organizations. However, immediate challenges remain for agencies and victims due to the current funding shortfalls.

Section 3: Milestones and Achievements

Overview of 2024 Accomplishments

In 2024, the Sex Offender Management Board (SOMB) made significant progress in fulfilling the mandates outlined in the SOMB reauthorization bill, SB 23-164, while also continuing to effectively manage its ongoing responsibilities. Notable accomplishments include presenting the SOMB/DOC Treatment Solutions Report to the Joint Judiciary Committee and ongoing collaboration with the Department of Corrections Sex Offender Treatment and Management Program (SOTMP) to improve access to treatment services where possible. The SOMB also established a Determinate Sentence Workgroup. Finally, the SOMB developed resources to ensure compliance with the new requirement for regular compliance reviews of Approved Providers.

Equally important, the SOMB made meaningful strides in promoting culturally responsive care by the provider community. This included launching the second phase of the ODVSOM provider recruitment project, designed to attract and retain professionals from diverse groups. Additionally, the SOMB engaged in various outreach initiatives to strengthen connections with providers, stakeholders, and the broader community. The SOMB also prioritized implementation support and professional development for providers and stakeholders by hosting over 30 training events that reached more than 1,400 participants. The SOMB managed 13 committees and workgroups, published several reports, and hosted its annual conference at full capacity. The Application Review Committee (ARC) of the SOMB handled 273 applications for new listings, status upgrades, and renewals for the Approved Provider list. Together, these efforts underscore the SOMB's steadfast commitment to advancing public and victim safety, and offender rehabilitation, through effective treatment, education, and collaborative partnerships across the state.

Implementation of SOMB Reauthorization Bill (SB 23-164)

The SOMB was reauthorized for five years, until September 1, 2028, as outlined in SB 23-164. The Department of Regulatory Authority (DORA) recommended the reauthorization in the 2022 Sunset Report. A Sunset Report is a periodic assessment of a state board or program to evaluate its compliance with statutory requirements and determine whether the state legislature should continue its existence. SB 23-164 incorporated the recommendations from the 2022 sunset report and introduced additional mandates. **Appendix F** provides a summary of these amendments and repeals. Following is an update on the significant work undertaken by the SOMB in 2024 to fulfill the requirements of the bill.

SOMB/DOC Treatment Solutions Workgroup

The SOMB and DOC presented the Treatment Solutions Report to the Joint Judiciary Committee on February 1, 2024. The report was the culmination of a workgroup that had met since August 2023. The work group included representatives from the SOMB, community treatment providers, the DOC SOTMP, the division of adult parole in the DOC, and the State Parole Board, along with a number of members of

the public who attended meetings and provided public testimony. The work group addressed the legislative questions posed in SB 23-164 concerning offender access to sex offense treatment while in DOC custody. The Treatment Solutions Report considered potential solutions discussed by the workgroup or suggested by stakeholders.

The potential solution options outlined in the report are summarized below, with actions taken by the SOMB or DOC SOTMP:

- Revise the *Adult Standards and Guidelines* Section 3.600 to enhance the continuity of care between treatment within the SOTMP and treatment that continues in the community on parole.

  Subsequent Actions: The SOMB has proposed a revision to Section 3.600, which includes a requirement for providers to comply with Section 7.000 concerning Continuity of Care and Information Sharing. This revision specifically addresses the transition of clients from the SOTMP to community treatment. The proposed changes have undergone the necessary reviews by SOMB committees and have been subject to public comment. The proposed revisions were presented to the SOMB for ratification and approved in January 2025.

- Revise the DOC SOTMP treatment tracks and curriculum to streamline treatment, particularly for lower-risk offenders.

  Subsequent Actions: Progress on revising the curriculum began in 2023 and was completed by the spring 2024. The SOTMP now offers three treatment tracks instead of two, introducing a specific program for clients classified as low risk for sexual recidivism. By late November 2024, three treatment groups had successfully completed the low-risk program. Additionally, the Administrative Regulations were updated to improve overall discharge after successful program completion, freeing spaces for new candidates. As a result of these revisions, clients with low to moderate risk can expect to progress through the SOTMP in approximately six months.

- Utilize external community-based providers for in-person or teletherapy sessions, although it was also noted that using external providers creates additional strain on custodial staff due to the security and oversight requirements. Teletherapy was seen as an impractical option due to significant issues regarding technology capability and client confidentiality that are not adequately addressed in the DOC setting at this time.

  Subsequent Actions: SOTMP staff reported that some external Approved Providers had expressed interest in offering services to clients within the custodial setting. However, none have pursued this further after learning about the training and background check requirements necessary to become an approved DOC contractor.

- Use former and existing DOC SOTMP clients as peer mentors to support treatment. The report highlighted that the SOTMP model already includes peer mentors to assist clients with their assignments and support their treatment progress. However, it is not ethically or legally permissible to use peer mentors instead of Approved Providers to deliver offense-specific treatment.

- Increase DOC SOTMP staff resources. The report pointed out the challenges associated with hiring staff for prison locations and sex offense treatment programs, as well as the efforts

made to address these challenges. The SOMB *Adult Standards and Guidelines* were not seen as an obstacle to staff recruitment or deployment. Instead, it was noted that recent changes to the SOMB approval process have enabled new SOTMP treatment providers to start delivering treatment almost immediately.

Subsequent Actions: Recently, job listings for the SOTMP have shown that the DOC has significantly increased its recruitment starting bonus. The SOTMP management is also aware of staff retention issues as the program continues to operate with an understaffed workforce while simultaneously revising its programming.

- Clarify the meaning of SOTMP treatment progress when communicating with the Parole Board to aid in their decision-making about parole.

  Subsequent Actions: The SOMB has introduced a new discharge type for clients who complete the SOTMP program. This discharge, titled "Successful Completion - Continued Treatment Needed, " emphasizes that after successfully completing the SOTMP, clients require subsequent community treatment to fulfill all of the requirements of the applicable *Standards and Guidelines*. The SOMB will provide training and technical assistance to facilitate the implementation of these changes. In addition, the SOTMP staff continues to work closely with the Parole Board, participating in meetings, providing progress reports on clients, and consulting with the Board before and after client appearances.

- Continue to work on transparency and understanding the waitlist process to reduce frustration and disappointment with the wait time and perceived delays.

  Subsequent Actions: The SOTMP Administrator has indicated that the procedure for sharing waitlist information has been updated. Under the new protocol, the SOTMP Administrator is the sole provider of this information. In lieu of giving an exact placement number that may change as other referrals are added; a waitlist range is communicated instead.

- Consider the impact of the Lifetime Supervision Act, which requires that incarcerated individuals convicted of a sex offense participate in and complete the DOC SOTMP before being considered for parole. While one option could be to allow clients assessed as low-risk to receive all their treatment in the community, this approach would also present actual or perceived concerns about public safety, victim protection, and community challenges. Any changes to current practices would require a modification of the statute.

Updates to Adult Standards and Guidelines and Juvenile Standards and Guidelines

Updates to several sections of the *Adult Standards and Guidelines* and *Juveniles Standards and Guidelines* have been made to meet the adjustments required by SB 23-164 (see **Appendix F**). Most of these updates involved additions or clarifications that did not substantially change the meaning of the respective *Standards and Guidelines*. A series of updates involved revisions to the terminology used for fingerprint collection and definitions for "adult sex offender," "juvenile who committed a sexual offense," and "sex offender." In addition, new language was added to ensure that treatment provided under each *Standards and Guidelines* is responsive to the developmental status of clients at the time of treatment as well as their linguistic, cultural, religious, and racial characteristics along with their

sexual orientation, gender identity, and gender expression (per § 24-34-301, C.R.S). The Adult Standards Revision or Best Practices Committees initiated each of these changes, which have undergone the necessary reviews, public comments, and ratification steps to be officially included in the respective *Standards and Guidelines*.

Updates to the *Adult Standards and Guidelines* regarding supervising officers are ongoing. One involves clarifying that supervising officers must follow the *Adult Standards and Guidelines* and requires that mechanisms for accountability are developed. The other involves directing supervising agencies to provide the client access to a complete list of Approved Providers with the expertise to work with that particular client's specific risks and needs. Additional specifications included in the bill were that supervising agencies shall consider the individual risks and treatment needs of the particular offender, the ability of the treatment provider to accept new clients, the geographic proximity of the providers, the nature of the programs, tailored referrals to those considerations and any other factors relevant to the treatment of the offender, the capability of the provider, and safety of the community. Also, offenders with an intellectual or developmental disability shall be referred to a provider approved for that specialty, and offenders who prefer to undertake treatment in a language other than English should have referrals to providers who are fluent in that language to the extent possible. This update impacts current practices and elaborates on the recommendation from the 2022 Sunset Report, leading to increased discussion at the committee level.

State Parole Board Release Guideline Instrument

The SOMB, in collaboration with the State Parole Board, established a workgroup to revise the release guideline for prisoners with sex offense convictions serving determinate sentences. The workgroup was formed after the completion of the SOMB/DOC Treatment Solutions Workgroup, which also proposed options for consideration for the release guideline as part of its findings. The group comprises representatives of the SOMB, the State Parole Board, and the DOC SOTMP. As specified in SB 23-164 (see **Appendix F** for a summary), the revised release guideline must incorporate the concepts of RNR or another evidence-based correctional model, must be as flexible as possible to ensure that offenders have timely access to the necessary programs to prevent the offender from harming victims or potential victims, and must not include the inability to access treatment during incarceration as a basis for denying parole.

The working group held three meetings in 2024, all of which were open to stakeholders and the general public. During these meetings, the group reviewed the requirements outlined in the reauthorization bill, assessed the current release criteria, and considered suggestions from the SOMB/DOC Treatment Solutions Workgroup. The group also discussed several important issues affecting the revision of the guidelines. One critical concern was that the Parole Board has limited access to the information necessary for conducting risk-need assessments in many determinant cases. The Parole Board noted that the DOC SOTMP could not always provide this information, as many determinant sentenced offenders do not undergo SOTMP treatment before their parole eligibility date.[39] The Parole Board also preferred guidelines that offer a comprehensive framework that includes consideration of protective factors, previous access to offense-specific treatment, and treatment considerations in the community, alongside a risk assessment to inform parole decision-making fully.

[39] See SOMB/DOC Treatment Solutions Report.

The working group is coordinating with related initiatives that are happening concurrently, which include efforts to enhance information sharing with the Parole Board through other data management systems. Furthermore, the group is exploring expanding its focus to consider issues related to access to treatment for prisoners who are serving determinant sentences for sex offense convictions. The working group will continue to meet in 2025.

Compliance Reviews

Effective September 1, 2024, and every two years after that, the Board is required to initiate compliance reviews for a minimum of 10% of Approved Providers. The SOMB has an existing administrative policy and practice for Standards Compliance Reviews that is being adjusted to align with the new requirements. In addition to compliance reviews for cause due to a complaint or concern of the Application Review Committee (ARC), compliance reviews will also be conducted randomly to achieve the 10% minimum. Providers also have the option to volunteer themselves for compliance reviews if they wish. The administrative and technical resources have been completed to implement random and volunteer compliance reviews.

Efforts Toward Culturally Responsive Care

The SOMB continues to prioritize support for culturally responsive care by the provider community, including:

- Speakers and workshops at the ODVSOM annual conference that provided culturally based lenses on interpersonal violence and intergenerational trauma.
- Hosted training on Assessing Risk for Sexual and Domestic Violence: Latest Research Including Cross-Cultural Validity by Dr. Maaike Helmus, Simon Fraser School of Criminology.
- Hosted guest speakers at SOMB meetings that honor cultural heritage months and promote culturally responsive interventions.
- Hosted day training on working with clients who are part of the LGBTQ+ community.
- Seeking to recruit members to the SOMB and its committees to ensure diverse representation from the provider community and its stakeholders.
- Providing training events to Approved Providers that target supporting and increasing cultural competency.
- Developing an ODVSOM Training Conduct Policy that outlines expectations for training participants and SOMB Staff procedures for responding to inappropriate or abusive comments regarding a person's identity or culture.
- Additional revisions to the *Adult Standards and Guidelines* and *Juvenile Standards and Guidelines* to ensure policies respect different cultural perspectives and facilitate inclusion and responsiveness to individuals from diverse identities and cultures.
- Recruitment and retention communication plan have an emphasis on attracting future providers from a diverse range of identities and cultures.
- Research projects consider if findings are applicable across diverse demographic groups.

The goal of these efforts and training opportunities is to enhance the understanding and capacity of the SOMB and affiliated stakeholders to address cultural issues impacting their work. It also aims to foster a climate of respect, inclusiveness, and belonging for people of all backgrounds and identities within the SOMB community.

Efforts to Recruit New Providers

The ODVSOM began a multiphase project in 2022 to develop a communications plan to attract new providers to the sex offender and domestic violence treatment fields. The ODVSOM partnered with Orange Circle Consulting (Orange Circle), a marketing and research agency. The first phase of the project involved formative research of potential recruits and existing stakeholder groups. Strategies were used to ensure the findings could inform development of recruitment strategies and resources that would be effective across potential recruits from diverse cultures. This is part of an overall strategy to provide a culturally-responsive provider community. The main findings from that research are summarized in the SOMB 2024 Annual Legislative Report and were communicated to the SOMB and DVOMB at their monthly meetings and to stakeholder groups in attendance.

The second phase of the project commenced in FY 2024 once further funding was secured. It involved a continued partnership with Orange Circle to develop specific outreach strategies and materials for provider recruitment. The focus was on testing targeted messaging for specific audiences regarding the work of the ODVSOM, its importance for public safety, and the positive impact it has on individuals who engage in sexual violence and abuse. To gather feedback, three focus groups were assembled with key audiences to assess the messaging and information delivery methods. The insights obtained from these groups were used to design tailored outreach strategies that effectively connect with the people who need information about ODVSOM.

In the final phase of the project in the upcoming fiscal year, Orange Circle will collaborate with current Approved Providers to produce a video showcasing their clinical work and the positive impacts of being an Approved Provider. The final project phase will also involve creating appealing resources that can be used for recruitment drives and integrated into existing slide presentations to promote ODVSOM.

Community and Stakeholder Outreach

Traveling Board Meetings

The SOMB held a traveling board meeting in May 2024 in Pueblo. Traveling board meetings are designed to help the SOMB connect with the communities it serves across Colorado. SOMB staff contact Approved Providers and stakeholders who reside and practice in the host and surrounding counties to encourage attendance and participation. Typically, only minimal regular business is conducted at these meetings. The main focus is updating attendees about recent SOMB activities, gathering input on local concerns and initiatives, and building stronger networks with local providers and stakeholders. The knowledge gained from these outreach meetings is reported to the relevant SOMB committees and addressed in the policy and resource work as appropriate. The SOMB plans for one traveling board meeting per calendar year. Individuals or agencies can request a SOMB meeting in their community through the SOMB website or by contacting staff directly.

Round Tables

The SOMB held roundtable discussion meetings in September 2024 in Colorado Springs and November 2024 in Boulder. The purpose of roundtable discussions is to improve collaboration, engagement, and the exchange of feedback between the Board and communities statewide in a constructive and safe forum. The roundtable discussions are open to Approved Providers, stakeholders, and community members to dialogue about challenges, opportunities, and ways to work together to address and prevent sexual violence and abuse. The morning session focuses on dialogue and discussion, while the afternoon session offers training and discussion on specialized topics. SOMB staff contact Approved Providers and stakeholders who reside and practice in the host and surrounding counties to encourage attendance and participation. Individuals or agencies can request the SOMB hold a roundtable in their community through the SOMB website or by contacting staff directly.

Policy and Regulatory Work

The SOMB primarily works through committees to discuss and review policy and implementation issues. Appointed members, program staff, and other stakeholders attend the committee meetings. All committee meetings are open to the public and conducted online or in a hybrid format to maximize accessibility. The committees regularly update the SOMB about their work, bringing forth proposals to address policy and practice issues at monthly Board meetings. Some proposals involve recommendations for revisions to the *Adult Standards and Guidelines* and *Juvenile Standards and Guidelines*. In contrast, others can include suggestions for white papers, policy briefs, resource documents, or training to support best practices. All committees consider advancements in the sex offender treatment and management field when conducting their work. When recommending changes to the *Adult Standards and Guidelines* and *Juvenile Standards and Guidelines*, the committees support their proposals with research and best practices and suggest methods for educating practitioners and the public to implement effective offender management strategies.

Committees

The SOMB staffed 13 active committees and workgroups during 2024, as shown in **Figure 6**, to work on statutorily mandated duties. All committees were open to all stakeholders.

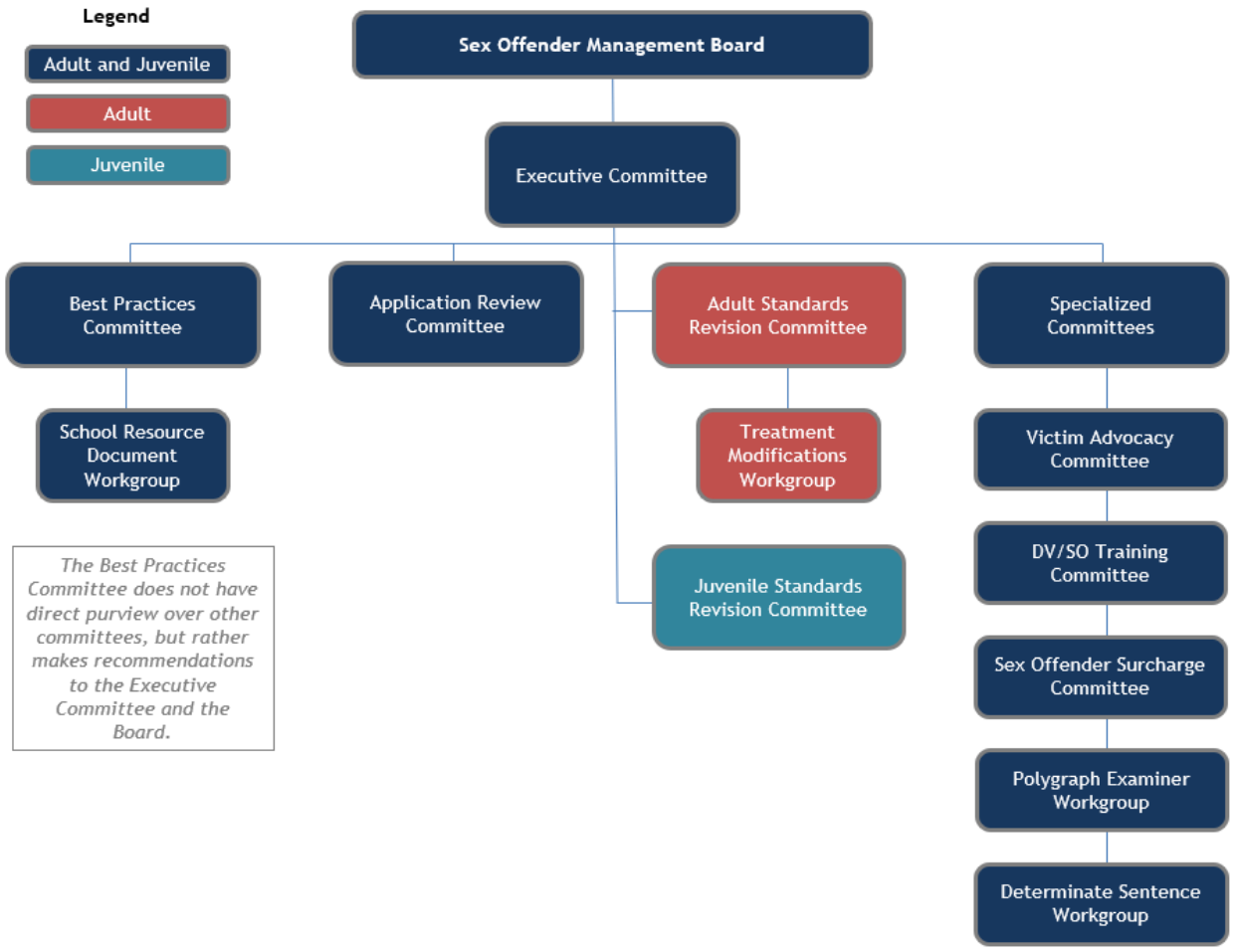
The committees were:

1. Executive Committee
2. Best Practices Committee
    a. School Resource Document Workgroup
3. Application Review Committee
4. Adult Standards Revisions Committee
    a. Treatment Modifications Workgroup
5. Juvenile Standards Revision Committee
6. Specialized Committees
    a. Victim Advocacy Committee

b. DV/SO Training Committee
c. Sex Offender Surcharge Allocation Committee
d. Polygraph Examiner Workgroup
e. Determinate Sentence Parole Guidelines Workgroup

Appendix G provides a summary of the main work of each committee in 2024.

Figure 6. Organizational Chart of SOMB Committees and Workgroups.



Applications for Listings on the SOMB Approved Provider List

In 2024[40], the SOMB ARC managed 273 applications for new listings, status upgrades, and renewals for the Approved Provider list. This number represented a significant increase from the 187 applications processed in 2023. The committee approved 182 of these applications, which included both those pending from the previous year and new applications received during the current 12-month period. Applications may be pending for several reasons, including waiting for missing information to be provided, awaiting additional submission of work products, or providers choosing to defer their applications for a later time. **Table 10** shows the SOMB count of applications for 2024.

Table 10. SOMB Count of Applications for 2024.

Application Type	Number Submitted	Number Approved	Number Pending[a]
Application 1 (Initial Listing)	62	49[b]	13
Application 2 (Status Upgrade)	88[c]	51	33
Application 3 (Renewal)	123	82[d]	41
Total	**273**	**182**	**87**

a. Pending refers to applications that are pending completion, staff review, or ARC review.
b. One application was approved with conditions.
c. One application to the ARC was missing information, which was in the process of being sought.
d. Two applications were approved with conditions.

Current Availability of SOMB Approved Providers

As of November 2024, there were 331 SOMB Approved Providers in Colorado. This total included 231 adult treatment providers and 158 juvenile treatment providers.[41] In addition, there were 25 polygraph examiners, all of whom were approved to work with adults and 13 who were also approved to work with juveniles. Providers may hold multiple listings, which means many Approved Providers work with both adults and juveniles, while some work exclusively with adults or juveniles only. Providers can pursue additional specializations to work with individuals with developmental and intellectual disabilities or to offer clinical supervision services. As a result, an Approved Provider may hold up to eight different listings.

Table 11 displays the current number of Adult Approved Providers by service listing. The numbers provide a snapshot of provider data from the SOMB PDMS on November 1, 2024.

[40] The 12-month period was November 1, 2023, to October 31, 2024.

[41] Providers can be approved to work with adult, juvenile, or adult and juvenile populations, hence the discrepancy between the total number of Approved Providers and the sum of the adult and juvenile treatment providers. Four additional providers were approved for adult evaluators only and three additional providers were approved juvenile evaluators only.

Table 11. Number of Approved Adult Sex Offender Service Providers in Colorado, 2024.

Service Listing	Associate Level	Full Level	Total
Adult Treatment Provider	**84**	**147**	**231**
Treatment Provider DD/ID	*21*	*33*	*54*
Clinical Treatment Supervisor	*N/A*	*83*	*83*
Clinical Treatment Supervisor DD/ID	*N/A*	*21*	*21*
Adult Evaluator	**39**	**70**	**109**
Evaluator DD/ID	*8*	*12*	*20*
Clinical Evaluator Supervisor	*N/A*	*41*	*41*
Clinical Evaluator Supervisor DD/ID	*N/A*	*11*	*11*
Adult Polygraph Examiner	**2**	**23**	**25**
Polygraph Examiner DD/ID	*2*	*11*	*13*

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

Table 12 displays similar information for Juvenile Approved Providers. Again, the numbers provide a snapshot of provider data from the SOMB PDMS on November 1, 2024. It is important to note that the italicized categories denote providers who are approved to offer additional services and are not included in the total counts.

In addition, each Approved Provider has specific counties in which they have applied to provide services. **Figures 7 through 12** show the distribution of Approved Adult and Juvenile Evaluators, Treatment Providers, and Polygraph Providers across Coloradoan counties. See Appendix H for this data presented in table format. On average, each Approved Provider operated in four different counties. In total, the SOMB has Approved Providers located in all 22 judicial districts in the state.

Table 12. Number of Approved Juvenile Sex Offender Service Providers in Colorado, 2024.

Service Listing	Associate Level	Full Level	Total
Juvenile Treatment Provider	**57**	**103**	**158**
Treatment Provider DD/ID	*7*	*20*	*27*
Clinical Treatment Supervisor	*N/A*	*55*	*55*
Clinical Treatment Supervisor DD/ID	*N/A*	*15*	*15*
Juvenile Evaluator	**19**	**41**	**58**
Evaluator DD/ID	*4*	*8*	*12*
Clinical Evaluator Supervisor	*N/A*	*23*	*23*
Clinical Evaluator Supervisor DD/ID	*N/A*	*6*	*6*
Juvenile Polygraph Examiner	**2**	**12**	**14**
Polygraph Examiner DD/ID	1	6	7

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

Figure 7. Number of SOMB Adult Treatment Providers by County. For data table, see Appendix H.F7.

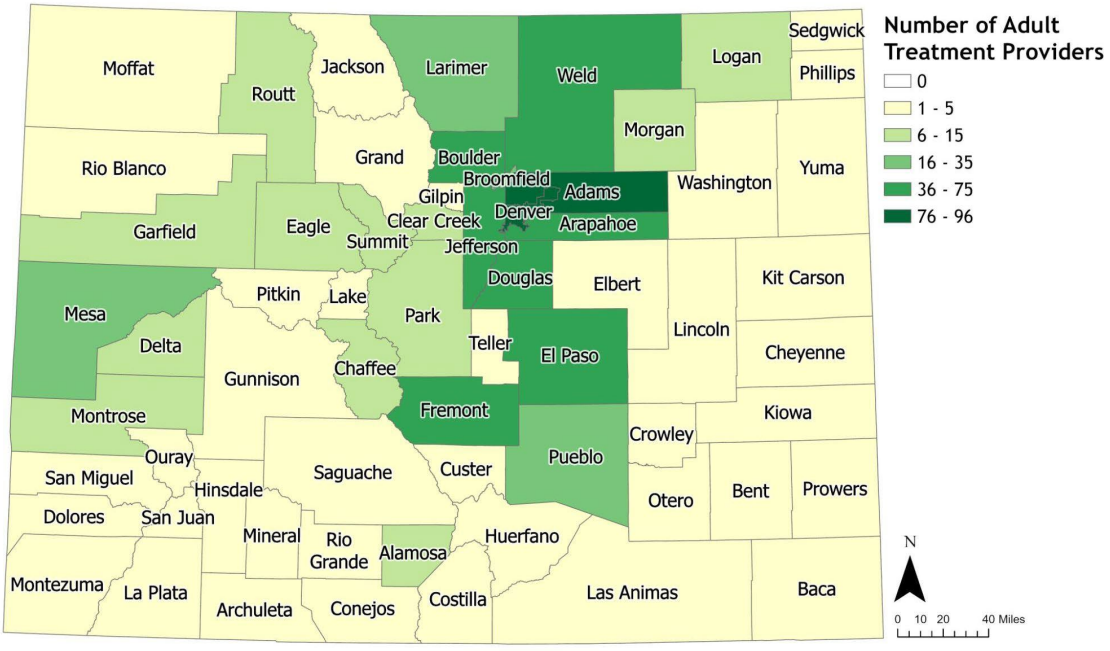


Figure 8. Number of SOMB Juvenile Treatment Providers by County. For data table, see Appendix H.F7.

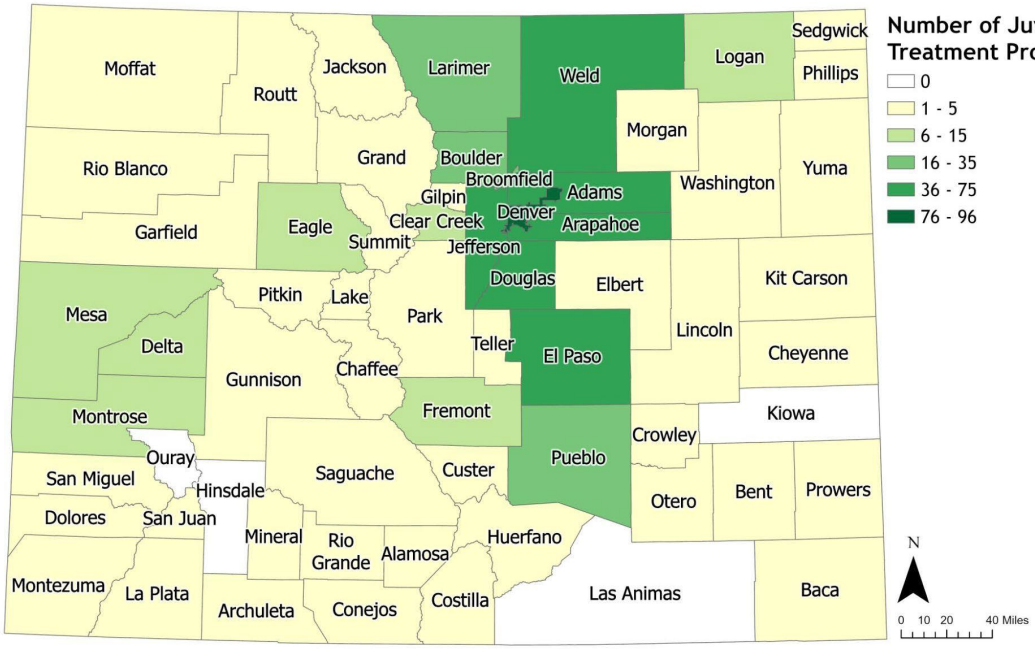


Figure 9. Number of SOMB Adult Evaluators Providers by County. For data table, see Appendix H.F7.

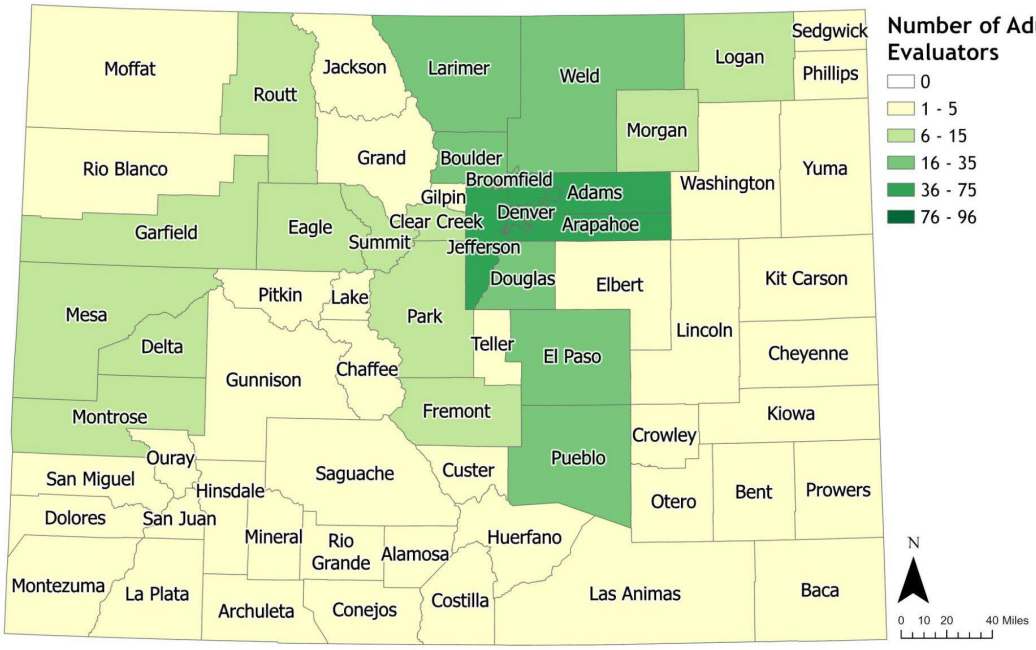


Figure 10. Number of SOMB Juvenile Evaluators by County. For data table, see Appendix H.F7.

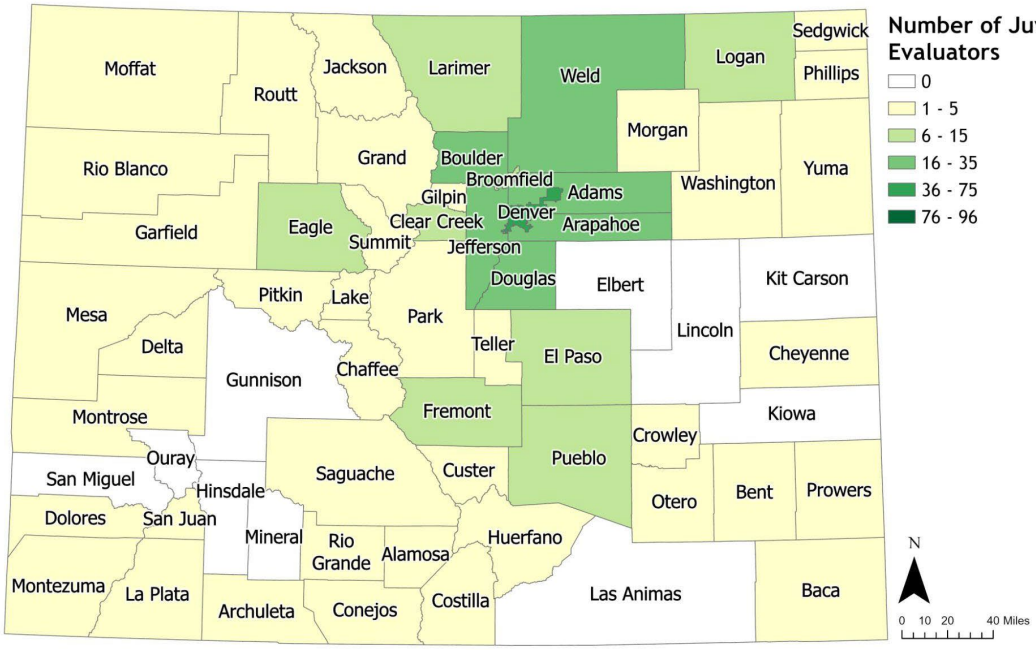


Figure 11. Number of SOMB Adult Polygraphers by County. For data table, see Appendix H.F7.

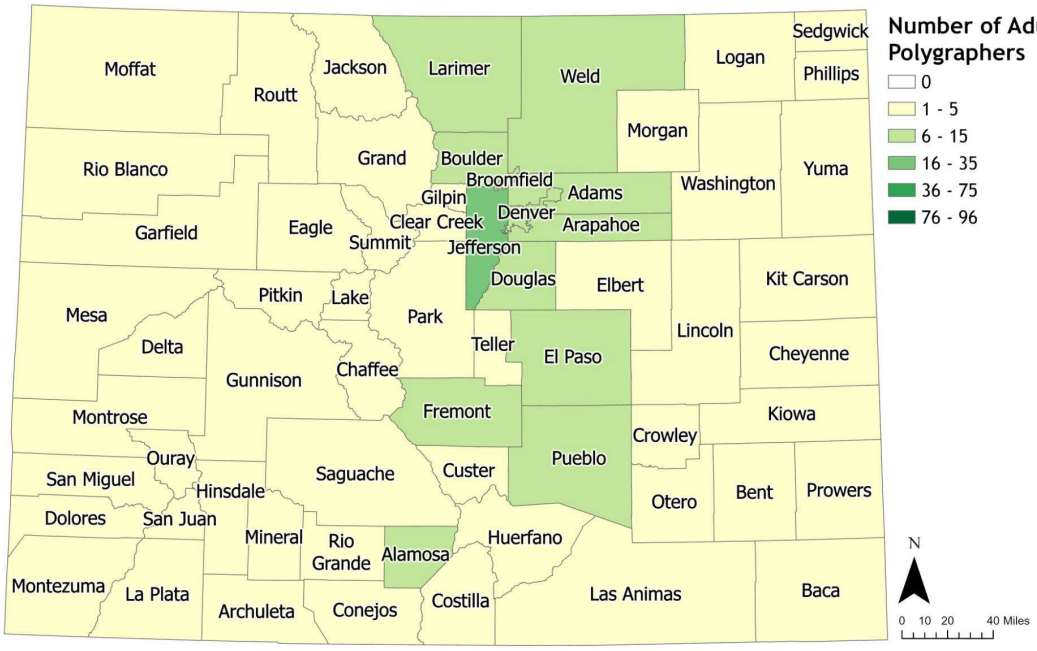
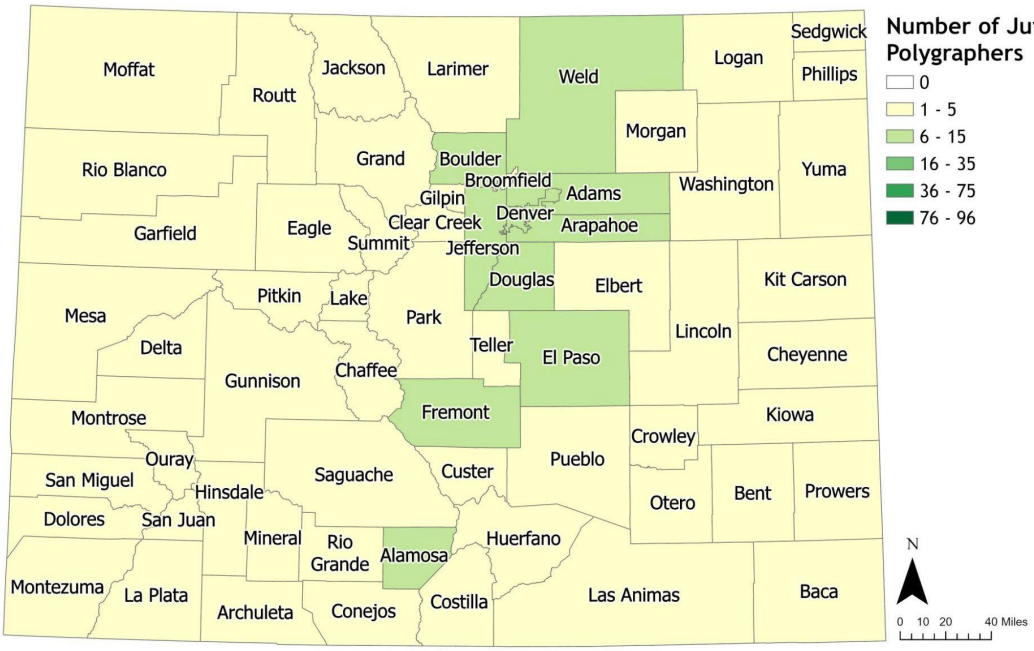


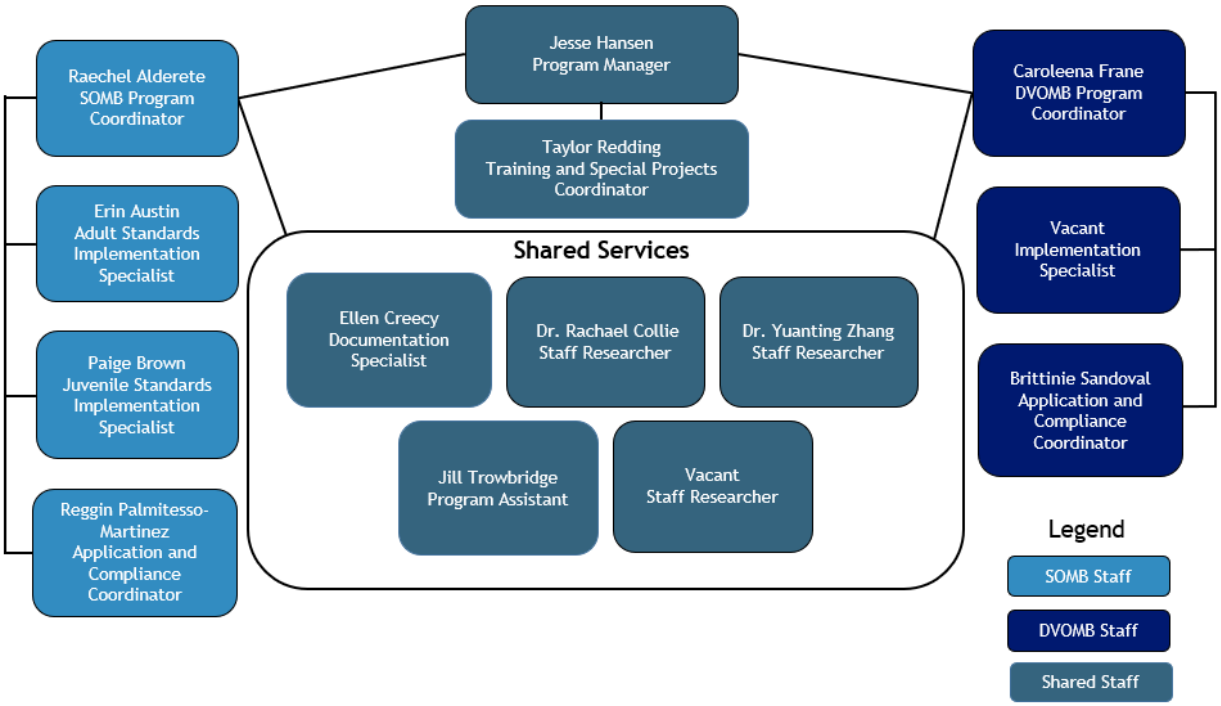
Figure 12. Number of SOMB Juvenile Polygraphers by County. For data table, see Appendix H.F7.



Update on the ODVSOM Shared Services Model

The Office of Domestic Violence and Sex Offender Management (ODVSOM) provides the program staff that supports the SOMB and the Domestic Violence Offender Management Board (DVOMB). Initially, the staff for the SOMB and DVOMB were separate. However, in 2016, the staff was merged into one office because both entities had similar structures, guiding principles, and mandates. This merger helped minimize overlapping duties and streamlined technical and policy responsibilities while continuing to support each Board's distinct legal status. In 2022, the support staff organizational model was refined to integrate staff roles to be more responsive to the increase in Approved Providers, the complexity of the respective *Standards and Guidelines*, and additional expectations following Sunset Reports. **Figure 13** shows the current staff configuration. The new organizational structure was fully implemented in 2023.

Figure 13. The ODVSOM Shared Services Model and Organizational Chart 2024. See Appendix H.F13 for the chart table.



In the Shared Services Model, all administrative, planning, and logistical resources are centralized to support the SOMB and DVOMB. Additional specialized positions for each Board designate primary staff to provide direct support and leadership. These include SOMB and DVOMB program coordinators for strategy and operations, SOMB and DVOMB implementation specialists for the respective *Standards and Guidelines*, and SOMB and DVOMB Application and Compliance Coordinators. Research, project management, and administrative support staff work across the SOMB and DVOMB. The Program Manager is responsible for staff support for the Boards.

Several impacts of the revised organizational structure are apparent, including:

- Enhanced outreach and support for the provider community and other stakeholders in rural and frontier areas.
- Increased training for the provider community and stakeholders across the state.
- Expansion and refinement of the implementation specialist role through staff undertaking training and certification in implementation.
- Streamlined provider application and renewal process to benefit the provider community and reduce the administrative workload of the Application Review Committee.
- Increased research to support policy and standards revisions.

Ongoing Implementation

The implementation process involves sharing information from the SOMB with Approved Providers and members of the community supervision and CSTs/MDTs to ensure understanding and compliance with the *Adult Standards and Guidelines* and *Juveniles Standards and Guidelines*. Critical elements of implementation involve communication, training, and support. Communication strategies and activities include emails to share information, a quarterly newsletter, announcements at committee and Board meetings, and training events. The SOMB website is kept up-to-date and houses the *Standards and Guidelines*, other resources, and access to training.

A key resource is the training and technical assistance hub, which describes training provided by the SOMB and where these can be accessed or requested. These include a series of core trainings to support compliance with the *Standards and Guidelines* and specialty or advanced training. Some trainings are available in pre-recorded webinars. The SOMB is always willing to consider training requests from subject matter experts who wish to deliver relevant training and providers or stakeholders who identify a training need.

Other highlights of implementation efforts in 2024 included:

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

Training Delivery

In 2024, the SOMB provided 33 trainings and the ODVSOM annual conference to over 1400 attendees across Colorado. Over 500 stakeholders attended the ODVSOM annual conference in person. In addition, the training hub provides access to a series of core standards training sessions, as well as the lunch-and-learn sessions, via web recordings. The training events covered a range of topics related to the treatment and supervision of individuals convicted of sex offenses, such as:

Training topics included:

- *SOMB 100 Introduction to Colorado Sex Offender Management*
- *SOMB 101 SOMB Standards Overview*
- *SOMB 102 Advanced Series: Standards and Policy Implementation*
- *SVP & Community Notification Training*
- Introductory Training on the VASOR–2 and SOTIPS Risk Assessment Instruments
- Introductory Training on the JSOAP-II Assessment Instrument
- Desistance from Sexual Offending
- Estimating Lifetime and Residual Risk of Sexual Offending: Practical Approaches
- Assessing Risk for Sexual and Domestic Violence: Latest Research Including Cross-Cultural Validity
- Racial and Generational Trauma: Evidence-based Somatic Interventions for BIPOC Clients
- Approved Supervision Training
- Informed Supervision Training
- Risk Assessment
- Treatment Planning
- Using Evaluations to Guide Individualized Treatment Planning
- SONICS Overview
- SONICS for Evaluators
- Application Review Committee Q&A
- CST/MDT Strategies for Working with CSEM and Non-Identifiable Victim Offenses
- SOMB Standards Training for Judicial
- SOMB Standards Training for Community Corrections

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

- Cultural Implications of Working with African-American Individuals within the ODVSOM
- Applying Risk Assessment Research to Policy and Practice
- Victim Service Funding for Colorado
- Presentation by Pueblo Task Force
- Presentation of Sexual Treatment and Evaluation Training Program at Colorado Mental Health Hospital Pueblo
- Hispanic Heritage Month and Domestic Violence Awareness Month
- Sexual Recidivism Decreases Over Time: Implications for Public Safety Policy

Summary of Year-End Accomplishments

The following highlights some of the many achievements of the SOMB in 2024:

- Presented the SOMB/DOC Treatment Solutions Report to the Joint Judiciary Committee. Taken a series of actions and collaborated with the DOC SOTMP to enhance accessibility to SOTMP to the extent possible.

- Updated language to the *Adult Standards and Guidelines* and *Juveniles Standards and Guidelines* to comply with changes made in SB 23-164. Continue to progress changes to the policy and processes related to supervising agencies providing clients access to a complete list of Approved Providers with the expertise to work with their specific risks and needs.

- Established a Determinate Sentence Workgroup to update the release guidelines for parole.

- Developed the additional administrative and technical resources to adhere to the requirement to conduct compliance reviews on a minimum of 10% of Approved Providers every two years, beginning September 1, 2024.

- Continued priority was given to culturally responsive care by the SOMB provider community.

- Undertaken the second phase of ODVSOM recruitment and retention project involving the development of outreach strategies and materials by Orange Consulting, ensuring these are appealing and reach upcoming professionals from diverse groups.

- Engaged in multiple outreach strategies to connect with providers, stakeholders, and the community.

- Managed 13 SOMB committees and workgroups.

- Conducted multiple research reviews and data analysis projects to support the work of the SOMB committees and inform the provider community.

- Managed 273 applications for placement or continued placement on the SOMB Approved Provider List.

- As of November 2024, there are 231 adult treatment providers and 158 juvenile treatment providers approved by the SOMB in Colorado. There are 25 adult polygraph examiners and 13 juvenile polygraph examiners.

- Every Colorado county has an SOMB Approved Provider for adult evaluation, treatment, and polygraph examination. All judicial districts have an SOMB Approved Provider for juvenile evaluation, treatment, and polygraph examination.

- Continue to optimize the ODVSOM shared services model, including development of the Implementation Specialist roles with specialized training and certification.

- Prioritized ongoing implementation of the *Adult Standards and Guidelines* and *Juveniles Standards and Guidelines* through the SOMB training hub, staff positions as Implementation Specialists, a range of communication strategies, training, and research.

- Hosted the Annual ODVSOM conference in July 2024, which was fully subscribed with over 500 in-person attendees.

- Conducted 33 training events with over 1,400 attendees from across Colorado.

- Published the 2025 SOMB Annual Legislative Report, the 2024 Lifetime Supervision of Sex Offenders Annual Report, and the 2024 SOMB/DOC Treatment Solutions Report.

Section 4: Future Goals and Directions

The mission of the SOMB, as written in its enabling statute, is to have a continuing focus on public safety. To carry out this mission for communities across the state, the SOMB strives toward the successful rehabilitation of offenders through effective treatment and management strategies while balancing the welfare of victims of sexual crimes, their families, and the public at large. The SOMB recognizes that over the past 30 years, much of the knowledge and information on sexual offending has evolved. Since the creation of the SOMB, the *Adult Standards and Guidelines* and *Juveniles Standards and Guidelines* for the evaluation and treatment of sexual offenders have been a "work in progress." Thus, periodic revisions to improve the *Adult Standards and Guidelines* and *Juvenile Standards and Guidelines* remains a key strategic priority for the SOMB through its process of adopting new research and evidence-based practices as they emerge from the literature and the field. The SOMB will continue to recognize the key role that the RNR model plays in the successful rehabilitation and management of adults and juveniles who commit sexual offenses.

Strategic Goals and Initiatives

Over the next year, the SOMB will continue its focus on executing its statutory duties and supporting Approved Providers to implement the *Standards and Guidelines* with fidelity. The SOMB will continue to emphasize efforts toward culturally responsive care by the SOMB provider community to maximize the effectiveness of treatment and protection of victims and potential victims. The SOMB will continue implementing the new requirement to conduct compliance reviews on 10% of Approved Providers every two years. The SOMB will further analyze the recidivism and desistance dataset to support evidence-based policy for the evaluation, treatment, and polygraph examination for individuals under its purview in Colorado. Revisions and changes to the SOMB *Adult Standards and Guidelines* and *Juvenile Standards and Guidelines* will continue to keep pace with emerging research and literature. The SOMB consistently demonstrates and fulfills its statutory authority and mandate to ensure that a community safety and victim-centered approach is the focus of its work. To that end, the SOMB will continue supporting current projects led by the Victim Advocacy Committee.

References

Abbott, B. R. (2020). Illuminating the dark figure of sexual recidivism. *Behavioral Science and Law, 38*, 543-558.

Alper, M., & Durose, M. R. (2019). Recidivism of sex offenders released from state prison: A 9-year follow-up (2005-14). Bureau of Justice Statistics, Office of Justice Programs, US Department of Justice. https://bjs.ojp.gov

Alper, M., Durose, M. R., & Markman, J. (2018). *2018 update on prisoner recidivism: A 9-year follow-up period (2005-2014) (NCJ 250975)*. Bureau of Justice Statistics, Office of Justice Programs, US Department of Justice. https://bjs.ojp.gov

Antenangeli, L., & Durose, M. R. (2021). *Recidivism of prisoners released in 24 states in 2008: A 10-year follow-up period (2008-2018) (NCJ256094)*. Bureau of Justice Statistics, Office of Justice Programs, US Department of Justice. https://bjs.ojp.gov

Bourke, M. L., Fragomeli, L., Detar, P. J., Sullivan, M. A., Meyle, E., & Riordan, M. (2015). The use of tactical polygraph with sex offenders. *Journal of Sexual Aggression, 21*(3), 354–367.

Caldwell, M. F. (2016). Quantifying the decline in juvenile sexual recidivism rates. *Psychology, Public Policy, & Law, 22*(4), 414-426.

Chen, Y., & Ullman, S. E. (2010). Women's reporting of sexual and physical assaults to police in the National Violence Against Women Survey. *Violence Against Women, 16*(3), 262–279.

Cohen, T. H., & Spidell, M. C. (2016). How dangerous are they? An analysis of sex offenders under federal post-conviction supervision. *Federal Probation, 80*(2), 21-32.

Collie, R. Dalen, A. Zhang, Y., & Lobanov-Rostovsky, C. (2024). *Sex Offender Management Board 2024 Annual Legislative Report*. Office of Domestic Violence and Sex Offender Management, Division of Criminal Justice, Colorado Department of Public Safety. https://cdpsdocs.state.co.us/dcj/DCJ%20External%20Website/SOMB/Research.Reports/24.1.24_SOMB_2024_Annual_Legislative_Report-FV2_Accessible.pdf

Collie, R., Zhang, Y., & Lobanov-Rostovsky, C. (2023). *Sex Offender Management Board 2023 Annual Legislative Report*. Office of Domestic Violence and Sex Offender Management, Division of Criminal Justice, Colorado Department of Public Safety. https://cdpsdocs.state.co.us/dcj/DCJ%20External%20Website/SOMB/Research.Reports/2023%20Legislative%20Report.pdf

Colorado Division of Criminal Justice Department of Public Safety (2024a, October 1). *Decline of Victims of Crime Act (VOCA) Federal Funds and Impacts on Victim Services (Fact Sheet by County*. https://dcj.colorado.gov/news-article/decline-of-victims-of-crime-act-voca-federal-funds-and-impacts-on-victim-services-on

Colorado Division of Criminal Justice Department of Public Safety (2024b, January 24). *Understanding VOCA Funding*. https://dcj.colorado.gov/news-article/understanding-voca-funding

Cortoni, F., Hanson, R. K., & Coache, M.-E. (2010). The recidivism rates of female sexual offenders are low: A meta-analysis. *Sexual Abuse: A Journal of Research & Treatment, 22*(4), 387-401.

Drury, A. J., Elbert, M. J.,& DeLisi, M. (2020). The dark figure of sexual offending: A replication and extension. *Behavioral Sciences & the Law, 38*(6), 559–570.

English, K., Flick, P., Harrison, L., & Ford, K. (2023). *Sexually violent predator assessment screening instrument (SVPASI): Background and instructions*. Office of Research Statistics, Division of Criminal Justice, Colorado Department of Public Safety. https://cdpsdocs.state.co.us/ors/docs/Risks/SVPASIHandbook.pdf

Epperson, E., Fuller, N., & Phenix, A. (2018). *Female sexual offender recidivism: An empirical analysis of registered female sex offenders in California*. SARATSO. https://saratso.org/pdf/Female_Sexual_Recidivism_Study.pdf

Gannon, T. A., Olver, M. A., Mallion, J. S., & James, M. (2019). Does specialized psychological treatment for offending reduce recidivism? A meta-analysis examining staff and program variables as predictors of treatment effectiveness. *Clinical Psychology Review, 73*, 101752, https://www.sciencedirect.com/science/article/pii/S0272735818303295

Ghossoub, E., & El Harake, N. (2023). Insights on female sex offenders from the Missouri registry. *Journal of the American Academy of Psychiatry and the Law, 51*(4), 500–505.

Hanson, R. K., Harris, A. J. R., Letourneau, E., Helmus, L. M., & Thornton, D. (2018). Reductions in risk based on time offense-free in the community: Once a sexual offender, not always a sexual offender. *Psychology, Public Policy, and Law, 24*(1), 48-63.

Helmus, L. (2009). *Re-norming Static-99 recidivism estimates: Exploring base rate variability across sex offender samples* (Master's Thesis). Carleton University.

Helmus, M. (2021). Estimating the probability of sexual recidivism among men charged or convicted of sexual offenses: Evidence-based guidance for applied evaluators. *Sexual Offending: Theory, Research, and Prevention, 16*, Article e4283.

Holper, L., Mokros, A., & Heabermeyer, E. (2024). Moderators of sexual recidivism as indicator of treatment effectiveness in persons with sexual offense histories: An updated meta-analysis. *Sexual Abuse, 36*(3), 255-291.

Kelley, S. M., Kahn, R. E., & Zaw, G. (2024). The influence of race on detected and undetected sexual offense histories: A comparison of white and black men committed as sexually violent persons. *Sexual Abuse, 0*(0), 1-26.

Kettrey, H. H. & Lipsey, M. W. (2018). The effects of specialized treatment on the recidivism of juvenile sex offenders: A systematic review and meta-analysis. *Journal of Experimental Criminology, 14*(3), 1-27.

Langan, P. A., Schmitt, E. L., & Durose, M. R. (2003). *Recidivism of sex offenders released from prison 1994. (NCJ 198281).* Bureau of Justice Statistics, Office of Justice Programs, US Department of Justice. https://bjs.ojp.gov

Lave, T. R., Prescott, J.J., & Bridges, G. (2021). The problem with assumptions: Revisiting the dark figure of sexual recidivism. *Behavioral Sciences & the Law, 39*(3), 279-306.

Lee, S. C., Restrepo, A., Satariano, A. & Hanson, R. K. *The predictive validity of Static-99R for sexual offenders in California: 2016 update*. Report prepared for SARATSO Committee, California Sex Offender Management Board. https://saarna.org/wp-content/uploads/2021/03/Lee-et-al.-Static-99R-in-California-Government-Report-June-20-16.pdf

Lee, S. C., Hanson, R. K., Fullmer, N. Neeley, J., Ramos, K. (2018). *The predictive validity of Static-99R for sexual offenders in California: 2018 update*. https://saratso.org/pdf/lee_hanson_fullmer_neeley_ramos_2018_the_predictive_validity_of_s_.pdf

Lisak, D., & Miller, P. M. (2002). Repeat rape and multiple offending among undetected rapists. *Violence & Victims, 17*(1), 73–84.

Lussier, P., Van Den Berg, C., Bijleveld, C., & Hendriks, J. (2012). A developmental taxonomy of juvenile sex offenders for theory, research, and prevention: The adolescent-limited and high-rate slow desister. *Criminal Justice & Behavior, 39*(12), 1559-1581.

Lussier, P. McCuish, E., & Corrado, R. R. (2015). The adolescence-adulthood transition and desistance from crime: Examining the underlying structure of desistance. *Journal of Life Course Criminology, 1*, 87-117.

Lussier, P., McCuish, E., Chouinard Thivierge, S., & Frechette, J. (2024). A meta-analysis of trends in general, sexual, and violent recidivism among youth with histories of sex offending. *Trauma, Violence, & Abuse, 25*(1), 54-72.

Lussier, P. (2017). Juvenile sex offending through a developmental life course criminology perspective: An agenda for policy and research. *Sexual Abuse, 29*(1), 51–80.

Marshall, E., Miller, H. A., Cortoni, F., & Helmus, L. M. (2021). The Static-99R is not valid for women: Predictive validity in 739 females who have sexually offended. *Sexual Abuse, 33*(6), 631–653.

Marshall, E. A., Miller, H. A., & Grubb, L. (2022). Examining the utility of the LSI-R in a sample of women who have sexually offended. *Criminal Justice and Behavior, 49*(3), 311–329.

National Institute of Justice (2014). *Recidivism*, retrieved October 23, 2024, from https://nij.ojp.gov/topics/corrections/recidivism.

Office for Victim Programs (2023). *Colorado Crime Victim Compensation Program Report Fiscal Year 2023*. Colorado Department of Public Safety Division of Criminal Justice. https://dcj.colorado.gov/news-article/understanding-voca-funding

Ozkan, T., Clipper, S. J., Piquero, A. R., Baglivio, M., & Wolff, K. (2020). Predicting sexual recidivism. *Sexual Abuse, 32*(4), 375-399.

Rocque, M. (2021). *But what does it mean? Defining, measuring, and analyzing desistance from crime in criminal justice*. NCJ 301498, in Desistance from Crime: Implications for Research, Policy, and Practice. Washing, DC: US Department of Justice, National Institute of Justice, NCJ 301497.

Scurich, N., & John, R. S. (2019). The dark figure of sexual recidivism. *Behavioral Sciences & the Law, 37*(2), 158–175.

Seto, M., Augustyn, C., Roche, K. M., & Hilkes, G. (2023). Empirically-based dynamic risk and protective factors for sexual offending. *Clinical Psychology Review, 106*, 102355.

Swick, K. (2024, October 30). *The Blue Bench Organizational and Programmatic Changes*. The Blue Bench.https://thebluebench.org/about-us/media-center/blog.html/article/2024/10/30/the-blue-bench-organizational-and-programmatic-changes

Weinrott, M. R., & Saylor, M. (1991). Self-report of crimes committed by sex offenders. *Journal of Interpersonal Violence, 6*(3), 286–300.

Appendices

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Appendix A: Recidivism and Desistance Study Screenreader Tables

A.F1. Number of Treatment Records Extracted from the PDMS and Included in the Analyses.

Type of Record	Number of Records
Treatment Records in PDMS (1/2020–1/2024)	2,527
Records with Court Case ID's for Linking	1,156
Records Linked to Judicial Data	1,007
Linked Records with Valid Treatment Discharge Dates	1,004

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A.T3. Demographic Characteristics of the Final Sample Used in the Analyses and the Total Sample Extracted from the PDMS.

A.T3.A. Demographic Characteristics and Statistical Significance

Client Demographic Characteristic	Statistical Significance*
Gender	n.s
Race/Ethnicity	n.s
Developmental or Intellectual Disability	n.s
Education	p<.01
Age (At Time of Offense)	p<.05

* n.s = not significantly different each other

A.T3.B. Client Gender

Client Gender	Final Sample (Count 1,004) Number of Clients	Final Sample (Count 1,004) Percent of Clients	Initial Sample (Count 2,527) Number of Clients	Initial Sample (Count 2,527) Percent of Clients
Male	958	95%	2,316	96%
Female	36	3.6%	83	3.4%
Other	10	1.0%	24	1.0%
Missing	0	NA	104	NA

A.T3.C. Client Race/Ethnicity

Client Race/Ethnicity	Final Sample (Count 1,004) Number of Clients	Final Sample (Count 1,004) Percent of Clients	Initial Sample (Count 2,527) Number of Clients	Initial Sample (Count 2,527) Percent of Clients
White	607	60%	1,434	59%
Hispanic or Latino	244	24%	638	26%
Black or African American	103	10%	240	9.9%
Native American or American Indian	22	2.2%	43	1.8%
Asian or Pacific Islander	11	1.1%	25	1.0%
Other	8	0.8%	22	0.9%
Unknown	9	0.9%	18	0.7%
Missing	0	NA	107	NA

A.T3.D. Client Age (At Time of Offense)

Client Age (At Time of Offense)	Final Sample (Count 1,004)	Initial Sample (Count 2,527)
Mean (Range)	42 (13 - 84)	41 (11 - 92)
Number of Missing Records	1	163

A.T3.E. Client Developmental or Intellectual Disability

Client Developmental or Intellectual Disability	Final Sample (Count 1,004) Number of Clients	Final Sample (Count 1,004) Percent of Clients	Initial Sample (Count 2,527) Number of Clients	Initial Sample (Count 2,527) Percent of Clients
No	955	95%	2,260	94%
Yes	49	4.9%	141	5.9%
Missing	0	NA	126	NA

A.T3.F. Client Education

Client Education	Final Sample (Count 1,004) Number of Clients	Final Sample (Count 1,004) Percent of Clients	Initial Sample (Count 2,527) Number of Clients	Initial Sample (Count 2,527) Percent of Clients
High school degree or equivalent	566	56%	1,272	53%
Less than high school degree	144	14%	453	19%
Some college but no degree	183	18%	413	17%
Bachelor degree	47	4.7%	149	6.2%
Associate degree	43	4.3%	82	3.4%
Graduate degree	21	2.1%	36	1.5%
Missing	0	NA	122	NA

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A.T4. Risk Levels and Discharge Types of the Final Sample Used in the Recidivism Analyses and the Total Sample Extracted from the PDMS.

A.T4.A. Characteristic and Statistical Significance

Characteristic	Statistical Significance*
Beginning Risk Level	n.s
Ending Risk Level	n.s
Outcome Type	n.s

* n.s = not significantly different each other

A.T4.B. Beginning Risk Level

Client Beginning Risk Level	Final Sample (Count 1,004) Number of Clients	Final Sample (Count 1,004) Percent of Clients	Initial Sample (Count 2,527) Number of Clients	Initial Sample (Count 2,527) Percent of Clients
Low	284	28%	625	27%
Low-Moderate	188	19%	482	21%
Moderate	268	27%	625	27%
Moderate-High	130	13%	270	12%
High	132	13%	304	13%
Missing	2	NA	221	NA

A.T4.C. Ending Risk Level

Ending Risk Level	Final Sample (Count 1,004) Number of Clients	Final Sample (Count 1,004) Percent of Clients	Initial Sample (Count 2,527) Number of Clients	Initial Sample (Count 2,527) Percent of Clients
Low	284	28%	625	27%
Low-Moderate	188	19%	482	21%
Moderate	268	27%	625	27%
Moderate-High	130	13%	270	12%
High	132	13%	304	13%
Missing	2	NA	221	NA

A.T4.D. Outcome Type

Outcome Type	Final Sample (Count 1,004) Number of Clients	Final Sample (Count 1,004) Percent of Clients	Initial Sample (Count 2,527) Number of Clients	Initial Sample (Count 2,527) Percent of Clients
Successful	427	43%	1,097	46%
Unsuccessful	404	40%	920	38%
Administrative	173	17%	378	16%
Missing	0	NA	132	NA

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A.T6. Proportion of Clients Who Recidivated Following Successful Treatment Discharge from Adult Community, Adult DOC, and Juvenile Subgroups at One-Year, Two-Year, and Three-Year Follow-Up Periods.

A.T6.A. One-Year Follow-Up Subsample

Recidivism Type	% of Adult Community Clients with New Charges (Count 299)	% of Adult Community Clients with New Convictions (Count 299)	% of Adult DOC Clients with New Charges (Count 67)	% of Adult DOC Clients with New Convictions (Count 67)	% of Juvenile Clients with New Charges (Count 33)	% of Juvenile Clients with New Convictions (Count 33)
Sexual	0.3%	0%	1.5%	1.5%	0%	0%
Violent*	2.7%	2.0%	1.5%	1.5%	3.0%	0%
Any	11.0%	6.0%	3.0%	3.0%	12.1%	0%
Failure to register**	3.7%	2.7%	1.5%	1.5%	3.0%	0%

* Violent recidivism was inclusive of sexual recidivism.
** Failure to register offenses are also counted in the any recidivism category

A.T6.B. Two-Year Follow-Up Subsample

Recidivism Type	% of Adult Community Clients with New Charges (Count 192)	% of Adult Community Clients with New Convictions (Count 192)	% of Adult DOC Clients with New Charges (Count 41)	% of Adult DOC Clients with New Convictions (Count 41)	% of Juvenile Clients with New Charges (Count 24)	% of Juvenile Clients with New Convictions (Count 24)
Sexual	0.5%	0%	2.4%	2.4%	0%	0%
Violent*	3.1%	2.6%	2.4%	2.4%	8.3%	4.2%
Any	10.9%	7.3%	9.8%%	7.3%	25.0%	4.2%
Failure to register**	3.6%	2.6%	2.4%	2.4%	4.2%	0%

* Violent recidivism was inclusive of sexual recidivism.
** Failure to register offenses are also counted in the any recidivism category

A.T6.C. Three-Year Follow-Up Subsample

Recidivism Type	% of Adult Community Clients with New Charges (Count 92)	% of Adult Community Clients with New Convictions (Count 92)	% of Adult DOC Clients with New Charges (Count 27)	% of Adult DOC Clients with New Convictions (Count 27)	% of Juvenile Clients with New Charges (Count 18)	% of Juvenile Clients with New Convictions (Count 18)
Sexual	1.1%	0%	3.7%	3.7%	0%	0%
Violent*	4.3%	3.3%	3.7%	3.7%	11.1%	11.1%
Any	13.0%	9.8%	16.7%	7.4%	27.8%	11.1%
Failure to register**	6.5%	4.3%	0%	0%	5.6%	0%

* Violent recidivism was inclusive of sexual recidivism.
** Failure to register offenses are also counted in the any recidivism category

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A.T7. Proportion of Adult Community Clients Who Recidivated Following Unsuccessful Treatment Discharge in the One-Year, Two-Year, and Three-Year Follow-Up Subgroups

A.T7.A. One-Year Follow-Up Subsample

Recidivism Type	% of Adult Community Clients with New Charges (Count 365)	% of Adult Community Clients with New Convictions (Count 365)
Sexual	2.5%	1.9%
Violent*	12.6%	6.3%
Any	33.4%	21.9%
Failure to register**	15.9%	8.5%

* Violent recidivism was inclusive of sexual recidivism.
** Failure to register offenses are also counted in the any recidivism category

A.T7.B. Two-Year Follow-Up Subsample

Recidivism Type	% of Adult Community Clients with New Charges (Count 267)	% of Adult Community Clients with New Convictions (Count 267)
Sexual	3.4%	2.6%
Violent*	13.9%	7.9%
Any	38.2%	27.0%
Failure to register**	18.7%	10.9%

* Violent recidivism was inclusive of sexual recidivism.
** Failure to register offenses are also counted in the any recidivism category

A.T7.C. Three-Year Follow-Up Subsample

Recidivism Type	% of Adult Community Clients with New Charges (Count 151)	% of Adult Community Clients with New Convictions (Count 151)
Sexual	3.3%	2.6%
Violent*	17.2%	9.9%
Any	43.7%	31.8%
Failure to register**	24.5%	14.6%

* Violent recidivism was inclusive of sexual recidivism.
** Failure to register offenses are also counted in the any recidivism category

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A.F2.a. Treatment Discharge Outcomes of Adult Community Clients by the Presence of New Charges.

Treatment Discharge Type	% of Clients with New Sex Offense Charges (Count 12)	% of Clients with New Violent Offense Charges (Count 62)	% of Clients with Any New Charges (Count 181)	% of Clients with No New Charges (Count 636)
Unsuccessful Discharge	75%	74%	67%	38%
Administrative Discharge	17%	13%	14%	20%
Successful Discharge	8%	13%	18%	42%

Return to Figure 2.a. main document

A.F2.b. Treatment Discharge Outcomes of Adult Community Clients by the Presence of New Convictions.

Treatment Discharge Type	% of Clients with New Sex Offense Convictions (Count 8)	% of Clients with New Violent Offense Convictions (Count 34)	% of Clients with Any New Convictions (Count 114)	% of Clients with No New Convictions (Count 703)
Unsuccessful Discharge	88%	68%	70%	41%
Administrative Discharge	12%	15%	14%	18%
Successful Discharge	0%	18%	16%	40%

Return to Figure 2.b. main document

A.F3. Cumulative recidivism rates for sexual, violent, and any recidivism among adult community clients with Three-year follow-up time frames (Count 308).

A.F3.A. Recidivism Rates for New Charges

Recidivism Type	Recidivism Rate (%) at Year 1	Recidivism Rate (%) at Year 2	Recidivism Rate (%) at Year 3
Sexual	0.6%	1.3%	1.9%
Violent*	4.5%	7.1%	8.4%
Any	16.6%	22.7%	26.9%

* Violent recidivism was inclusive of sexual recidivism.

A.F3.B. Recidivism Rates for New Convictions

Recidivism Type	Recidivism Rate (%) at Year 1	Recidivism Rate (%) at Year 2	Recidivism Rate (%) at Year 3
Sexual	0.6%	0.6%	1.3%
Violent*	1.9%	3.9%	5.5%
Any	12.3%	16.9%	20.1%

* Violent recidivism was inclusive of sexual recidivism.

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A.F4. Cumulative recidivism rates for violent and any recidivism among juvenile clients with Three-year follow-up time frames (Count 24).

A.F4.A. Recidivism Rates for New Charges

Recidivism Type	Recidivism Rate (%) at Year 1	Recidivism Rate (%) at Year 2	Recidivism Rate (%) at Year 3
Sexual	0%	0%	0%
Violent*	4.2%	8.3%	16.7%
Any	16.7%	25.0%	33.3%

* Violent recidivism was inclusive of sexual recidivism.

A.F4.B. Recidivism Rates for New Convictions

Recidivism Type	Recidivism Rate (%) at Year 1	Recidivism Rate (%) at Year 2	Recidivism Rate (%) at Year 3
Sexual	0%	0%	0%
Violent*	4.2%	8.3%	16.7%
Any	4.2%	8.3%	16.7%

* Violent recidivism was inclusive of sexual recidivism.

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A.F5. Progress Toward Desistance for Adult Community Treatment Clients Who Successfully Completed Treatment.

Recidivism	One-Year Follow-Up (Count 299)	Two-Year Follow-Up (Count 192)	Three-Year Follow-Up (Count 92)
No New Sexual or Violent Charges	97.3%	96.9%	95.7%
No New Charges	89%	89.1%	87.0%

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Appendix B: Recidivism and Desistance Study Supplementary Tables

B. Supplementary Table 1. Proportion of Clients Who Recidivated Following All Types of Treatment Discharge from Adult Community, Adult DOC, and Juvenile Subgroups at One-Year, Two-Year, and Three-Year Follow-Up Periods

Table 1.A. One-Year Follow-Up Subsample

Recidivism Type	% of Adult Community Clients with New Charges (Count 817)	% of Adult Community Clients with New Convictions (Count 817)	% of Adult DOC Clients with New Charges (Count 94)	% of Adult DOC Clients with New Convictions (Count 94)	% of Juvenile Clients with New Charges (Count 42)	% of Juvenile Clients with New Convictions (Count 42)
Sexual	1.0%	0.7%	1.1%	1.1%	0%	0%
Violent*	4.3%	2.2%	1.1%	1.1%	4.8%	2.4%
Any	14.1%	9.7%	3.2%	2.1%	19.0%	4.8%
Failure to register**	5.5%	3.6%	1.1%	1.1%	9.5%	2.4%

* Violent recidivism was inclusive of sexual recidivism.

** Failure to register offenses are also counted in the any recidivism category

Table 1.B. Two-Year Follow-Up Subsample

Recidivism Type	% of Adult Community Clients with New Charges (Count 570)	% of Adult Community Clients with New Convictions (Count 570)	% of Adult DOC Clients with New Charges (Count 59)	% of Adult DOC Clients with New Convictions (Count 59)	% of Juvenile Clients with New Charges (Count 31)	% of Juvenile Clients with New Convictions (Count 31)
Sexual	1.5%	0.9%	1.7%	1.7%	0%	0%
Violent*	6.7%	3.7%	1.7%	1.7%	9.7%	6.5%
Any	21.2%	15.1%	8.5%	5.1%	25.8%	6.5%
Failure to register**	9.0%	5.6%	1.7%	1.7%	6.5%	0%

* Violent recidivism was inclusive of sexual recidivism.

** Failure to register offenses are also counted in the any recidivism category

Table 1.C. Three-Year Follow-Up Subsample

Recidivism Type	% of Adult Community Clients with New Charges (Count 308)	% of Adult Community Clients with New Convictions (Count 308)	% of Adult DOC Clients with New Charges (Count 35)	% of Adult DOC Clients with New Convictions (Count 35)	% of Juvenile Clients with New Charges (Count 24)	% of Juvenile Clients with New Convictions (Count 24)
Sexual	1.9%	1.3%	2.9%	2.9%	0%	0%
Violent*	8.4%	5.5%	2.9%	2.9%	16.7%	16.7%
Any	26.9%	20.1%	11.4%	5.7%	33.3%	16.7%
Failure to register**	14.3%	8.4%	2.9%	0%	8.3%	0%

* Violent recidivism was inclusive of sexual recidivism.

** Failure to register offenses are also counted in the any recidivism category

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B. Supplementary Table 2. Demographic Characteristics of the Adult Community Treatment Included in the One-Year Follow-Up Sample by Presence of a New Sex Offense Charge and New Violent Offense Charge Across All Discharge Types.

Table 2.A. Client Gender

Client Gender	Count of Clients with No New Sex Offense Charges (Count 817)	% of Clients with No New Sex Offense Charges (Count 817)	Count of Clients with a New Sex Offense Charge (Count 12)	% of Clients with a New Sex Offense Charge (Count 12)	Count of Clients with No New Violent Charges (Count 755)	% of Clients with No New Violent Charges (Count 755)	Count of Clients with a New Violent Charge (Count 62)	% of Clients with a New Violent Charge (Count 62)
Male	780	96.9%	12	100%	731	96.8%	62	98.4%
Female	18	2.2%	0	0%	17	2.3%	*	*
Other	7	0.9%	0	0%	7	0.9%	*	*

* Data suppressed to maintain client confidentiality for identifiable demographic categories with less than 5 cases

Table 2.B. Client Race/Ethnicity

Client Race/Ethnicity	Count of Clients w/ No New Sex Offense Charges (Count 817)	% of Clients w/ No New Sex Offense Charges (Count 817)	Count of Clients w/ a New Sex Offense Charge (Count 12)	% of Clients w/ a New Sex Offense Charge (Count 12)	Count of Clients w/ No New Violent Charges (Count 755)	% of Clients w/ No New Violent Charges (Count 755)	Count of Clients w/ a New Violent Charge (Count 62)	% of Clients w/ a New Violent Charge (Count 62)
White	520	61.5%	7	58.3%	493	62.0%	34	54.0%
Hispanic or Latino	201	23.8%	*	25.0%	189	23.4%	15	23.8%
Black or African American	87	10.2%	*	*	78	9.8%	10	15.9%
Native American or American Indian	16	1.9%	0	0%	6	0.8%	*	*
Asian or Pacific Islander	7	0.8%	0	0%	6	0.8%	*	*
Other	7	0.8%	0	0%	7	0.9%	0	0%
Unknown	8	0.9%	1	8.3%	8	1.0%	1	1.6%

* Data suppressed to maintain client confidentiality for identifiable demographic categories with less than 5 cases

Table 2.C. Client Age (At Time of Offense)

Statistic	Clients with No New Sex Offense Charges (Count 817)	Clients with a New Sex Offense Charge (Count 12)	Clients with No New Violent Charges (Count 755)	Clients with a New Violent Charge (Count 62)
Client Mean Age (years)	42.8	34.8	43.2	36.2
Client Age Standard Deviation (years)	14.2	11.9	14.2	11.8

Table 2.D. Client Developmental or Intellectual Disability

Developmental or Intellectual Disability Present	Count of Clients w/ No New Sex Offense Charges (Count 817)	% of Clients w/ No New Sex Offense Charges (Count 817)	Count of Clients w/ a New Sex Offense Charge (Count 12)	% of Clients w/ a New Sex Offense Charge (Count 12)	Count of Clients w/ No New Violent Charges (Count 755)	% of Clients w/ No New Violent Charges (Count 755)	Count of Clients w/ a New Violent Charge (Count 62)	% of Clients w/ a New Violent Charge (Count 62)
No	763	94.8%	10	83.3%	719	95.2%	54	87.1%
Yes	42	5.2%	2	16.7%	36	4.8%	8	12.9%

Table 2.E. Client Education

Client Education	Count of Clients w/ No New Sex Offense Charges (Count 817)	% of Clients w/ No New Sex Offense Charges (Count 817)	Count of Clients w/ a New Sex Offense Charge (Count 12)	% of Clients w/ a New Sex Offense Charge (Count 12)	Count of Clients w/ No New Violent Charges (Count 755)	% of Clients w/ No New Violent Charges (Count 755)	Count of Clients w/ a New Violent Charge (Count 62)	% of Clients w/ a New Violent Charge (Count 62)
High School degree or equivalent (e.g., GED)	451	56.0%	5	41.7%	421	55.8%	35	56.5%
Less than high school degree	106	13.2%	5	41.7%	95	12.6%	16	25.8%
Some college but no degree	153	19.0%	2	16.7%	147	19.5%	8	12.9%
Bachelor degree	39	4.8%	0	0%	38	5.0%	1	1.6%
Associate degree	39	4.8%	0	0%	37	4.9%	2	3.2%
Graduate degree	17	2.1%	0	0%	17	2.3%	0	0%

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B. Supplementary Table 3. Demographic Characteristics of the Adult Community Treatment Included in the One-Year Follow-Up Sample by Presence of a New Sex Offense Conviction and New Violent Offense Conviction Across All Discharge Types.

Table 3.A. Client Gender

Client Gender	Count of Clients with No New Sex Offense Convictions (Count 809)	% of Clients with No New Sex Offense Convictions (Count 809)	Count of Clients with a New Sex Offense Conviction (Count 8)	% of Clients with a New Sex Offense Conviction (Count 8)	Count of Clients with No New Violent Convictions (Count 783)	% of Clients with No New Violent Convictions (Count 783)	Count of Clients with a New Violent Conviction (Count 34)	% of Clients with a New Violent Conviction (Count 34)
Male	784	96.9%	8	100%	759	96.9%	33	97.1%
Female	18	2.2%	0	0%	17	2.2%	*	*
Other	7	0.9%	0	0%	7	0.9%	*	*

* Data suppressed to maintain client confidentiality for identifiable demographic categories with less than 5 cases

Table 3.B. Client Race/Ethnicity

Client Race/Ethnicity	Count of Clients w/ No New Sex Offense Convictions (Count 809)	% of Clients w/ No New Sex Offense Convictions (Count 809)	Count of Clients w/ a New Sex Offense Conviction (Count 8)	% of Clients w/ a New Sex Offense Conviction (Count 8)	Count of Clients w/ No New Violent Convictions (Count 783)	% of Clients w/ No New Violent Convictions (Count 783)	Count of Clients w/ a New Violent Conviction (Count 34)	% of Clients w/ a New Violent Conviction (Count 34)
White	522	61.4%	5	62.5%	508	61.7%	19	55.9%
Hispanic or Latino	203	23.9%	*	*	196	23.8%	8	23.5%
Black or African American	87	10.2%	*	*	83	10.7%	5	15.2%
Native American or American Indian	16	18.8%	0	0%	16	1.9%	0	0%
Asian or Pacific Islander	7	0.8%	0	0%	6	0.7%	*	*
Other	7	0.8%	0	0%	7	0.8%	0	0%
Unknown	8	0.9%	1	12.5%	8	1.0%	*	*

* Data suppressed to maintain client confidentiality for identifiable demographic categories with less than 5 cases

Table 3.C. Client Age (At Time of Offense)

Statistic	Clients with No New Sex Offense Convictions (Count 809)	Clients with a New Sex Offense Conviction (Count 8)	Clients with No New Violent Convictions (Count 783)	Clients with a New Violent Conviction (Count 34)
Client Mean Age (years)	42.7	36.4	42.9	36.9
Client Age Standard Deviation (years)	14.2	14.0	14.12	11.5

Table 3.D. Client Developmental or Intellectual Disability

Developmental or Intellectual Disability Present	Count of Clients w/ No New Sex Offense Convictions (Count 809)	% of Clients w/ No New Sex Offense Convictions (Count 809)	Count of Clients w/ a New Sex Offense Conviction (Count 8)	% of Clients w/ a New Sex Offense Conviction (Count 8)	Count of Clients w/ No New Violent Convictions (Count 783)	% of Clients w/ No New Violent Convictions (Count 783)	Count of Clients w/ a New Violent Conviction (Count 34)	% of Clients w/ a New Violent Conviction (Count 34)
No	766	94.7%	7	87.5%	744	95.0%	29	85.3%
Yes	43	5.3%	1	12.5%	39	5.0%	5	14.7%

Table 3.E. Client Education

Client Education	Count of Clients w/ No New Sex Offense Convictions (Count 809)	% of Clients w/ No New Sex Offense Convictions (Count 809)	Count of Clients w/ a New Sex Offense Conviction (Count 8)	% of Clients w/ a New Sex Offense Conviction (Count 8)	Count of Clients w/ No New Violent Convictions (Count 783)	% of Clients w/ No New Violent Convictions (Count 783)	Count of Clients w/ a New Violent Conviction (Count 34)	% of Clients w/ a New Violent Conviction (Count 34)
High School degree or equivalent (e.g., GED)	451	55.7%	5	62.5%	436	55.7%	19	58.8%
Less than high school degree	109	13.5%	2	25.0%	102	13.0%	9	26.5%
Some college but no degree	154	19.0%	1	12.5%	152	19.4%	3	8.8%
Bachelor degree	39	4.8%	0	0%	38	4.9%	1	2.9%
Associate degree	39	4.8%	0	0%	38	4.9%	1	2.9%
Graduate degree	17	2.1%	0	0%	17	2.2%	0	0%

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B. Supplementary Table 4. Demographic Characteristics of the Adult Community Treatment Sample by Presence of Any New Offense or Conviction.

Table 4.A. Client Gender

Client Gender	Count of Clients with No New Charges (Count 636)	% of Clients with No New Charges (Count 636)	Count of Clients with a New Charge (Count 181)	% of Clients with a New Charge (Count 181)	Count of Clients with No New Convictions (Count 703)	% of Clients with No New Convictions (Count 703)	Count of Clients with a New Conviction (Count 114)	% of Clients with a New Conviction (Count 114)
Male	613	96.4%	179	98.9%	679	96.6%	113	99.1%
Female	16	2.5%	*	*	17	2.4%	*	*
Other	7	1.1%	*	*	7	1.0%	*	*

* Data suppressed to maintain client confidentiality for identifiable demographic categories with less than 5 cases

Table 4.B. Client Race/Ethnicity

Client Race/Ethnicity	Count of Clients w/ No New Charges (Count 636)	% of Clients w/ No New Charges (Count 636)	Count of Clients w/ a New Charge (Count 181)	% of Clients w/ a New Charge (Count 181)	Count of Clients w/ No New Convictions (Count 703)	% of Clients w/ No New Convictions (Count 703)	Count of Clients w/ a New Conviction (Count 114)	% of Clients w/ a New Conviction (Count 114)
White	520	61.5%	7	58.3%	493	62.0%	34	54.0%
Hispanic or Latino	201	23.8%	*	*	189	23.4%	15	23.8%
Black or African American	87	10.2%	*	*	78	9.8%	10	15.9%
Native American or American Indian	16	1.9%	0	0%	14	1.8%	*	*
Asian or Pacific Islander	7	0.8%	0	0%	6	0.8%	*	*
Other	7	0.8%	0	0%	7	0.9%	0	0%
Unknown	8	0.9%	1	8.3%	8	1.0%	1	1.6%

* Data suppressed to maintain client confidentiality for identifiable demographic categories with less than 5 cases

Table 4.C. Client Age (At Time of Offense)

Statistic	Clients with No New Charges (Count 636)	Clients with a New Charge (Count 181)	Clients with No New Convictions (Count 703)	Clients with a New Conviction (Count 114)
Client Mean Age (years)	43.75	38.7	43.5	37.6
Client Age Standard Deviation (years)	14.5	12.4	14.4	11.8

Table 4.D. Client Developmental or Intellectual Disability

Developmental or Intellectual Disability Present	Count of Clients w/ No New Charges (Count 636)	% of Clients w/ No New Charges (Count 636)	Count of Clients w/ a New Charge (Count 181)	% of Clients w/ a New Charge (Count 181)	Count of Clients w/ No New Convictions (Count 703)	% of Clients w/ No New Convictions (Count 703)	Count of Clients w/ a New Conviction (Count 114)	% of Clients w/ a New Conviction (Count 114)
No	610	95.9%	163	90.1%	673	95.7%	100	8.7%
Yes	26	4.1%	18	9.9%	30	4.3%	14	12.3%

Table 4.E. Client Education

Client Education	Count of Clients w/ No New Charges (Count 636)	% of Clients w/ No New Charges (Count 636)	Count of Clients w/ a New Charge (Count 181)	% of Clients w/ a New Charge (Count 181)	Count of Clients w/ No New Convictions (Count 703)	% of Clients w/ No New Convictions (Count 703)	Count of Clients w/ a New Conviction (Count 114)	% of Clients w/ a New Conviction (Count 114)
High School degree or equivalent (e.g., GED)	350	55.0%	106	58.6%	394	56.0%	62	54.4%
Less than high school degree	72	11.3%	39	21.5%	83	11.8%	28	24.6%
Some college but no degree	126	19.8%	29	16.0%	136	19.3%	19	16.7%
Bachelor degree	36	5.7%	3	1.7%	37	5.3%	2	1.8%
Associate degree	36	5.7%	3	1.7%	36	5.1%	3	2.6%
Graduate degree	16	2.5%	1	0.6%	17	2.4%	0	0%

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Appendix C: SOMB Data Collection Analysis 2024

Introduction

The Colorado Department of Public Safety developed the SOMB Provider Data Management System (PDMS) following the recommendations from the 2016 Sunset Review. This system was established according to the mandate of HB 16-1345, requiring all SOMB Approved Providers to submit service information related to evaluation, treatment, and polygraph examinations upon completion of each service, regardless of the outcome of the service. The data collection aligns with the requirement for the *Standards and Guidelines* set by the SOMB to be evidence-based [see § 16-11.7-103 (4) (e), C.R.S.].

The PDMS was officially implemented on January 1, 2020. Approved Providers must enter client information in a deidentified format, ensuring no names or birth dates are recorded. Providers are requested to seek a *release of information consent* from clients, allowing for future matching of criminal recidivism data. If clients grant consent, a unique court case identifier is linked to their client record. If consent is not provided, the provider enters the service information, omitting the unique linking identifier.

The SOMB regularly updates its data collection process based on committee input and provider feedback. The SOMB also offers training and technical assistance to ensure the system is used correctly. While the SOMB cannot identify who submitted specific data entries, it can track which providers have not entered data over a certain period. Through the use of regular and targeted reminders, compliance with the PDMS requirement has improved year by year. In 2024, fewer than 20 providers did not enter data before the November 1 deadline for the current reporting period.[42]

Research Questions

The PDMS data collection serves multiple purposes. Initially, the objectives were to: (i) use the information to assess overall adherence to the *Standards and Guidelines* among providers and (ii) match recidivism data to evaluate the longer-term outcomes of clients. As the system has become embedded, the collected data has also been utilized to deliver a comprehensive overview of the services provided and clients seen under the purview of the SOMB. It has also been instrumental in informing revisions to the *Standards and Guidelines* and shaping policy positions.

The current report of 2024 PDMS data provides a 12-month overview of clients seen for evaluation, treatment, and polygraph examination who were discharged between November 1, 2023, and October 31, 2024. This overview provides an assessment of the degree to which these services

1. Adhere to the *Standards and Guidelines*
2. Are being implemented as required by the *Standards and Guidelines*
3. Are consistent with the RNR Principles and individualize services to client risk and need levels

[42] In 2023 the number was 63.

Methodology

Over the 12-month period of November 1, 2023, and October 31, 2024, providers entered data for 408 evaluations, 517 treatments, and 2,857 polygraph examinations. After filtering for missing data, the final counts were 401 evaluations, 514 treatments, and 2,829 polygraph examination records.[43]

The PDMS employs three distinct surveys to collect information regarding evaluation, treatment, and polygraph examinations. The surveys inquire about the services provided and the implementation of the *Standards and Guidelines*. They also collect crucial client demographics and information about significant findings and outcomes on clients. Separate versions of the surveys apply for clients under the *Adult Standards and Guidelines* and those under the *Juvenile Standards and Guidelines*. It is important to highlight that factors other than age can sometimes determine whether the *Adult* or *Juvenile Standards and Guidelines* apply.[44] **In this report, "juvenile client" refers to an individual adjudicated in a juvenile court and subject to the *Juvenile Standards and Guidelines*. Conversely, "adult client" refers to an individual convicted in adult court and subject to the *Adult Standards and Guidelines*.** Of the clients adjudicated in a juvenile court, 30 were 18 or older at the time of adjudication.[45]

Table C1 shows the number of evaluation, treatment, and polygraph examination records for adult and juvenile clients. As indicated, adult clients account for most of the evaluation and treatment services and nearly all the polygraph examinations. Since 30 juvenile court clients were older than 18 when adjudicated, a substantial proportion of the data regarding juvenile clients represents young adults. Please note that data for adult and juvenile clients is presented separately throughout this section of the report when possible.

Table C1. Number and Percent of Evaluation, Treatment, and Polygraph Examination Records by Adult and Juvenile Clients 2024.

Court Type	Number of Evaluation Clients	% of Evaluation Clients	Number of Treatment Clients	% of Treatment Clients	Number of Polygraph Clients	% of Polygraph Clients
Adult Criminal Court	342	85%	463	90%	2,771	98%
Juvenile Court	59	15%	51	10%	58	2%
Total	**401**	**100%**	**514**	**100%**	**2,829**	**100%**

[43] When clients do not provide consent to participate in the data collection process, providers can take a shortcut and submit the client record after entering only the initial screening questions.

[44] The determination of whether the Adult Standards and Guidelines or Juveniles Standards and Guidelines apply depends on several factors including: the age of the client when the offense was committed; the age of the client at the date of adjudication or conviction; and whether the case is handled in an adult or juvenile court. In addition, some young adults who were adjudicated in juvenile court for a sex crime may receive a subsequent adult criminal court conviction for a non-sex crime, making them subject to both sets of Standards and Guidelines.

[45] These clients are commonly referred to as "crossover" cases.

Client Characteristics

Table C2.a. shows the number of adult clients who agreed to participate in data collection based on their involvement in evaluations, treatments, and polygraph examinations. As indicated, more than half consented to future data matching to obtain recidivism information. This represents a slight increase in consent rates compared to 2023. **Table C2.b.** shows the number of juvenile clients who agreed to participate in data collection. The rate for evaluations and polygraph examinations represents a significant increase compared to 55% and 41% in 2023, respectively. The rate of consent for treatment clients decreased from 38% in 2023.

Table C2.a. Consent Rates for Adult Evaluation, Treatment, and Polygraph Clients 2024.

Client Consent Status	Count of Evaluation Clients	% of Evaluation Clients	Count of Treatment Clients	% of Treatment Clients	Count of Polygraph Clients	% of Polygraph Clients	Overall % of Clients
Yes	218	64%	347	75%	1,500	54%	**58%**
No	124	36%	116	25%	1,271	46%	**42%**
Total	**342**	**NA**	**463**	**NA**	**2,771**	**NA**	**100%**

Table C2.b. Consent Rates for Juvenile Evaluation, Treatment, and Polygraph Clients 2024.

Client Consent Status	Count of Evaluation Clients	% of Evaluation Clients	Count of Treatment Clients	% of Treatment Clients	Count of Polygraph Clients	% of Polygraph Clients	Overall % of Clients
Yes	43	73%	15	30%	39	67%	**58%**
No	16	27%	36	71%	19	33%	**42%**
Total	**59**	**NA**	**51**	**NA**	**58**	**NA**	**100%**

Figure C1.a. displays the client referral sources for adult clients seen for evaluations, treatments, and polygraph examinations. The predominant referral source is probation, although Parole/TASC and DOC contribute significantly to treatment and polygraph examination referrals. **Figure A1.b.** displays the client referral sources for juvenile clients.

Figure C1.a. Referral Sources for Adult Evaluation, Treatment, and Polygraph Clients 2024. For the data table, see Appendix D.C1.a.

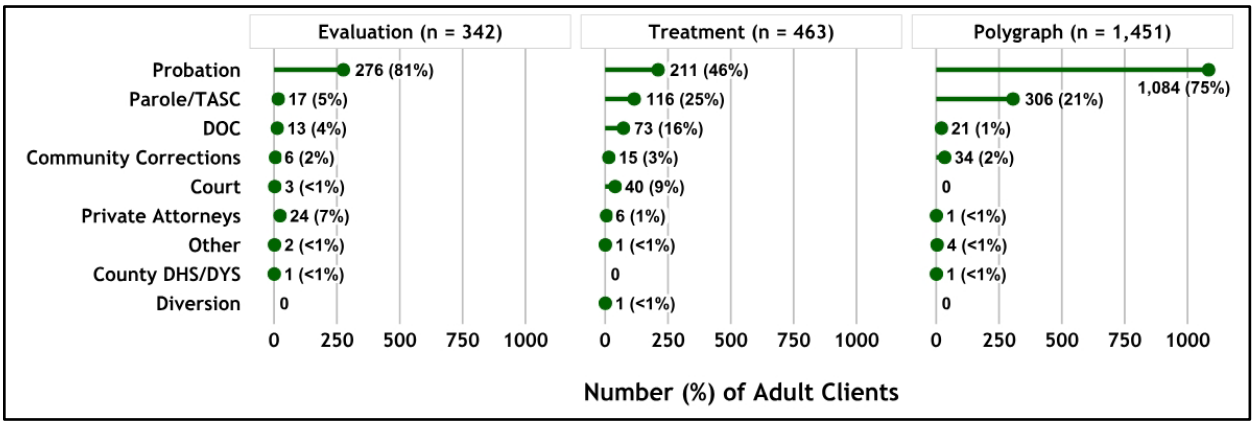


Figure C1.b. Referral Sources for Juvenile Evaluation, Treatment, and Polygraph Clients 2024. For the data table, see Appendix D.C1.b.

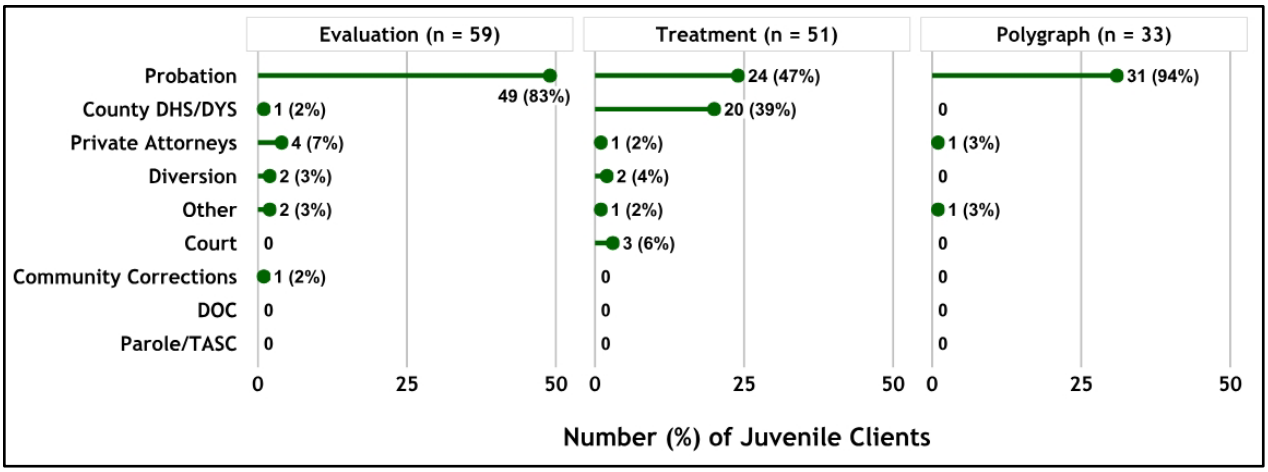


Table C3.a. shows the demographic characteristics of adult clients seen for evaluations, treatments, and polygraph examinations. **Table C3.b.** shows the demographic characteristics of juvenile clients. Treatment and evaluation providers are additionally asked to provide information about clients' age when adjudicated. Of those that provided this information, 83% of Evaluation clients and 88% of Treatment clients were 18 years or older at the time of adjudication. Among polygraph clients specifically, 77 (3%) spoke a language other than English (e.g., Spanish).

Table C3.a. Demographic Characteristics for Adult Evaluation, Treatment, and Polygraph Clients 2024. For screenreader accessible tables, see Appendix D.C3.a.

Adult Client Characteristics	Evaluation (Count 342) n (%) / Mean (Range)	Treatment (Count 463) n (%) / Mean (Range)	Polygraph (Count 2,771) n (%) / Mean (Range)
Gender			
Male	331 (97%)	438 (95%)	1,410 (97%)
Female	9 (3%)	17 (4%)	37 (3%)
Other	*	8 (2%)	*
Missing	*	0	*
Race/Ethnicity**			
White	194 (57%)	269 (58%)	890 (40%)
Hispanic or Latino	92 (27%)	132 (29%)	387 (23%)
Black or African American	45 (13%)	47 (10%)	124 (9%)
Native American or American Indian	8 (2%)	5 (1%)	10 (1%)
Asian or Pacific Islander	*	9 (2%)	13 (1%)
Other	8 (2%)	4 (1%)	12 (1%)
Unknown	*	4 (1%)	10 (1%)
Missing	0	0	1,325
Developmental or Intellectual Disability			
Yes	17 (5%)	26 (6%)	50 (4%)
No	325 (95%)	437 (94%)	1,394 (97%)
Missing	0	0	1,327
Education***			
Less than high school degree	76 (22%)	60 (13%)	-
High school degree or equivalent (e.g., GED)	149 (44%)	259 (56%)	-
Some college but no degree	75 (22%)	74 (16%)	-
Associate degree	17 (5%)	26 (6%)	-
Bachelor degree	17 (5%)	33 (7%)	-
Graduate degree	7 (2%)	11 (2%)	-
Missing	1	0	-
Age****			
Mean (Range)	38 (19 - 80)	45 (20 - 87)	42 (19 - 87)
Missing	0	0	1,337

* Data suppressed to maintain client confidentiality for identifiable demographic categories with less than 5 cases
** Race/Ethnicity reporting was modified in March 2024 to enable providers to select multiple categories for each client. Support for providers to acclimate to the new reporting structure is ongoing and, in future years, should allow clients with mixed racial-ethnic identities to be more accurately represented.
*** Education questions are not included in the polygraph examination survey.
**** Age refers to age at the time the evaluation was conducted, age at the time of the sex offense, or age at the time the polygraph examination was conducted.

Table C3.b. Demographic Characteristics of Juvenile Evaluation, Treatment, and Polygraph Clients 2024. For screenreader accessible tables, see Appendix D.C3.b.

Juvenile Client Characteristics	Evaluation (Count 59) n (%) / Mean (Range)	Treatment (Count 51) n (%) / Mean (Range)	Polygraph (Count 58) n (%) / Mean (Range)
Gender			
Male	58 (100%)	48 (94%)	33 (100%)
Female	0 (0%)	*	0 (0%)
Other	0 (0%)	*	0 (0%)
Missing	1	0	25
Race/Ethnicity**			
White	38 (64%)	32 (63%)	18 (42%)
Hispanic or Latino	12 (20%)	12 (24%)	12 (32%)
Black or African American	7 (12%)	6 (12%)	0 (0%)
Native American or American Indian	0 (0%)	*	0 (0%)
Asian or Pacific Islander	*	0 (0%)	0 (0%)
Other	*	*	0 (0%)
Unknown	0 (0%)	0 (0%)	3 (11%)
Missing	0	0	25
Developmental or Intellectual Disability			
Yes	2 (3%)	7 (14%)	0 (0%)
No	56 (97%)	44 (86%)	33 (100%)
Missing	1	0	25
Education***			
Less than high school degree	44 (76%)	23 (45%)	-
High school degree or equivalent (e.g., GED)	12 (21%)	24 (47%)	-
Some college but no degree	2 (3%)	4 (8%)	-
Missing	1	0	-
Age****			
Mean (Range)	18 (12 - 46)	19 (14 - 36)	19 (15 - 56)
Missing	1	2	25

* Data suppressed to maintain client confidentiality for identifiable demographic categories with less than 5 cases
** Race/Ethnicity reporting was modified in March 2024 to enable providers to select multiple categories for each client. Support for providers to acclimate to the new reporting structure is ongoing and, in future years, should allow clients with mixed racial-ethnic identities to be more accurately represented.
*** Education questions are not included in the polygraph examination survey.
**** Age refers to age at the time the evaluation was conducted, age at the time of the sex offense, or age at the time the polygraph examination was conducted.

Figures C2.a. and **C2.b.** display the offense types for adult and juvenile clients seen for evaluations, treatments, and polygraph examinations. The majority of adult and juvenile clients had felony contact sex offenses.[46]

Figure C2.a. Number of Adult Evaluation and Treatment Clients with Charge(s) by Offense Type 2024. For the data table, see Appendix D.C2.a.

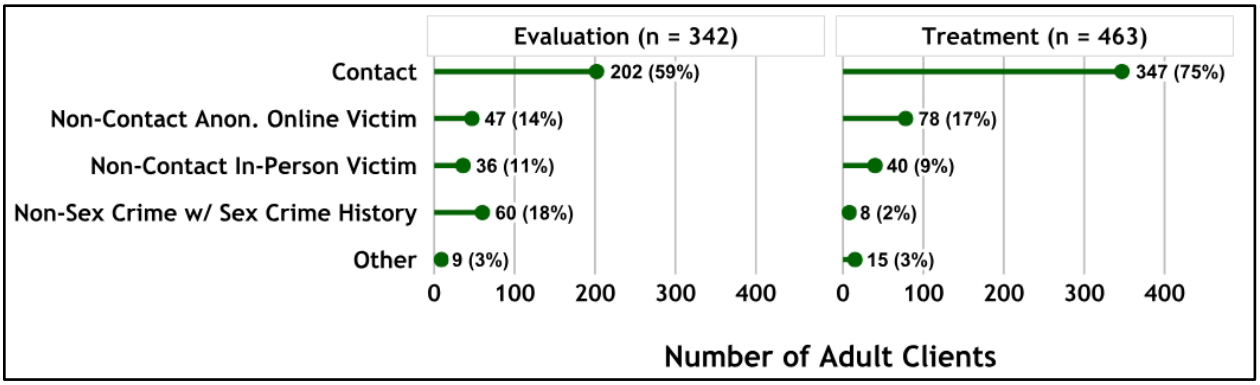
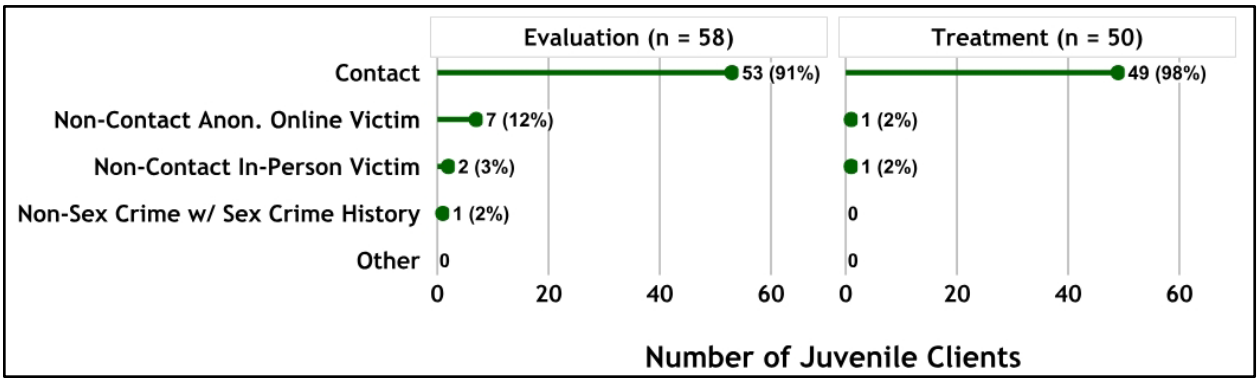


Figure C2.b. Number of Juvenile Evaluation and Treatment Clients with Charge(s) by Offense Type 2024.[47] For the data table, see Appendix D.C2.b.



Evaluation Results

The evaluation survey asks providers to indicate what strategies were recommended from the evaluation to align future offense-specific treatment with the RNR treatment model from the *Standards and Guidelines*. The survey provides options for matching treatment to risk level, criminogenic and non-criminogenic needs, and addressing treatment responsivity barriers.

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

[47] One juvenile client for the evaluation sample and one juvenile client for the treatment sample had missing offense type information so were not included in this figure.

Table C4 shows the top five recommendations to match treatment to client risk level. The endorsement of recommendations was similar to 2023.

Table C4. Risk Matching Strategies Recommended by Evaluators 2024 (Count 401) (Top 5). For Full Table, See Appendix E.C4.

Top Five Risk Matching Strategies*	Percent (%) Recommended
Adjunct non-sex offense-specific treatment	64%
Adjustments to community access (e.g., level of restrictions)	38%
Adjustments in the frequency of treatment services	25%
Type of placement, length of stay, or step-down	24%
Adjustments to types of groups	20%

*Multiple choices are possible; therefore, the percentages do not equal 100%.

The evaluation survey also asks providers to indicate the strategies they used to individualize the treatment recommendations. Nearly all providers reported that they reviewed previous records and collateral information. Similarly, almost all indicated they addressed the client's self-reported needs in the report. Other strategies were consulting the Community Supervision and MDT members (CST/MDT) (32%) and discussing the client's needs with their support systems (18%) or relevant others (1%).

Table C5 shows the top five recommendations to address the client's criminogenic and non-criminogenic needs resulting from evaluations.

Table C5. Strategies to Address Client Criminogenic and Non-Criminogenic Needs Recommended from Evaluations 2024 (Count 401) (Top 5). For Full Table, See Appendix E.C5.

Top Five Most Commonly Reported Client Need Strategies*	Percent (%) Recommended
An individualized treatment plan	77%
Increased support	46%
Increased resources	44%
Implemented modification to treatment modality (group, individual, telemental health, and adjunct treatment)	17%
Modify supervision conditions	13%

*Multiple choices are possible; therefore, the percentages do not equal 100%.

Table C6 shows the top five recommendations to address the client's treatment responsivity barriers resulting from evaluations.

Table C6. Strategies to Address Client Treatment Responsivity Barriers Recommended from Evaluations 2024 (Count 401). For Full Table, See Appendix E.C6.

Top Five Treatment Responsivity Strategies*	Percent (%) Recommended
Use of mental health-related adjunct therapy	65%
Use of external supports	49%
Feedback from the client	37%
Use of specialized resources	26%
Interventions to increase motivation for treatment	22%
Adjustments in frequency or modality of treatment services	22%

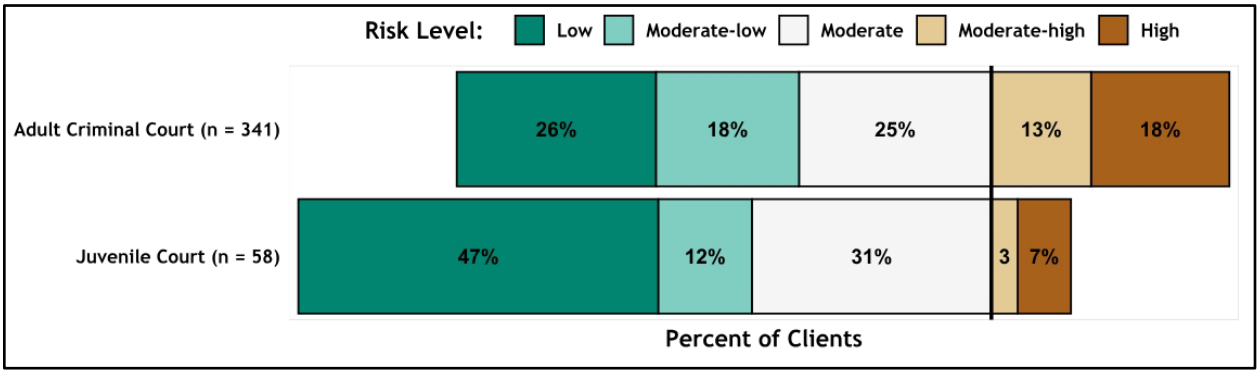
*Multiple choices are possible; therefore, the percentages do not equal 100%.

The top three recommended treatment settings for adult clients were community providers (60%), community corrections (21%), and the Department of Corrections (12%). Treatment with a community provider was recommended for most juvenile clients (83%). About one-third of the adult clients (33%) and 16% of juvenile clients had previously been in sex offense-specific treatment.

Most evaluators indicated using three to four standardized and validated risk assessment instruments in their evaluations. The Sex Offender Treatment and Progress Scale (SOTIPS), Static-99R (Static-2002R), and the Vermont Assessment of Sex Offender Risk-2 (VASOR-2) were the most commonly used for adults. The Juvenile Sex Offender Assessment Protocol-II (J-SOAP-II) and ERASOR were the most commonly used for juveniles.

As shown in **Figure C3**, the majority of adult and juvenile clients were classified as being at Low, Low-Moderate, or Moderate risk levels.

Figure C3. Percent of Evaluation Clients in Each Risk Level Category by Court 2024 (Count 399). For the data table, see Appendix D.C3.



Treatment Results

The treatment survey asks providers what sources of information were used to identify the client's treatment needs. Most providers indicated self-report (98%), discussion with CST/MDT (89%), or a review of records and collateral data (85%), followed by a discussion with support systems (44%). Of note, approximately 45% of the clients had prior sex offense-specific treatment.

The survey also asks providers to indicate the treatment strategies and resources used to address client needs. The top five strategies and resources are shown in **Table C7**.

Table C7. Treatment Strategies and Resources Used 2024 (Count 514) (Top 5). For Full Table, See Appendix E.C7.

Top Five Treatment Strategies and Resources*	Percent of Clients (%)
An individualized treatment plan	95%
Modified assignments	44%
Increased support	42%
Increased resources	41%
Flexible scheduling	34%

*Multiple choices are possible; therefore, the percentages do not equal 100%.

The treatment survey also asks providers how client treatment responsivity barriers were assessed and addressed. Nearly all providers reported assessing responsivity barriers using client feedback, while 80% used topics in treatment sessions, 50% used collateral contacts, and 10% used other channels including discussion with parole, probation, or the Community Supervision Team (CST).

Table C8 shows the top five treatment responsivity barriers identified during treatment, while **Table C9** shows the top five strategies and resources used to modify treatment to address these issues.

Table C8. Treatment Responsivity Barriers Identified 2024 (Count 514) (Top 5). For Full Table, See Appendix E.C8.

Top Five Treatment Responsivity Barriers*	Percent of Clients (%)
Client factors	57%
Poor motivation for treatment	34%
Lack of support	29%
Mental health/trauma needs	29%
Substance use	22%

*Multiple choices are possible; therefore, the percentages do not equal 100%.

Table C9. Strategies and Resources Used to Modify Treatment to Address Client Treatment Responsivity Issues 2024 (Count 514) (Top 5). For Full Table, See Appendix E.C9.

Top Five Strategies and Resources to Address Treatment Responsivity Issues*	Percent of Clients (%)
Feedback from client	71%
Adjustments in frequency or modality of treatment services	55%
Interventions to increase motivation for treatment	32%
Use of mental health-related adjunct therapy	28%
Use of external supports	26%

*Multiple choices are possible; therefore, the percentages do not equal 100%.

Treatment requires that clients are assigned a risk classification level. As shown in **Figure C4.a**, most adult clients were classified as low to moderate risk at the start of treatment. By the end of treatment, a larger proportion of adults had been reclassified as low risk, indicating a positive shift. However, there were also small increases in the proportions of adults classified as moderate-high and high-risk. These increases may reflect either more accurate assessments as evaluators gain a deeper understanding of the clients' risk factors or actual changes in those factors over time.

Figure C4.b shows that most juvenile clients also began treatment at low to moderate risk levels. By the end of treatment, the majority of juveniles demonstrated reductions in their risk levels, suggesting a trend toward improvement.

Figure C4.a. Percent of Adult Treatment Clients in Each Risk Level Category at the Beginning and End of Treatment 2024 (Count 463). For the data table, see Appendix D.C4.a.

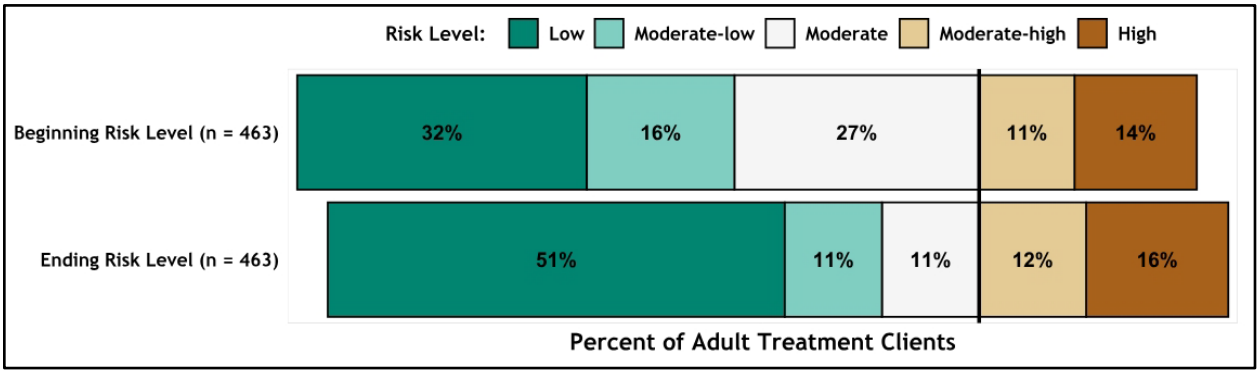


Figure C4.b. Percent of Juvenile Treatment Clients in Each Risk Level Category at the Beginning and End of Treatment 2024 (Count 51). For the data table, see Appendix D.C4.b.

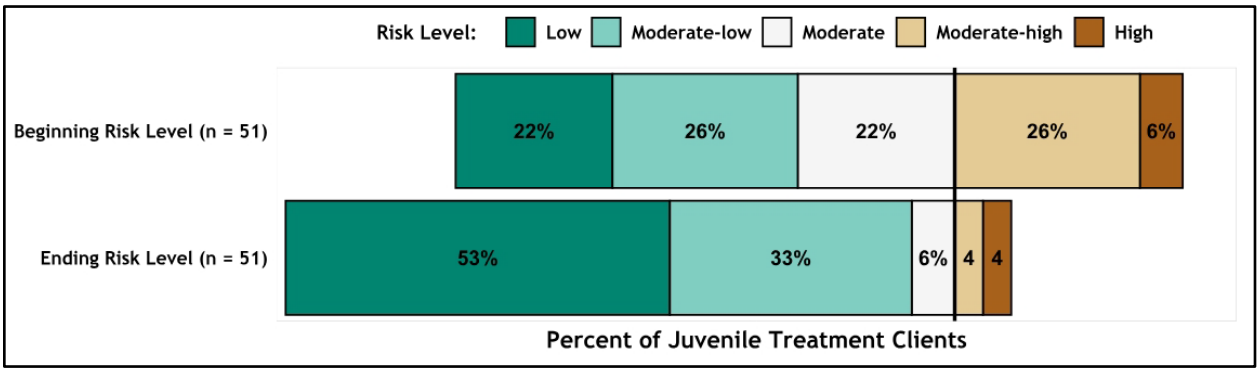


Figure C5.a and **Figure C5.b** focus on individual-level changes rather than overall group classifications. These figures display the percentages of adult and juvenile clients, respectively, within each initial risk level (low, moderate, moderate-high, and high) who experienced a decrease, no change, or an increase in their risk level following treatment. Unlike **Figures C4.a** and **C4.b**, which summarize overall trends in risk classification for the entire sample, these figures highlight individual trajectories over the course of treatment.

Figure C5.a shows that approximately half of all clients reduced their risk level by the end of treatment. Conversely, between 10% to 30% of the adult clients experienced an increase in their risk level, emphasizing the variability in individual outcomes.

Figure C5.b. shows that most juvenile clients who were initially classified as moderate risk or higher, reduced their risk classification by the end of treatment, reflecting notable improvement. Only a small proportion of juvenile clients, between 8-18%, increased their risk level classification from the beginning to the end of treatment.

Figure C5.a. Percent of Adult Treatment Clients in Each Beginning Risk Level that Decreased, Maintained, or Increased Risk Levels by the end of Treatment 2024 (Count 463). For the data table, see Appendix D.C5.a.

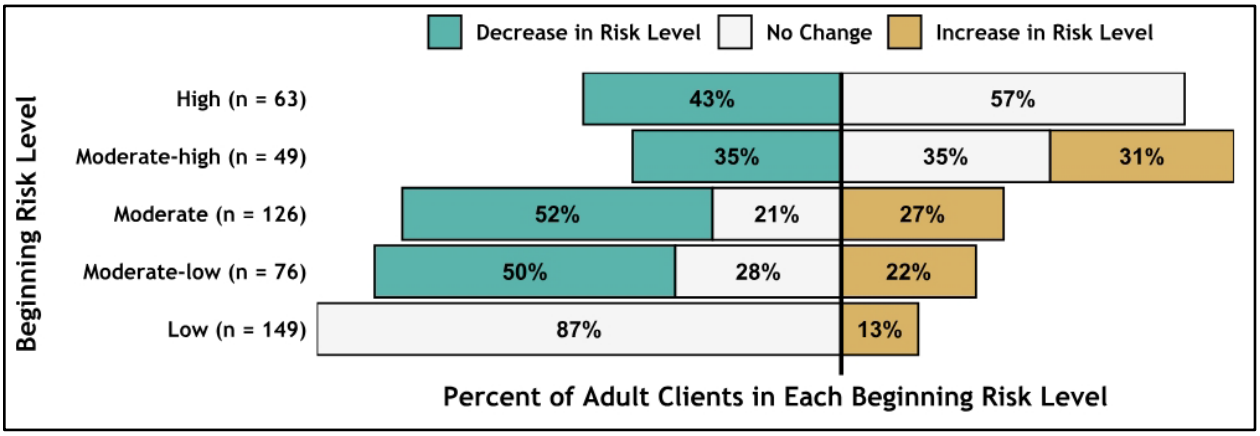
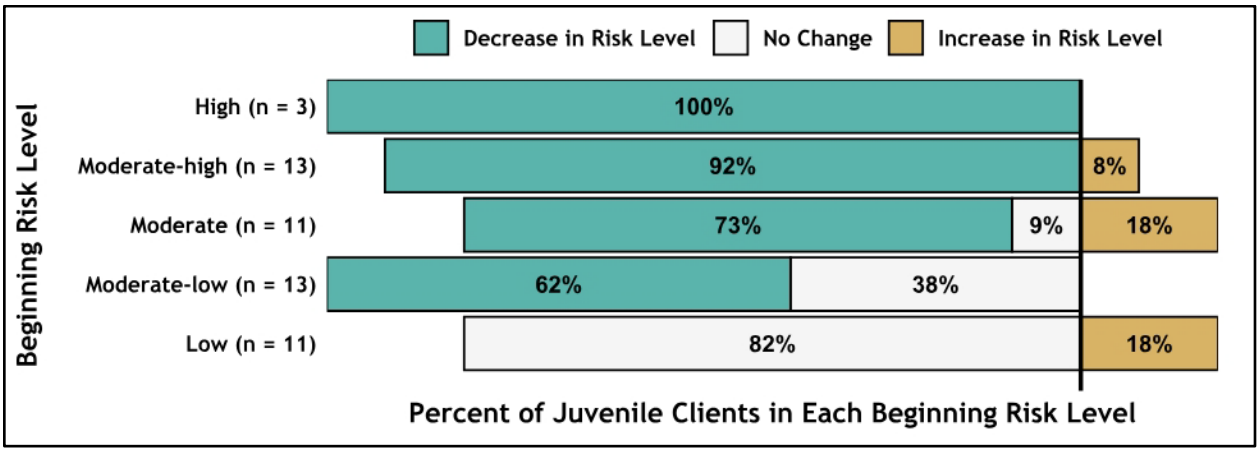


Figure C5.b. Percent of Juvenile Treatment Clients in Each Beginning Risk Level that Decreased, Maintained, or Increased Risk Levels by the end of Treatment 2024 (Count 51). For the data table, see Appendix D.C5.b.



A new survey question introduced in March 2024 identified clients who attended a Deniers Intervention. Clients attend a Deniers Intervention before being admitted to sex offense-specific treatment when they are in high denial of their offending. The introduction of the new question was to separate Deniers Interventions from regular sex offense-specific treatment. Records relating to 32 clients (6%) were entered in 2024 for attendance at a Denier Intervention. The information indicated the average length of attendance was 54 days (range 1-120 days).

An existing treatment survey question asks providers to indicate the level at which a client denies responsibility for the current sex offense at the beginning and end of treatment. **Figure C6a.** and **Figure C6.b.** show the proportion of adult and juvenile clients, respectively, at each level of denial during these two points in treatment. It is important to note that clients beginning treatment with high denial are referred to a Deniers Intervention, while those with moderate or lower levels of denial are referred to sex offense-specific treatment.

Figure C6.a., highlights a notable transition among adult clients from higher levels of denial to increased responsibility taking over the course of treatment. At the beginning of treatment, 9% of adult clients exhibited high (categorical) denial regarding their current sex offense. This proportion decreased to 4% by the end of treatment. Most of these clients likely participated in a Deniers Intervention, either transitioning to sex offense-specific treatment after reducing their denial or being discharged upon completion of the Deniers Intervention if they maintained high denial. It is worth noting that, although infrequent, clients initially assessed with lower levels of denial in sex offense-specific treatment may exhibit increased denial and be reassessed as high denial by the end of treatment. Furthermore, the proportion of adult clients with moderate denial decreased from 28% to 12%, while the proportion with no denial (full acceptance of responsibility) increased from 23% to 45%.

Figure C6.b. demonstrates significant progress among juvenile clients, with a substantial shift from higher levels of denial to full acceptance of responsibility for their sex offenses. At the beginning of treatment, 19% of juvenile clients were assessed as having high denial, whilst by the end of treatment none remained in this category. Meanwhile, the proportion of juveniles exhibiting no denial increased markedly, from 26% at the start of treatment to 62% by the end.

Figure C6.a. Percent of Adult Treatment Clients in Each Denial Level Category at the Beginning and End of Treatment 2024 (Count 463). For the data table, see Appendix D.C6.a.

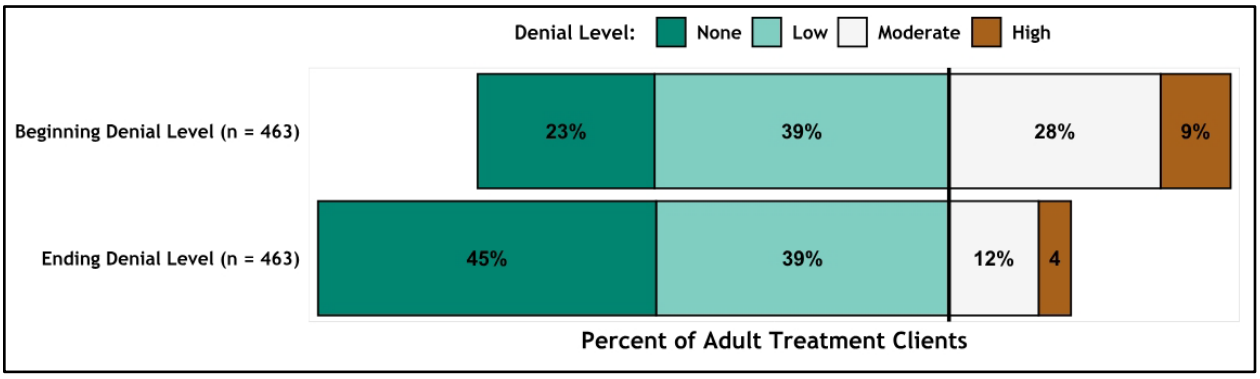


Figure C6.b. Percent of Juvenile Treatment Clients in Each Denial Level Category at the Beginning and End of Treatment 2024 (Count 47). For the data table, see Appendix D.C6.b.

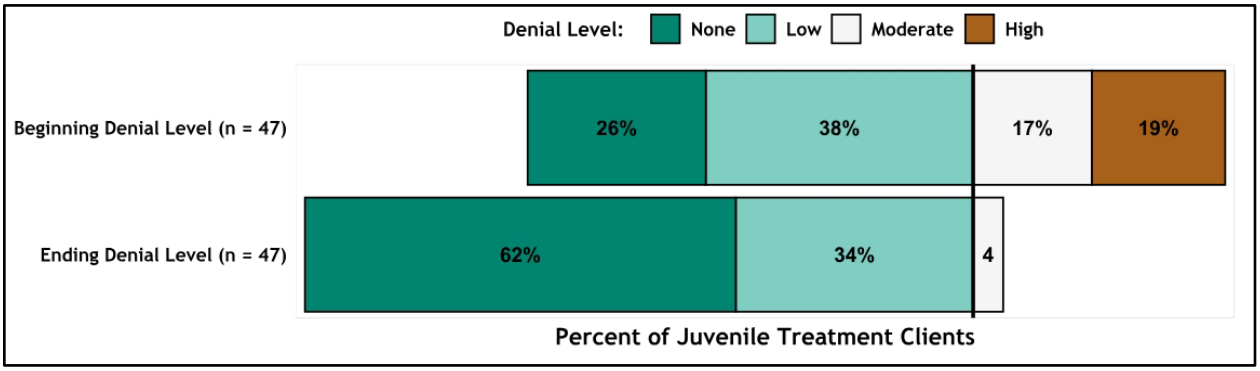


Figure C7.a and **Figure C7.b** focus on individual-level changes in denial level rather than overall group classifications. These figures display the percentages of adult and juvenile clients, respectively, within each initial denial level (none, low, moderate, and high) who experienced a decrease, no change, or an increase in their denial level following treatment. Unlike **Figures C6.a** and **C6.b**, which present overall trends in denial levels for the entire sample, these figures highlight individual trajectories over the course of treatment.

Figure C7.a shows a large proportion of adult clients reduced their denial level by the end of treatment, with very few cases of increased denial. However, a significant proportion of clients (34% to 62%) showed no change despite opportunities for reduction.

Figure C7.b. shows that almost all juvenile clients experienced a reduction in denial levels over the course of treatment. Notably, only a small proportion (33%) of clients with low denial at the start of treatment remained unchanged. Importantly, all clients who began treatment with moderate or high denial showed improvement by the end of treatment.

Figure C7.a. Percent of Adult Treatment Clients in Each Beginning Denial Level that Decreased, Maintained, or Increased Risk Levels by the end of Treatment 2024 (Count 463). For the data table, see Appendix D.C7.a.

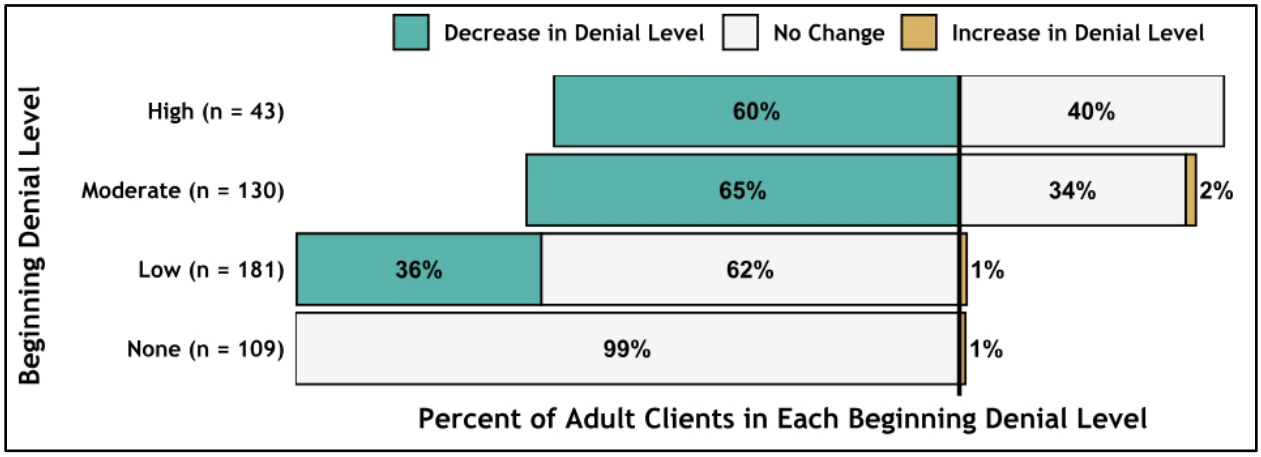
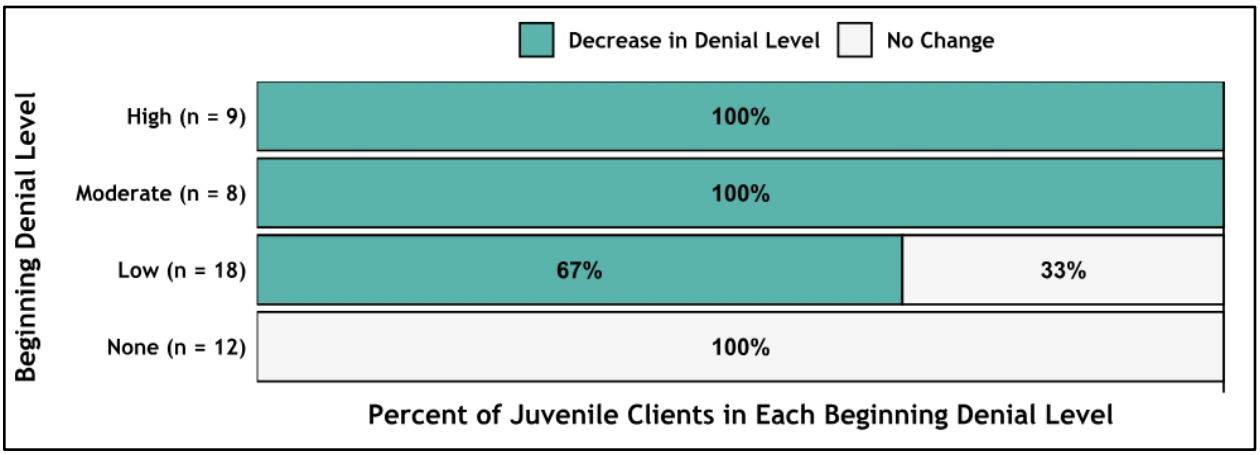
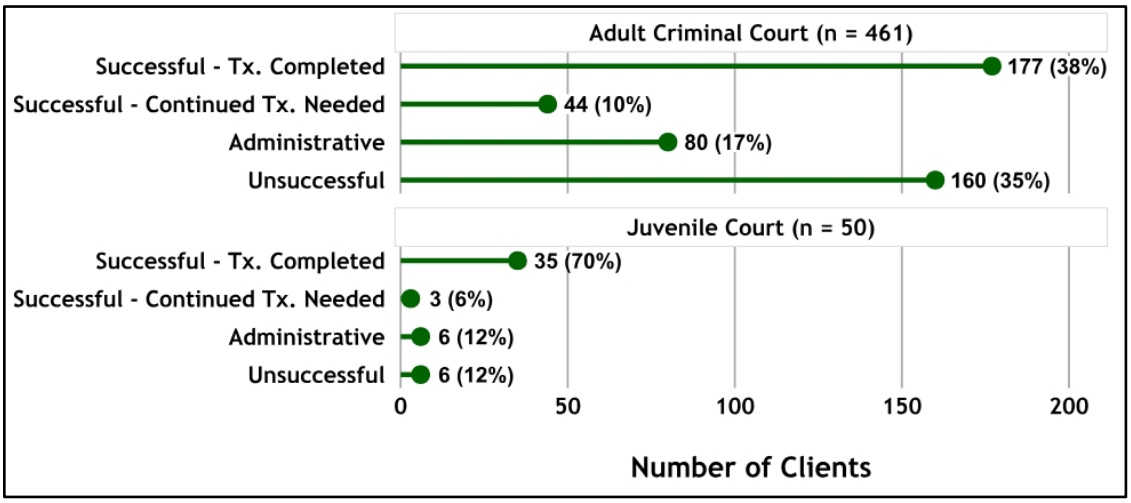


Figure C7.b. Percent of Juvenile Treatment Clients in Each Beginning Denial Level that Decreased, Maintained, or Increased Risk Levels by the end of Treatment 2024 (Count 47). For the data table, see Appendix D.C7.b.



At the completion or termination of treatment contact, each client is given a discharge type. A successful discharge is when the client completes all treatment goals and achieves the requirements stipulated in the *Adult Standards and Guidelines* or *Juvenile Standards and Guidelines*. The "successful discharge with continued treatment needed" is used in cases where clients have successfully completed the Department of Corrections Sex Offender Treatment Management Program (DOC SOTMP) and should have further community-based treatment if granted parole. An unsuccessful discharge is when there is significant non-compliance with the treatment contract. An administrative discharge is used when a change in circumstances interferes with the client continuing in treatment with the provider. **Figure C8** shows the treatment discharge outcomes for adult and juvenile clients during the study period.

Figure C8. Treatment Outcomes by Court Type 2024 (Count 511). For the data table, see Appendix D.C8.



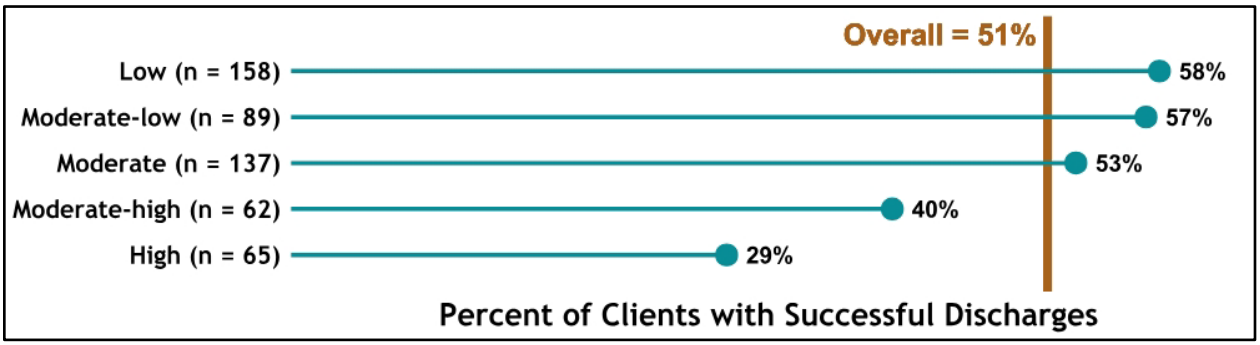
Providers should document at least one reason when a client receives an unsuccessful/non-compliant discharge. **Table C10** displays the reasons documented in 2024. Discharge reasons were recorded for 74 of the 166 adult and juvenile unsuccessful discharges. New sex crimes were the reason for three of these unsuccessful discharges. In 2024, discharge reasons were recorded for all 195 adult and juvenile unsuccessful discharges, with 11 new sex crimes given as the reason. It is not possible to determine if the lower rate of reported new sex crimes in 2024 reflects fewer instances or missing data about the reasons for discharge.

Table C10. Discharge Reasons for Treatment Clients with Unsuccessful Discharges 2024.

Discharge Reasons (Count 74)	Number of Clients	Percent of Clients (%)
Violation of treatment contract or supervision terms and conditions	38	51.4%
New non-sexual crime	9	12.2%
Client resistant to treatment / lack of investment in treatment goals	4	5.4%
New sex crime	3	4.1%
Aged out of system (DSY/DCW only)	1	1.4%
Maximum sentence time reached	1	1.4%
Other	18	24.3%

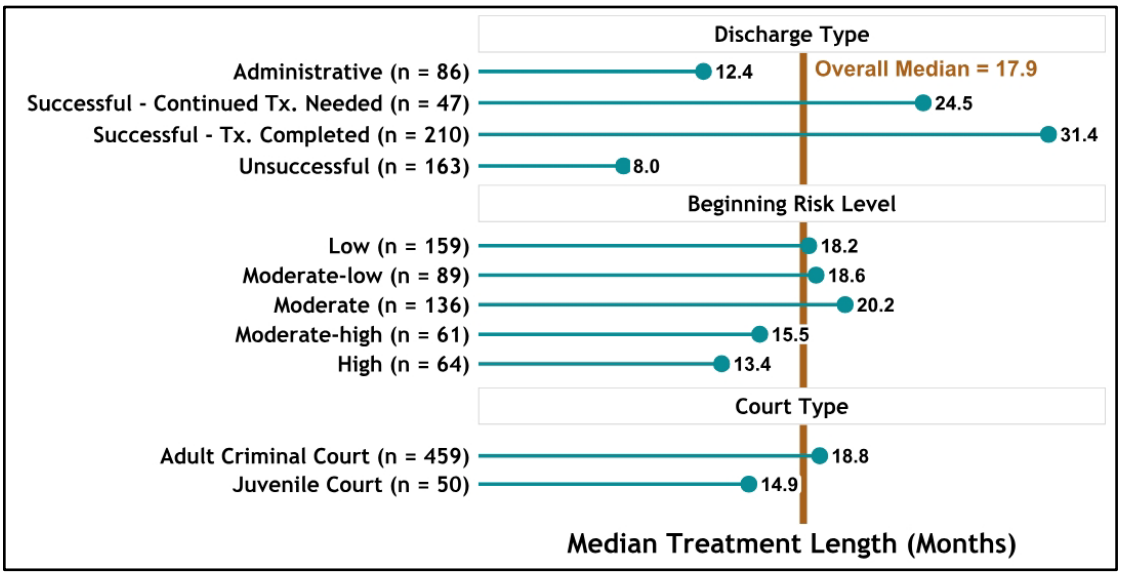
Figure C9 presents the number of clients with successful discharges by client beginning risk level. This figure combines all clients due to the small juvenile sample size. Unsurprisingly, clients at higher risk had lower successful discharge rates than clients of lower risk.

Figure C9. Percent of Clients with Successful Discharges by Beginning Risk Level 2024 (Count 511). For the data table, see Appendix D.C9.



Lastly, treatment clients spent a median of 17.9 months in treatment.[48] **Figure C10** displays the median length of time of treatment categorized by discharge type, beginning risk level, and court type. As shown, clients with the two types of successful discharges spent more time in treatment compared to those with administrative or unsuccessful discharges. Additionally, clients classified at moderate to lower risk levels tended to remain in treatment longer than those at high-risk levels. This trend is at least partly explained by the fact that higher-risk clients are more likely to have unsuccessful discharges, which are associated with shorter treatment durations.

Figure C10. Median Treatment Lengths for Treatment Clients by Discharge Type, Beginning Risk Level, and Court Type 2024 (Count 509). For the data table, see Appendix D.C10.



[48] The median represents the midpoint of a sample, where 50% of clients are below this value and 50% are above it.

Polygraph Results

Of the 2,829 polygraph examinations conducted, 2,119 (75%) were initial exams, while 709 (25%) involved retests. Retest examinations are used to clarify the findings from initial exams when there is a significant response indicative of deception (SR/Deception), no opinion resulting in an inconclusive test result (NO/Inconclusive), or an attempt to manipulate the test results. **Table C11** displays the number of each specific exam type conducted among adult and juvenile clients during the 12-month reporting period.

Table C11. Number of Exams Conducted for Adult and Juvenile Polygraph Clients by Court Type 2024 (Count 2,829).

Exam Types	Count of Adult Criminal Court Clients	% of Adult Criminal Court Clients	Count of Juvenile Court Clients	% of Juvenile Court Clients
Maintenance/Monitoring Exams	2003	72%	39	67%
Sex History Exam	602	23%	7	12%
Specific Issue	117	4%	9	16%
Instant/Index Offense Exams	41	2%	3	5%
Child Contact Screening Exam	10	<1%	NA	NA
Other	1	<1%	NA	NA

During the polygraph examination, about 1.5% of clients (23 cases) were found to use countermeasures, while another 4% (55 cases) were suspected of using countermeasures.

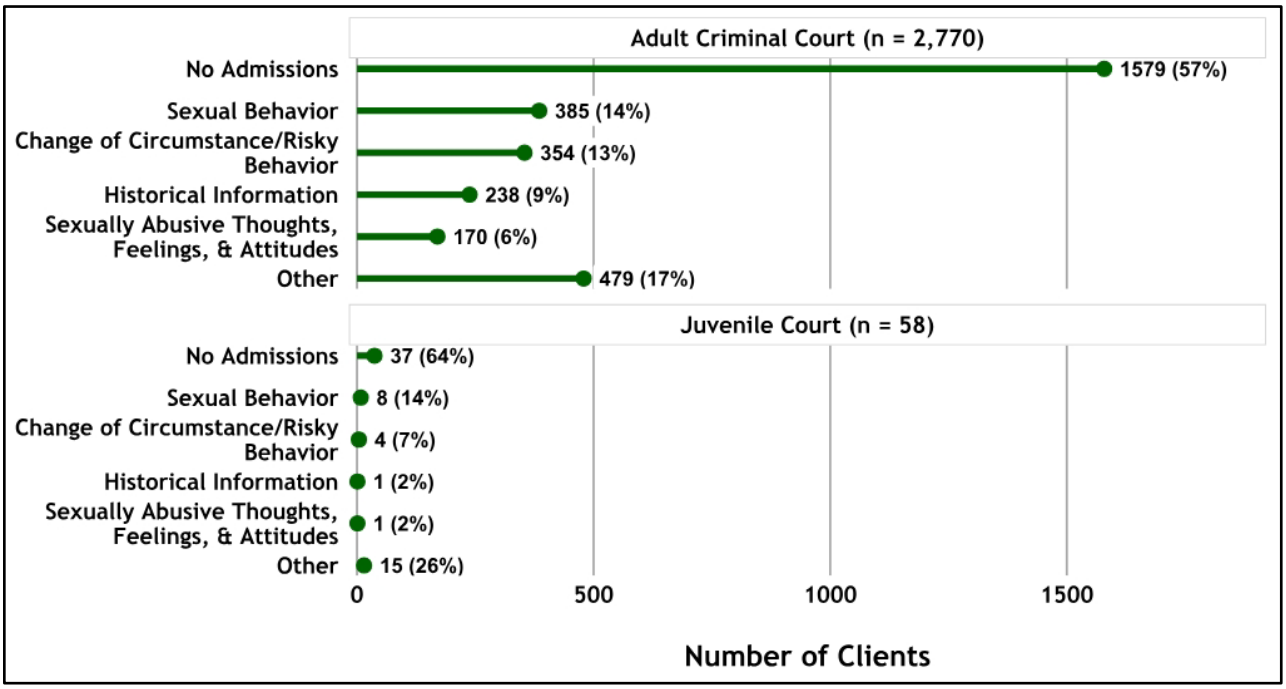
As shown in **Table C12**, 43% of the examinations conducted on adult clients and 36% on juvenile clients resulted in clinically significant disclosures during the pre-test, test, or post-test components.

Table C12. Number of Adult and Juvenile Polygraph Exams by the Presence of a Clinically Significant Disclosure 2024 (Count 2,828).

Disclosure Type (Count 2,828)	Count of Adult Clients	Percent of Adult Clients	Count of Juvenile Clients	Percent of Juvenile Clients
Disclosure Made	1,196	43%	21	36%
No Disclosure Made	1,574	57%	37	64%

Figure C11 shows the types of disclosures made during the polygraph examinations.

Figure C11. Types of Disclosures Made During Adult and Juvenile Polygraph Exams 2024 (Count 2,828). For the data table, see Appendix D.C11.



A total of 1,985 (70%) polygraph exams were classified as No Significant Reactions (NSR)/Non-Deceptive, which is a category that combines the 'No Deception Indicated/No Significant Response' and 'No Deception Indicated/No Opinion' results. As shown in **Figure C12,** most adult and juvenile clients were classified as non-deceptive.

Figure C12. Polygraph Exam Outcomes by Court Type 2024 (Count 2,829). For the data table, see Appendix D.C12.

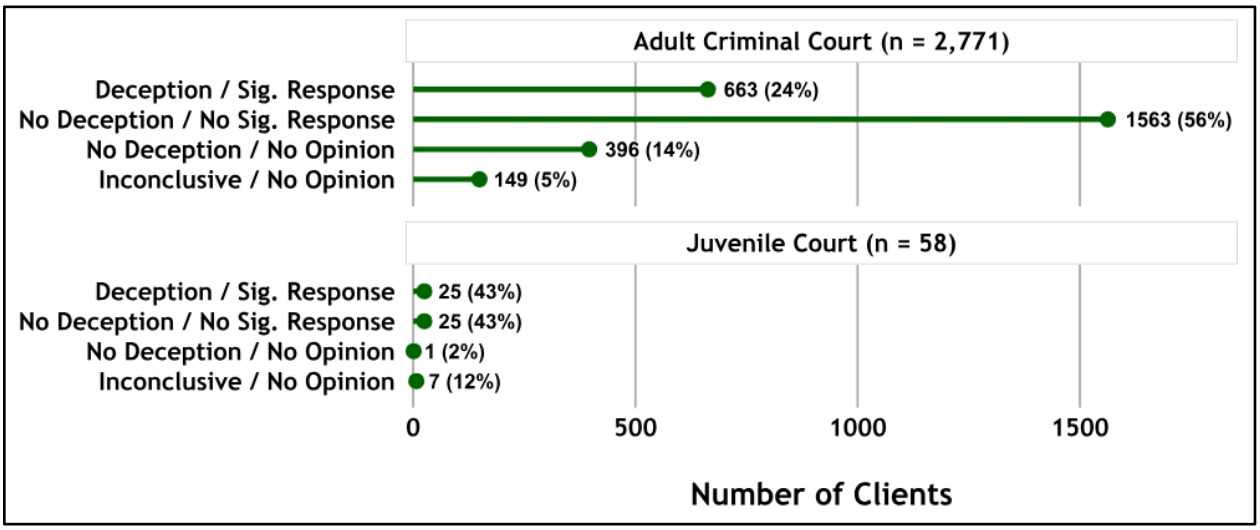
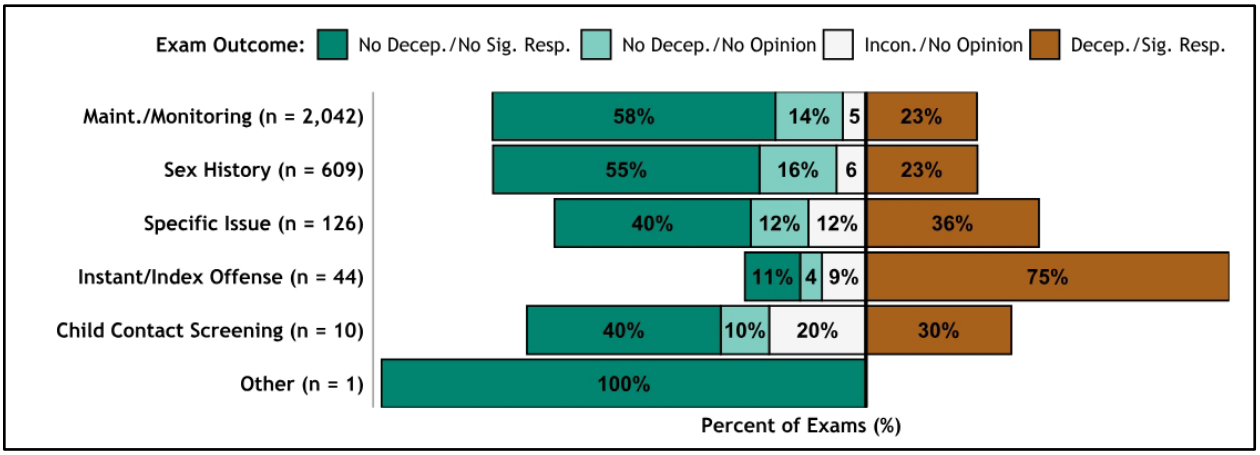


Figure C13 shows that Instant/Index Offense examinations had the highest rate of Significant Reactions (SR)/Deception Indicated results. This is as expected, given these examinations are most likely to be used when there is significant denial of the offense of conviction by the client.

Figure C13. Polygraph Exam Outcomes by Exam Type 2024 (Count 2,829). For the data table, see Appendix D.C13.



Comparing Results Across the Five Years of Data Collection

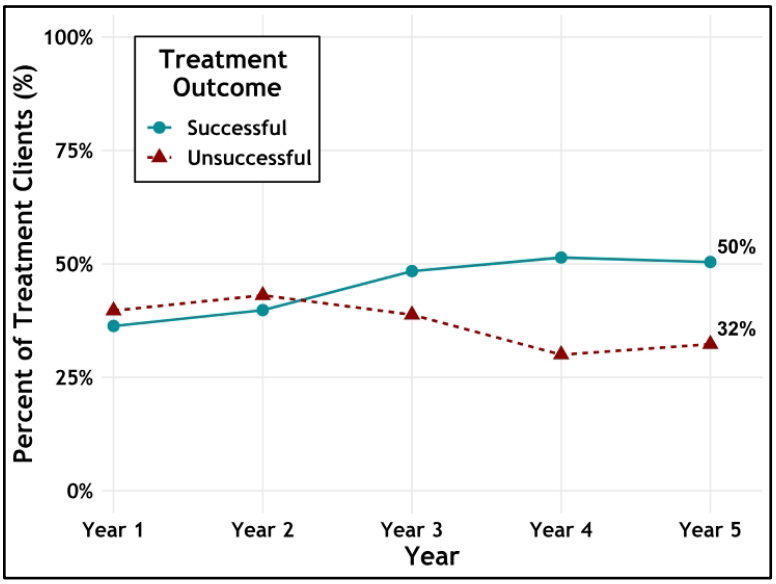
Table C13 shows the total number of records entered in the PDMS across all five years the data collection has been in place. A significant amount of data has been entered into the PDMS, and there has been a reasonably high consistency across the years.

Table C13. Total Number of Records entered into the data collection system from Year 1 through Year 5.

Submission Type	Count of Records Year 1	Count of Records Year 2	Count of Records Year 3	Count of Records Year 4	Count of Records Year 5	Count of Records Total
Evaluation	383	670	427	486	401	**2,367**
Treatment	411	836	539	650	514	**2,950**
Polygraph	4,950	3,743	2,992	3,142	2,829	**17,656**

The data collected over the past five years highlights how Approved Providers utilize the principles of the RNR model stipulated in the *Adult Standards and Guidelines* and *Juveniles Standards and Guidelines* to individualize evaluation and treatment. As shown in **Figure C14,** the successful treatment discharge rates have increased over time as this model has been further embedded into practice.

Figure C14. Percent of all Treatment Clients with Successful and Unsuccessful Discharge Types Over Years 1 through 5 of Data Collection. For the data table, see Appendix D.C14.



Limitations

Some limitations include that the data may not represent all evaluation, treatment, and polygraph examinations discharged during the study period. A few providers did not enter data, some data fields had missing entries, and data fatigue may have contributed to some providers skipping questions when the client declined to participate in the data collection project. As data are entered at discharge, treatment data may reflect treatments delivered several years before the current study period and potentially before the most recent updates to the *Adult Standards and Guidelines* and *Juvenile Standards and Guidelines*. Lastly, many juvenile clients were over 18 at discharge and, while subject to the *Juvenile Standards and Guidelines*, were not technically adolescents throughout their contact.

Summary and Conclusions

The SOMB has received a substantial amount of data over the past year, reflecting the commitment of Approved Providers to adhere to the *Adult* and *Juvenile Standards and Guidelines* and support the evidence-based approach to practice defined by these standards. Evaluators and polygraph examiners have reported higher consent rates and lower declination rates for participation in the data collection project among clients. In particular, more juvenile clients consented to participate in 2024. Although clients who decline participation can still have their service records entered into the PDMS without being linked to a unique client identifier, this practice limits the ability to include this data in future studies on recidivism.

Following a review of five years of data collection, it is clear Approved Providers are using Risk-Need-Responsivity (RNR) principles to individualize evaluation and treatment when implementing the *Adult* and *Juvenile Standards and Guidelines*. In addition, the PDMS has become a crucial resource for revising each set of the *Standards and Guidelines* and informing policy positions. It offers valuable insights that support an evidence-based, data-driven approach to the *Standards and Guidelines* based

on findings at the local level. The SOMB will continue its commitment to streamline survey questions to ensure data entry is efficient, user-friendly, and aligned with the needs of ongoing revisions.

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Appendix D: PDMS Data 2024 Screenreader Tables

D.C1.a. Referral Sources for Adult Evaluation, Treatment, and Polygraph Clients.

Referral Source	Count of Evaluation Clients (Count 342)	Percent of Evaluation Clients (Count 342)	Count of Treatment Clients (Count 463)	Percent of Treatment Clients (Count 463)	Count of Polygraph Clients (Count 1,451)	Percent of Polygraph Clients (Count 1,451)
Probation	276	81%	211	46%	1,084	75%
Parole/TASC	17	5%	116	25%	306	21%
DOC	13	4%	73	16%	21	1%
Community Corrections	6	2%	15	3%	34	2%
Court	3	0.9%	40	9%	0	NA
Private Attorneys	24	7%	6	1%	1	<1%
Other	2	<1%	1	<1%	4	<1%
County DHS/DYS	1	<1%	0	NA	1	<1%
Diversion	0	NA	1	<1%	0	NA

Return to Figure C1.a main document

D.C1.b. Referral Sources for Juvenile Evaluation, Treatment, and Polygraph Clients.

Referral Source	Count of Evaluation Clients (Count 59)	Percent of Evaluation Clients (Count 59)	Count of Treatment Clients (Count 51)	Percent of Treatment Clients (Count 51)	Count of Polygraph Clients (Count 33)	Percent of Polygraph Clients (Count 33)
Probation	49	83%	24	47%	31	94%
County DHS/DYS	1	2%	20	39%	0	NA
Private Attorneys	4	7%	1	2%	1	3%
Diversion	2	3%	2	4%	0	NA
Other	2	3%	1	2%	1	3%
Court	0	NA	3	6%	0	NA
Community Corrections	1	2%	0	NA	0	NA
DOC	0	NA	0	NA	0	NA
Parole/TASC	0	NA	0	NA	0	NA

Return to Figure C1.b main document

D.C3.a. Demographic Characteristics for Adult Evaluation, Treatment, and Polygraph Clients

Table 1. Client Gender

Client Gender	Count of Evaluation Clients (Count 342)	% of Evaluation Clients (Count 342)	Count of Treatment Clients (Count 463)	% of Treatment Clients (Count 463)	Count of Polygraph Clients (Count 2,771)	% of Polygraph Clients (Count 2,771)
Male	331	97%	438	95%	1,410	97%
Female	9	3%	17	4%	37	3%
Other	*	*	8	2%	*	*
Missing	*	NA	0	NA	*	NA

* Data suppressed to maintain client confidentiality for identifiable demographic categories with less than 5 cases

Table 2. Client Race/Ethnicity

Client Race/Ethnicity**	Count of Evaluation Clients (Count 342)	% of Evaluation Clients (Count 342)	Count of Treatment Clients (Count 463)	% of Treatment Clients (Count 463)	Count of Polygraph Clients (Count 2,771)	% of Polygraph Clients (Count 2,771)
White	194	57%	269	58%	890	40%
Hispanic or Latino	92	27%	132	2%	387	23%
Black or African American	45	13%	47	10%	124	9%
Native American or American Indian	8	2%	5	1%	10	1%
Asian or Pacific Islander	*	*	9	2%	13	1%
Other	8	2%	4	1%	12	1%
Unknown	*	*	4	1%	10	11%
Missing	0	NA	0	NA	1,325	NA

* Data suppressed to maintain client confidentiality for identifiable demographic categories with less than 5 cases

** Race/Ethnicity reporting was modified in March 2024 to enable providers to select multiple categories for each client. Support for providers to acclimate to the new reporting structure is ongoing and, in future years, should allow clients with mixed racial-ethnic identities to be more accurately represented.

Table 3. Client Developmental or Intellectual Disability

Developmental or Intellectual Disability Present	Count of Evaluation Clients (Count 342)	% of Evaluation Clients (Count 342)	Count of Treatment Clients (Count 463)	% of Treatment Clients (Count 463)	Count of Polygraph Clients (Count 2,771)	% of Polygraph Clients (Count 2,771)
Yes	17	5%	26	6%	50	4%
No	325	95%	437	94%	1,394	97%
Missing	0	NA	0	NA	1,327	NA

Table 4. Client Education

Client Education*	Count of Evaluation Clients (Count 342)	% of Evaluation Clients (Count 342)	Count of Treatment Clients (Count 463)	% of Treatment Clients (Count 463)
Less than high school degree	76	22%	60	13%
High School degree or equivalent (e.g., GED)	149	44%	259	56%
Some college but no degree	75	22%	74	16%
Associate degree	17	5%	26	6%
Bachelor degree	17	5%	33	7%
Graduate degree	7	2%	11	2%
Missing	1	NA	0	NA

*Education questions are not included in the polygraph examination survey.

Table 5. Client Age*

Statistic	Evaluation Clients (Count 342)	Treatment Clients (Count 463)	Polygraph Clients (Count 2,771)
Client Mean Age (years)	38	45	42
Client Age Range (years)	19-80	20-87	19-87
Number of Missing Records	0	0	1,337

*Age refers to age at the time the evaluation was conducted, age at the time of the sex offense, or age at the time the polygraph examination was conducted

Return to Table C3.a main document

D.C3.b. Demographic Characteristics for Juvenile Evaluation, Treatment, and Polygraph Clients

Table 1. Client Gender

Client Gender	Count of Evaluation Clients (Count 59)	% of Evaluation Clients (Count 59)	Count of Treatment Clients (Count 51)	% of Treatment Clients (Count 51)	Count of Polygraph Clients (Count 58)	% of Polygraph Clients (Count 58)
Male	58	100%	48	94%	33	100%
Female	0	0%	*	*	0	0%
Other	0	0%	*	*	0	0%
Missing	1	NA	0	NA	25	NA

* Data suppressed to maintain client confidentiality for identifiable demographic categories with less than 5 cases

Table 2. Client Race/Ethnicity

Client Race/Ethnicity**	of Evaluation Clients (Count 59)	% of Evaluation Clients (Count 59)	Count of Treatment Clients (Count 51)	% of Treatment Clients (Count 51)	Count of Polygraph Clients (Count 58)	% of Polygraph Clients (Count 58)
White	38	64%	32	63%	18	42%
Hispanic or Latino	12	20%	12	24%	12	32%
Black or African American	7	12%	6	12%	0	0%
Native American or American Indian	0	0%	*	*	0	0%
Asian or Pacific Islander	*	*	0	0%	0	0%
Other	*	*	*	*	0	0%
Unknown	0	0%	0	0%	3	11%
Missing	0	NA	0	NA	25	NA

* Data suppressed to maintain client confidentiality for identifiable demographic categories with less than 5 cases

** Race/Ethnicity reporting was modified in March 2024 to enable providers to select multiple categories for each client. Support for providers to acclimate to the new reporting structure is ongoing and, in future years, should allow clients of mixed race-ethnicities to be more accurately represented.

Table 3. Client Developmental or Intellectual Disability

Developmental or Intellectual Disability Present	Count of Evaluation Clients (Count 59)	% of Evaluation Clients (Count 59)	Count of Treatment Clients (Count 51)	% of Treatment Clients (Count 51)	Count of Polygraph Clients (Count 58)	% of Polygraph Clients (Count 58)
Yes	2	3%	7	14%	0	0%
No	56	97%	44	86%	33	100%
Missing	1	NA	0	NA	25	NA

Table 4. Client Education

Client Education*	Count of Evaluation Clients (Count 59)	% of Evaluation Clients (Count 59)	Count of Treatment Clients (Count 51)	% of Treatment Clients (Count 51)
Less than high school degree	44	76%	23	45%
High School degree or equivalent	12	21%	24	47%
Some college but no degree	2	3%	4	8%
Missing	1	NA	0	NA

*Education questions are not included in the polygraph examination survey.

Table 5. Client Age*

Statistic	Evaluation Clients (Count 59)	Treatment Clients (Count 51)	Polygraph Clients (Count 58)
Client Mean Age (years)	18	19	19
Client Age Range (years)	12-46	14-36	15-56
Number of Missing Records	1	2	25

*Age refers to age at the time the evaluation was conducted, age at the time of the sex offense, or age at the time the polygraph examination was conducted

Return to Table C3.b main document

D.C2.a. Number of Adult Evaluation and Treatment Clients with Charge(s) by Offense Type.

Offense Type	Number of Evaluation Clients (Count 342)	Percent of Evaluation Clients (Count 342)	Number of Treatment Clients (Count 463)	Percent of Treatment Clients (Count 463)
Contact	202	60%	347	75%
Non-Contact Anonymous Online Victim	47	14%	78	17%
Non-Contact In-Person Victim	36	11%	40	9%
Non-Sex Crime with a History of Sex Crime	60	18%	8	2%
Other	9	3%	15	3%

Return to Figure C2.a main document

D.C2.b. Number of Juvenile Evaluation and Treatment Clients with Charge(s) by Offense Type

Offense Type	Count of Evaluation Clients (Count 58)	Percent of Evaluation Clients (Count 58)	Count of Treatment Clients (Count 50)	Percent of Treatment Clients (Count 50)
Contact	53	91%	49	98%
Non-Contact Anonymous Online Victim	7	12%	1	2%
Non-Contact In-Person Victim	2	3%	1	2%
Non-Sex Crime with a History of Sex Crime	1	2%	0	0%
Other	0	0%	0	0%

Return to Figure C2.b main document

D.C3. Percent of Evaluation Clients in Each Risk Level Category by Court (Count 399).

Risk Level	Percent of Adult Clients (Count 341)	Percent of Juvenile Clients (Count 58)
Low	26%	47%
Moderate-Low	18%	12%
Moderate	25%	31%
Moderate-High	13%	3%
High	18%	7%

Return to Figure C3. main document

D.C4.a. Percent of Adult Treatment Clients in Each Risk Level Category at the Beginning and End of Treatment (Count 463).

Risk Level	% of Adult Clients at Each Beginning Risk Level	% of Adult Clients at Each Ending Risk Level
Low	32%	51%
Moderate-Low	16%	11%
Moderate	27%	11%
Moderate-High	11%	12%
High	14%	16%

Return to Figure C4.a. main document

D.C4.b. Percent of Juvenile Treatment Clients in Each Risk Level Category at the Beginning and End of Treatment (Count 51).

Risk Level	% of Juvenile Clients at Each Beginning Risk Level	% of Juvenile Clients at Each Ending Risk Level
Low	22%	53%
Moderate-Low	26%	33%
Moderate	22%	6%
Moderate-High	26%	4%
High	6%	4%

Return to Figure C4.b main document

D.C5.a. Percent of Adult Treatment Clients in Each Beginning Risk Level that Decreased, Maintained, or Increased Risk Levels by the end of Treatment (Count 463).

Beginning Risk Level	% of Adult Clients with a Decrease in Risk Level	% of Adult Clients with No Change in Risk Level	% of Adult Clients with an Increase in Risk Level
High (Count 63)	43%	57%	NA
Moderate-High (Count 49)	35%	35%	31%
Moderate (Count 126)	52%	21%	27%
Moderate-Low (Count 76)	50%	28%	22%
Low (Count 149)	NA	87%	13%

Return to Figure C5.a main document

D.C5.b. Percent of Juvenile Treatment Clients in Each Beginning Risk Level that Decreased, Maintained, or Increased Risk Levels by the end of Treatment (Count 51).

Beginning Risk Level	% of Juvenile Clients with a Decrease in Risk Level	% of Juvenile Clients with No Change in Risk Level	% of Juvenile Clients with an Increase in Risk Level
High (Count 3)	100%	0%	NA
Moderate-High (Count 13)	92%	0%	8%
Moderate (Count 11)	73%	9%	18%
Moderate-Low (Count 13)	62%	38%	0%
Low (Count 11)	NA	82%	18%

Return to Figure C5.b main document

D.C6.a. Percent of Adult Treatment Clients in Each Denial Level Category at the Beginning and End of Treatment (Count 463).

Denial Level	% of Adult Clients at Each Beginning Denial Level	% of Adult Clients at Each Ending Denial Level
None	23%	45%
Low	39%	39%
Moderate	28%	12%
High	9%	4%

Return to Figure C6.a main document

D.C6.b. Percent of Juvenile Treatment Clients in Each Denial Level Category at the Beginning and End of Treatment (Count 47)

Denial Level	% of Juvenile Clients at Each Beginning Denial Level	% of Juvenile Clients at Each Ending Denial Level
None	26%	62%
Low	38%	34%
Moderate	17%	4%
High	19%	0%

Return to Figure C6.b main document

D.C7.a. Percent of Adult Treatment Clients in Each Beginning Denial Level that Decreased, Maintained, or Increased Risk Levels by the end of Treatment (Count 463).

Beginning Denial Level	% of Adult Clients with a Decrease in Denial Level	% of Adult Clients with No Change in Denial Level	% of Adult Clients with an Increase in Denial Level
High (Count 43)	60%	40%	NA
Moderate (Count 130)	65%	34%	2%
Low (Count 181)	36%	62%	1%
None (Count 109)	NA	99%	1%

Return to Figure C7.a. main document

D.C7.b. Percent of Juvenile Treatment Clients in Each Beginning Denial Level that Decreased, Maintained, or Increased Risk Levels by the end of Treatment (Count 47).

Beginning Denial Level	% of Juvenile Clients with a Decrease in Denial Level	% of Juvenile Clients with No Change in Denial Level	% of Juvenile Clients with an Increase in Denial Level
High (Count 9)	100%	0%	NA
Moderate (Count 8)	100%	0%	0%
Low (Count 18)	67%	33%	0%
None (Count 12)	NA	100%	0%

Return to Figure C7.b. main document

D.C8. Treatment Outcomes by Court Type (Count 511).

Treatment Outcome	Number of Adult Clients (Count 461)	Percent of Adult Clients (Count 461)	Number of Juvenile Clients (Count 50)	Percent of Juvenile Clients (Count 50)
Successful - Tx. Completed	177	38%	35	70%
Successful - Continued Tx. Needed	44	10%	3	6%
Administrative	80	17%	6	12%
Unsuccessful	160	35%	6	12%

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D.C9. Percent of Clients with Successful Discharges by Beginning Risk Level (Count 511).

Beginning Risk Level	% of All Clients with Successful Discharges	Overall % of All Clients Successful Discharge
Low (Count 158)	58%	51%
Moderate-Low (Count 89)	57%	51%
Moderate (Count 137)	53%	51%
Moderate-High (Count 62)	40%	51%
High (Count 65)	29%	51%

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D.C10. Median Treatment Lengths for Treatment Clients by Discharge Type, Beginning Risk Level, and Court Type (Count 509).

Discharge Type	Median Treatment Length (Months)	Overall Median Treatment Length for All Clients (Months)
Administrative (Count 86)	12.4	17.9
Successful - Continued Tx. Needed (Count 47)	24.5	17.9
Successful - Tx. Completed (Count 210)	31.4	17.9
Unsuccessful (Count 163)	8.0	17.9

Beginning Risk Level	Median Treatment Length (Months)	Overall Median Treatment Length for All Clients (Months)
Low (Count 159)	18.2	17.9
Moderate-Low (Count 89)	18.6	17.9
Moderate (Count 136)	20.2	17.9
Moderate-High (Count 61)	15.5	17.9
High (Count 64)	13.4	17.9

Court Type	Median Treatment Length (Months)	Overall Median Treatment Length for All Clients (Months)
Adult Criminal Court (Count 459)	18.8	17.9
Juvenile Court (Count 50)	14.9	17.9

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D.C11. Types of Disclosures Made During Adult and Juvenile Polygraph Exams (Count 2,828).

Disclosure Type	Number of Adult Clients (Count 2,770)	Percent of Adult Clients (Count 2,770)	Number of Juvenile Clients (Count 58)	Percent of Juvenile Clients (Count 58)
No Admissions	1,579	57%	37	64%
Sexual Behavior	385	14%	8	14%
Change of Circumstance/Risky Behavior	354	13%	4	7%
Historical Information	238	9%	1	2%
Sexually Abusive Thoughts, Feelings & Attitudes	170	6%	1	2%
Other	479	17%	15	26%

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D.C12. Polygraph Exam Outcomes by Court Type (Count 2,829).

Outcome Type	Number of Adult Clients (Count 2,771)	Percent of Adult Clients (Count 2,771)	Number of Juvenile Clients (Count 58)	Percent of Juvenile Clients (Count 58)
Deception / Significant Response	663	24%	25	43%
No Deception / No Significant Response	1,563	56%	25	43%
No Deception / No Opinion	396	14%	1	2%
Inconclusive / No Opinion	149	5%	7	12%

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D.C13. Polygraph Exam Outcomes by Exam Type (Count 2,829).

Exam Type	% of Exams with No Deception / No Significant Response	% of Exams with No Deception / No Opinion	% of Exams with Inconclusive / No Opinion	% of Exams with Deception / Significant Response
Maintenance/Monitoring Exams (Count 2,042)	58%	14%	5%	23%
Sex History Exam (Count 609)	55%	16%	6%	23%
Specific Issue (Count 126)	40%	12%	12%	36%
Instant/Index Offense Exams (Count 44)	11%	4%	9%	75%
Child Contact Screening Exam (Count 10)	40%	10%	20%	30%
Other (Count 1)	100%	0%	0%	0%

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D.C14. Percent of all Treatment Clients with Successful and Unsuccessful Discharge Types Over Years 1 through 5 of Data Collection.

Data Collection Year	% of Treatment Clients w/ Successful Discharges	% of Treatment Clients w/ Unsuccessful Discharges
Year 1	36%	40%
Year 2	40%	43%
Year 3	48%	39%
Year 4	51%	30%
Year 5	50%	32%

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Appendix E: PDMS 2024 Data Supplementary Tables

E.C4. Risk Matching Strategies Recommended by Evaluators (Count 401) (Full Table).

Risk Matching Strategies	Percent (%) Recommended
Adjunct non-sex offense-specific treatment	64%
Adjustments to community access (e.g., level of restrictions)	38%
Adjustments in the frequency of treatment services	25%
Type of placement, length of stay, or step-down	24%
Adjustments to types of groups	20%
Recommended changes to supervision	16%
Other adjustments	5%
Implementing changes to supervision	2%

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E.C5. Strategies to Address Client Criminogenic and Non-Criminogenic Needs Recommended from Evaluations (Count 401) (Full Table).

Client Need Strategies	Percent (%) Recommended
An individualized treatment plan	77%
Increased support	46%
Increased resources	44%
Implemented modification to treatment modality (group, individual, telemental health, and adjunct treatment)	17%
Modify supervision conditions	13%
Modified assignments	11%
Modified programming	9%
Used the young adult modification protocol	9%
Modifications to treatment expectations	8%
Other treatments	7%
Used the sex offense history evaluation matrix	4%
Flexible scheduling options	3%
Implemented modification to supervision conditions	2%
Modified the *Standards and Guidelines* by the MDT/CST or through a variance	2%

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E.C6. Strategies to Address Client Treatment Responsivity Barriers Recommended from Evaluations (Count 401) (Full Table).

Treatment Responsivity Strategies	Percent (%) Recommended
Use of mental health-related adjunct therapy	65%
Use of external supports	49%
Feedback from the client	37%
Use of specialized resources	26%
Interventions to increase motivation for treatment	22%
Adjustments in frequency or modality of treatment services	22%
Assessment of intellectual/cognitive functioning with additional testing	15%
Assessment of cultural/language/sexual orientation/gender identification and family needs	12%
Recommendation to modify supervision conditions	11%
Modifications to increase progress	10%
Housing/transportation/treatment/polygraph/financial voucher provided by supervising officer	7%
Implemented modification to supervision conditions	6%
Other treatments, such as mental health or substance abuse treatment	3%

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E.C7. Treatment Strategies and Resources Used (Count 514) (Full Table).[49]

Treatment Strategies and Resources	Percent of Clients (%)
An individualized treatment plan	95%
Modified assignments	44%
Increased support	42%
Increased resources	41%
Flexible scheduling	34%
Modification to treatment modality (group, individual, telemental health, and adjunct treatment)	22%
Modified treatment expectations	16%
Recommendation to modify supervision conditions	12%
Modified programming	7%
Young adult protocol	7%
Implemented modification to supervision conditions	3%
Modifications to the *Standards and Guidelines* by the MDT/CST	2%
Sex offense history evaluation matrix	1%
Modifications to the *Standards and Guidelines* through a variance	<1%
Other	7%

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

E.C8. Treatment Responsivity Barriers Identified (Count 514) (Full Table).[50]

Treatment Responsivity Barrier	Percent of Clients (%)
Client factors	57%
Poor motivation for treatment	34%
Lack of support	29%
Mental health/trauma needs	29%
Substance use	22%
Finances	21%
Lack of engagement with the community	21%
Employment	20%
Housing	19%
Adjunct treatment needs	13%
Transportation	10%
Cultural needs	8%
Terms of supervision	6%
Community limitations	6%
Specific resources	4%
Standards and Guidelines	4%
Other factors	9%
None or not applicable	7%

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

E.C9. Strategies and Resources Used to Modify Treatment to Address Client Treatment Responsivity Issues (Count 514) (Full Table).[51]

Strategies and Resources to Address Treatment Responsivity Issues	Percent of Clients (%)
Feedback from client	71%
Adjustments in frequency or modality of treatment services	55%
Interventions to increase motivation for treatment	32%
Use of mental health-related adjunct therapy	28%
Use of external supports	26%
Housing/transportation/treatment/polygraph/financial voucher provided by supervising officer	19%
Assessment of cultural/language/sexual orientation/gender identification and family needs	14%
Assessment of intellectual/cognitive functioning (e.g., additional screening/testing)	12%
Use of specialized resources	12%
Implemented modification to supervision conditions	11%
Other efforts	7%
Recommendation to modify supervision conditions	5%
Feedback from support systems	1%

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

Appendix F: SOMB Reauthorization Bill SB 23-164.

The Department of Regulatory Agencies (DORA) completed a Sunset Review of the SOMB in 2022, as per § 24-34-104, C.R.S., and published its Sunset Report on October 14, 2022. The SOMB reauthorization bill, SB 23-164, adopted the recommendations made in the report and added several further mandates.

The recommendations adopted from the Sunset Report are summarized as follows:

- Continue the SOMB for 5 years until September 1, 2028.
- Clarify that supervising officers are required to follow the SOMB *Adult Standards and Guidelines* and *Juveniles Standards and Guidelines* when working with individuals convicted of sexual offenses. Additionally, directing agencies that employ supervising officers to collaborate with the SOMB to develop procedures to hold accountable supervising officers who fail to do so.
- Repeal the limitation on the number of treatment providers given to adults or juveniles when choosing a provider. Additionally, direct that the supervising agency provide a complete list of treatment providers who have the expertise to work with the specific risks and needs of that adult or juvenile. The supervising officer shall make specific recommendations that take into consideration individual risk and needs, the ability of the treatment provider to accept new clients, the geographic proximity of the treatment provider, the nature of the programs offered, and any other relevant factors to the client's treatment needs, capability of the provider, and safety of the community. If the adult or juvenile has an intellectual or developmental disability, the supervising agency shall make a recommendation for a treatment provider approved by the SOMB to work with clients with intellectual disability/developmental disability. The exception to these changes is the Division of Youth Services which can assign juveniles to a treatment provider based on the juveniles' risk and needs and will have procedures in place to allow for a juvenile or family to seek a change in treatment provider based on responsivity factors.
- Beginning September 1, 2024, and every two years thereafter, the Board shall conduct compliance reviews on at least 10% of Approved Providers.
- Update the language concerning fingerprint collection as part of the SOMB Approved Provider application process to reflect the current practice of having a third-party vendor take and forward these to the Colorado Bureau of Investigation.
- Repeal of the Department of Regulatory Agencies' responsibility to publish a list of Approved Providers.

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

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

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

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

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

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

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

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

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

    - Determine which, if any, SOMB *Standards and Guidelines* are barriers to providing timely access to treatment and make recommendations concerning changes or exceptions to the standard for sex offenders incarcerated in the Department of Corrections.

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

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

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

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

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

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

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

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Appendix G: SOMB Committee Updates

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

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

   Major Accomplishments: The Committee met regularly in 2024. The Committee managed the SOMB agenda and oversaw the work of the other committees. In addition, the committee monitored progress in implementing the requirements of the SOMB reauthorization bill and coordinated a traveling Board meeting to Pueblo in May 2024.

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

2. **Best Practices Committee**
   Active
   Committee Chairs: Hannah Pilla and Kyle Lucas

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

   Major Accomplishments: The Committee met on 10 of the 12 months in 2024. The committee did not convene when it fell during the ODVSOM annual conference and pending the winter break. The Committee reviewed and actioned various proposed revisions to the *Adult Standards and Guidelines* and *Juveniles Standards and Guidelines* and discussed issues arising in the field. Actions included advising the Adult and Juvenile Standards Revisions Committee of issues to consider, forwarding proposed revisions to the Board for consideration, reviewing and addressing public comment, and returning proposed revisions to the Board for ratification. Highlights include:

   - Review of proposed revisions to the *Adult Standards and Guidelines Section 3.000* concerning treatment plans, discharge summaries, and acceptance of responsibility and accountability (formerly denial). Review of proposed revisions to Section 5.000 regarding the responsibilities of supervising officers within the CST to address the requirements of the reauthorization bill SB 23-164 (see Appendix F).

   - Review of proposed revisions to the *Adult Standards and Guidelines Section 4.000* concerning polygraph examiner qualifications and requirements.

- Review of revisions to the *Juvenile Standards and Guidelines,* which included updates to the language in the *Introduction* required by the SOMB reauthorization bill and to *Section 2.000* concerning evaluations with juvenile clients. Notably, the revisions emphasize the appropriate use of risk and other assessment instruments per the user manual, the psychometric properties of the instruments, and their suitable application based on the client's characteristics (e.g., gender, race, ethnicity, culture, etc.).

- Discussing the implications for the *Adult Standards and Guidelines* of recent Colorado Court of Appeal decisions concerning client Fifth Amendment rights during offense-specific treatment (People vs. Vigil) and restriction of the use of electronic devices (People vs. Silvanic). Guidelines and a policy brief are being developed to address these issues and support treatment providers.

- Discussion of best practices working with clients with autistic spectrum conditions and provider needs for further guidance on sexual interest assessment.

- Creation of a standing polygraph examiner position on the Best Practices Committee.

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

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

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

Major Accomplishments: The Committee convened 22 times during 2024. The Committee diligently reviewed applications from providers and addressed complaints. The Committee continued to monitor variances and the application process to ensure proper oversight of listed providers. Highlights include:

- Managing 273 applications for placement or continued placement on the SOMB Approved Provider List.

- Managing complaints against 20 providers, resolving these for 13 providers. Some of these complaints were pending from the previous year. Complaints were resolved by a finding of either dismissed, unfounded, or founded. The remaining complaints are still under investigation, either by the Committee or the Department of Regulatory Agencies (DORA).

- Managing one appeal against a complaint resolution.
- Two Standards Compliance Reviews were performed to evaluate if standards were being met and to require corrective actions where necessary.
- The Committee has worked on revising policies and processes to conduct Standards Compliance Reviews on 10% of Approved Providers every two years.

Future Goals: Continue reviewing applications, complaints, variances, and appeals. Begin conducting randomized and voluntary Standards Compliance Reviews in addition to for-cause reviews to meet the new mandate of reviewing 10% of providers every two years.

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

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

Major Accomplishments: The Committee met on 9 of the 12 months in 2024. The committee did not convene when it fell on days with significant conference and training events (e.g., ODVSOM annual conference and Association for Treatment and Prevention of Sexual Abuse conference). Highlights of the work of the Committee include:

- Significant revisions were completed and ratified for *Section 3.000 Standard of Practice for Treatment Providers* concerning treatment plans, discharge summaries, and the management of denial. This revision work involved conducting and reviewing public comments, making necessary amendments, and presenting the proposed revisions to the Best Practices Committee and the Board. Proposed revisions concerning prison-based treatment at the SOTMP have been completed and were reviewed and ratified by the Board in January 2025.
- Review and revision of *Section 3.000 Standard of Practice for Treatment Providers* concerning core treatment concepts and use of interpreters and *Section 5.000 Standards of Practice for Community Supervision Teams Working with Adult Sex Offenders* concerning treatment referrals are ongoing.
- A Treatment Modifications Workgroup was convened to examine issues that have arisen from clarification that the SOMB purview includes low-risk or unique cases that were previously referred for alternative interventions. The workgroup is tasked with identifying potential conflicts and proposing evidence-informed strategies to address these cases more effectively while ensuring community safety, protecting victim rights, and maintaining the integrity of the *Adult Standards and Guidelines*. The workgroup is also considering whether additional guidance on tailoring treatment for those at the high-risk end of the continuum is needed.

Future Goals: The ASR Committee will continue reviewing and revising Section 3.000 Standard of Practice for Treatment Providers as part of its systematic approach to updating sections of the *Adult Standards and Guidelines*. Additionally, the Committee will continue to progress revising Section 5.000 to ensure compliance with the directives from the reauthorization bill, SB 23-264. The ASR will continue to review sections of the *Adult Standards and Guidelines* and respond to emerging issues and requests from the Best Practices Committee and the Board.

5. **Juvenile Standards Revision Committee**
Active
Committee Chair: Theresa Weiss
Co-Chair: Vacant

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

Major Accomplishments: The Committee met 6 times in 2024. The committee did not convene when there were conflicts with holidays. Highlights include:

- Revisions to *Section 2.000, Evaluation and Ongoing Assessment of Juveniles Who Have Committed Sexual Offenses,* to incorporate updates to the Association for Treatment and Prevention of Sexual Abuse practice guidelines, reflect legislative changes, and improve the clarity of the standards.

- Revisions to *Section 5.000, Establishment of a Multidisciplinary Team for the Management and Supervision of Juveniles Who Have Committed Sexual Offenses*, to address the responsibilities of the supervising agency, incorporate legislative changes, update the language about individualized treatment plans, and improve the clarity of the standards.

- Revisions to *Section 10.000 and Appendix K* to remove outdated language about *Additional Conditions of Supervision*. Instead, the revision clarifies that juveniles under supervision for sexual offenses must comply with court-specified terms and conditions and that MDT members are directed to consult the supervising agency for these terms. This change ensures flexibility for case-specific conditions and eliminates reliance on potentially outdated lists.

- The Committee convened the School Resources Workgroup to review and update the 2015 SOMB School Resource Guidelines.

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

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

Major Accomplishments: The Committee met 9 times in 2024. The committee discussed training needs for CSTs and MDTs. It supported a committee member to provide a 90-minute lunch-and-learn session on addressing victim issues when working with individuals convicted of CSEM offenses. The committee spent much of the year focused on a major piece of work, reviewing and revising the Guidance Regarding Victim/Family Member Readiness for Contact, Clarification, or Reunification. This guidance document is contained in Appendix B of the Adult and Juvenile Standards.

Future Goals: The Committee will continue revising the Victim/Family Member Readiness Guidance document until it is complete. Additionally, it will collaborate with SOMB staff to create a plan to support the implementation of the revised document once it is finalized and scheduled for rollout. The Committee will also work to enhance the SOMB's commitment to a victim-centered approach in sex offender management and strive to increase the presence of victim services stakeholders at committee and Board meetings.

7. **DV/SO Training Committee**
Active
Committee Chair: Sonja Hickson
Committee Co-Chair: Xaviera Turner

Purpose: The Training Committee consists of Approved Providers, supervising officers, DVOMB Treatment Victim Advocates, SOMB Victim Representatives, and other stakeholders who work together to achieve several goals. Their primary responsibilities include identifying relevant training topics and objectives, planning large-scale training events, including the annual conference, and assessing training needs related to domestic violence and sex offender management. Additionally, the committee focuses on developing trainers in collaboration with other agencies, providing support based on available resources, and recommending training needs and best practices to program staff.

Main Accomplishments: The Training Committee met monthly for two hours throughout 2024. The Committee reviewed the 2023 ODVSOM annual conference and hosted the 2024 conference. The Committee developed a code of conduct for both conferences and training sessions. The code aims to set clear expectations for respectful and constructive engagement and address culturally inappropriate comments or actions during training events if these occur. The committee continued to work on developing a broad range of training initiatives that both provide content-specific knowledge and create opportunities for the development of a practice community. The committee continued emphasizing attention to culturally responsive care within ODVSOM educational activities.

Future Goals: The Training Committee continues to plan training events and find opportunities for conjoint DVOMB and SOMB activities. The Committee is also working on creating opportunities for greater victim voices to be included at the ODVSOM conference and continuing to support cultural awareness within training.

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

   Purpose: The Sex Offender Surcharge Allocation Committee provides recommendations to the SOMB regarding allocating funds from the Sex Offender Surcharge Fund. Additionally, the Committee coordinates these allocations with any money expended by any of the Departments to identify, evaluate, and treat adult sex offenders and juveniles who have committed sexual offenses. The Committee meets as needed.

   Major Accomplishments: The Committee met and discussed account balances, revenues, expenditures, projected adjustments in future years, and the needs of the different agencies. In September 2024, the Committee presented its recommended allocations for fiscal year 2025-2026 to the SOMB, which were approved as follows:

   - $305,387 to the Division of Criminal Justice for the administration and implementation of the Standards. This includes $245,387 for personnel, contract, and operation expenses, plus $60,000 for funded FTE appropriated positions. $3,500 of these funds will be used to provide cross-system training, with additional matching dollars from grants where available.
   - $453,044 to the Judicial Department for direct services, beginning with the funding of sex offender evaluations, assessments, and polygraphs required by statute during the pre-sentence investigation.
   - $50,000 to the Department of Corrections to manage sex offender data collection, which includes entry of ViCAP, psychological and risk assessment test results, and demographics for treatment planning and research (covering personnel, operating, and POTS dollars for FTE appropriated positions).
   - $57,350 to the Department of Human Services for training and technical assistance to county departments, the Division of Youth Services, and the Division of Child Welfare.
   - The total expenditure from the funds will be $865,781. Once these needs are met, additional funding for direct services related to sex offender treatment, polygraphs, or related services should be considered.

   Future Goals: The Committee will meet as necessary to develop recommended allocations for the fiscal year 2026-2027.

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Appendix H: Section Three Screenreader Tables

H.F7. Number of Adult and Juvenile SOMB Providers by County

County	Count of Adult Evaluation Providers	Count of Juvenile Evaluation	Count of Adult Treatment	Count of Juvenile Treatment	Count of Adult Polygraphers	Count of Juvenile Polygraphers
Adams	50	27	76	55	14	9
Alamosa	5	2	8	4	10	8
Arapahoe	45	28	67	53	15	9
Archuleta	4	3	4	3	3	2
Baca	2	1	2	1	2	2
Bent	2	1	2	1	3	3
Boulder	29	17	39	30	13	9
Broomfield	16	9	24	16	6	5
Chaffee	5	4	8	4	5	5
Cheyenne	3	1	4	3	2	2
Clear Creek	9	6	10	7	2	2
Conejos	3	1	4	2	1	1
Costilla	3	1	4	2	1	1
Crowley	3	1	3	2	2	2
Custer	2	1	3	2	1	1
Delta	6	2	12	6	4	4
Denver	64	38	96	76	15	8
Dolores	2	1	2	1	4	3
Douglas	32	20	50	36	11	7
Eagle	10	6	14	8	5	4
El Paso	23	14	53	38	10	6
Elbert	3	0	4	3	2	2
Fremont	11	6	37	10	7	6
Garfield	12	4	15	4	4	4

County	Count of Adult Evaluation Providers	Count of Juvenile Evaluation	Count of Adult Treatment	Count of Juvenile Treatment	Count of Adult Polygraphers	Count of Juvenile Polygraphers
Gilpin	4	3	4	5	2	2
Grand	4	2	5	3	2	2
Gunnison	1	0	4	1	3	3
Hinsdale	1	0	1	0	2	2
Huerfano	3	1	3	1	1	1
Jackson	2	1	2	1	1	1
Jefferson	43	27	69	59	17	10
Kiowa	1	0	2	0	1	1
Kit Carson	1	0	2	1	2	2
La Plata	3	2	4	2	5	4
Lake	3	1	4	1	1	1
Larimer	24	12	30	25	7	5
Las Animas	2	0	2	0	1	1
Lincoln	1	0	1	1	2	2
Logan	7	7	7	7	2	2
Mesa	12	3	21	9	5	5
Mineral	1	0	2	1	1	1
Moffat	3	2	4	2	3	3
Montezuma	4	2	5	2	5	4
Montrose	6	2	11	6	5	5
Morgan	7	4	7	5	3	3
Otero	3	1	3	1	2	1
Ouray	1	0	1	0	4	4
Park	6	3	8	3	2	1
Phillips	2	1	2	1	1	1
Pitkin	3	1	3	2	3	3

County	Count of Adult Evaluation Providers	Count of Juvenile Evaluation	Count of Adult Treatment	Count of Juvenile Treatment	Count of Adult Polygraphers	Count of Juvenile Polygraphers
Prowers	2	1	2	1	1	1
Pueblo	19	7	30	17	6	3
Rio Blanco	5	3	5	3	2	2
Rio Grande	3	1	4	2	1	1
Routt	8	4	8	4	4	4
Saguache	3	1	4	2	1	1
San Juan	3	2	3	2	3	2
San Miguel	1	0	1	1	2	2
Sedgwick	3	2	3	2	2	2
Summit	7	3	9	4	4	3
Teller	4	2	5	3	2	1
Washington	3	2	3	2	2	2
Weld	32	18	41	39	9	6
Yuma	4	3	5	4	2	2

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H.F13. ODVSOM Shared Services Model and Organizational Chart 2023.

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

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

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