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.

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SOMB 2026 Annual Legislative Report

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Executive Summary

This annual legislative report, submitted pursuant to Section 16-11.7-109 (2), C.R.S, provides findings from the Sex Offender Management Board (SOMB) regarding best practices for the treatment and management of adults convicted and juveniles adjudicated for sexual offenses.

Established in 1992, the SOMB develops, implements, and continually updates evidence-based standards and guidelines for the evaluation, treatment, supervision, and long-term management of adults convicted and juveniles adjudicated for sexual offenses. The report summarizes emerging research and evidence-based practices, reviews policy issues of interest to the legislature and that may warrant legislative consideration, and documents the SOMB's accomplishments in 2025.

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 (CDPS), or other state agencies.

Section 1: Research and Evidence-Based Practices

The SOMB is statutorily mandated to develop and evaluate evidence-based standards for the treatment and management of adults convicted and juveniles adjudicated for sexual offenses, with the primary goal of preventing reoffending and protecting the public (§ 16-11.7-101(2), C.R.S.). In 2025, the SOMB conducted significant work to fulfill this mandate and assess its effectiveness. This work included: a literature review on treatment outcomes moderated by risk and treatment setting; a recidivism study using the Risk-Need-Responsivity (RNR) framework; and a summary of 2025 program data collected through the Provider Data Management System (PDMS).

Treatment Effectiveness Moderators

Effective treatment for individuals convicted of sexual offenses—primarily delivered through cognitive-behavioral and RNR-aligned programs—consistently produces a 10–30% reduction in sexual recidivism, enhancing public safety and supporting rehabilitation (Hanson et al., 2009; Holper et al., 2019; Gannon et al., 2019; Schmucker & Lösel, 2015). In addition, key research findings emphasize three crucial factors that moderate treatment outcomes, all aligned with the SOMB *Adult Standards and Guidelines*:

Risk Principle (Risk Level)

- Higher-risk individuals derive the largest and most substantial gains from intensive, structured, needs-focused interventions.
- Low-risk individuals show minimal—and occasionally adverse—effects from high-intensity treatment, confirming that intervention must be proportionate to the assessed risk level.
- Services for low-risk individuals may still be warranted to refine risk assessments, facilitate community reintegration, reinforce accountability, support victim interests, and ensure that all individuals convicted or adjudicated for sexual offenses receive meaningful rehabilitative support without unnecessary high-intensity programming.

Need Principle (Dynamic and Protective Factors)

- Treatment-related change is primarily driven by improvements in dynamic risk factors (criminogenic needs) such as atypical sexuality, self-regulation problems, and antisocial cognitions. Reductions in these domains reliably predict long-term decreases in recidivism.
- Protective factors—such as prosocial support and effective coping skills—also play a critical role. They help buffer against reoffending and add meaningful value to risk assessment. Effective programs should both reduce or mitigate dynamic risk factors and actively strengthen protective factors.

Treatment Setting and Continuity

- Community-based and outpatient programs generally produce stronger and more consistent reductions in recidivism than prison-only programs. Community settings support skill generalization and address critical reintegration needs (e.g., housing, employment) which are important for sustained behavior change.
- At the same time, for higher-risk individuals, the most durable recidivism reductions occur when institutional treatment is paired with structured, skills-focused community aftercare and strong continuity of care following release.

These conclusions support the SOMB's current risk-informed, needs-focused framework and reinforce the importance of strengthening system-wide implementation, particularly in risk-dosage matching and coordinated transitions between institutional and community providers.

SOMB Recidivism and Desistance Outcomes Project: Risk Levels and Responsivity Factors

The SOMB Recidivism and Desistance Outcomes Project constitutes the second phase of data analysis using the Provider Data Management System (PDMS), fulfilling the SOMB's statutory data collection mandate. As part of this project, the present study examines post-discharge recidivism outcomes for 831 adult male community treatment clients who consented to criminal record linkage. The analysis focuses on how post-treatment recidivism relates to Risk-Need Levels and key Responsivity Factors (core principles of the RNR framework) over an average follow-up period of 2.6 years.

Key Findings

- **Risk Level is a Strong Predictor:** As assessed Risk-Need Levels increased (Low to High), the likelihood of violent and general recidivism also increased. Sexual recidivism remained low across all groups (total rate: 1.3%).
- **End-of-Treatment Risk is Most Informative:** Risk ratings at discharge were stronger and more reliable predictors of violent and general recidivism than risk ratings at treatment entry. This suggests that discharge ratings capture meaningful treatment-related change in dynamic factors and provide a better indicator of post-treatment outcomes than initial assessments alone.

- **Responsivity Factors Signal Complexity:** Although most clients classified as high risk-need did not reoffend, certain responsivity factors were associated with increased violent and general recidivism, including:
    - Developmental/Intellectual Disability (DDID)
    - Need for substance abuse treatment
    - Higher denial at discharge
- These factors identify clients with complex clinical profiles who may require specialized or extended support. However, they do not predetermine failure, indicating that provider efforts to address these barriers are often effective.
- **Core Principles Affirmed:** The findings confirm that the RNR framework is functioning as expected within the PDMS data. Assessed risk corresponds to meaningful differences in reoffending, and positive changes in dynamic risk are reflected in lower post-treatment recidivism rates.

Study Implications

Community-based treatment, supervision, and monitoring appear effective for the majority of clients. The data validate the focus on dynamic risk indicators at discharge and underscore the need for continued, tailored interventions for individuals with specific responsivity barriers such as DDID and substance use needs. Continued investment in PDMS data is essential for ongoing evaluation and evidence-informed policy refinement.

While these implications are promising, they should be interpreted in the context of the study's methodological limitations and relatively short follow-up period. Continued data collection and longer-term analyses will help strengthen confidence in these preliminary conclusions and better inform future practice and policy decisions.

PDMS Data Collection Analysis

The SOMB utilizes the PDMS to collect and analyze client-level service data, fulfilling its statutory mandate to evaluate the efficacy of the *Adult and Juvenile Standards and Guidelines*. The sixth annual reporting phase summarizes 348 evaluations, 624 treatment discharges, and 2,093 polygraph exams completed between November 1, 2024, and October 31, 2025.

The Year 6 review provides compelling evidence of continued Approved Provider fidelity to evidence-based practice, strong provider commitment to data reporting, and a system increasingly capable of supporting data-informed quality improvement.

Evaluations (Count: 348)

- **Client Demographics:** Most evaluation clients were adult males (94%), with a mean age of 34 years. Probation was the primary referral source, accounting for 81% of evaluations.
- **Risk Classification:** The majority of clients were classified as Low, Low-Moderate, or Moderate risk. Juvenile clients were assigned Low-risk status more frequently (46%) than adult clients (16%).

- **RNR Alignment:** Providers demonstrated strong adherence to RNR principles. They frequently recommended adjunct non–sex offense-specific treatment to address broader needs (62%) and prioritized community-based treatment providers (69% for adults; 91% for juveniles).

Treatment Completion (Count: 624)

- **Acceptance of Responsibility:** Most clients increased their acceptance of responsibility over the course of treatment. Among adults who began in categorical denial, 75% improved responsibility-taking and were able to progress into offense-specific treatment.
- **Treatment Outcomes:** The overall successful treatment completion rate was 51%, consistent with the previous two years.
- **Risk Level and Discharge:** Risk level was clearly related to outcome with higher-risk clients having substantially lower rates of successful discharge (24% for High risk) compared to lower-risk clients (66%).
- **Dynamic Risk Change:** Approximately half of all clients in the Low-Moderate, Moderate, and Moderate-High categories decreased their risk level by treatment discharge, validating the importance of dynamic risk assessment at the end of treatment.
- **Treatment Duration:** Successful discharges were strongly associated with longer treatment duration (median 40.8 months) compared to unsuccessful discharges (median 9.2 months), underscoring the influence of treatment engagement.
- **Unsuccessful Discharges:** Unsuccessful discharges (219 adult clients; 36%) were primarily driven by client resistance or lack of investment in treatment goals (53.4%) and treatment contract violations (34.2%). General lack of motivation was noted in 37% of cases. These responsivity challenges are consistent with national research on offender rehabilitation and highlight opportunities for strengthened early engagement, motivational interventions, and responsivity-focused refinements within the *Adult and Juvenile Standards and Guidelines*.
- **Reoffense-Related Discharge Rates:** Among the 219 clients discharged unsuccessfully, 37 discharges (17%) were recorded as resulting from a new criminal offense. This included 27 clients (12.3%) with a new non-sexual offense and 11 clients (5.0%) with a new sexual offense, with one client cited for both.
- **Responsivity Strategies:** Providers showed continued RNR fidelity by using individualized treatment plans (95%) and implementing responsivity strategies such as adjusting treatment frequency or modality (56%) to address client-related barriers (identified in 62% of cases).

Polygraph Examinations (Count: 2,093)

- **Referral and Volume:** The vast majority of polygraphs (99.1%) were conducted for adult clients. Corrections agencies were the main referral source (92%), with Probation accounting for 72%.
- **Exam Outcomes and Disclosures:** Most polygraph exams resulted in No Significant Reactions/Non-Deceptive outcomes (71%), indicating that the client did not show evidence of deception during the exam. Separately, polygraphs yielded clinically significant disclosures in nearly half of adult exams (49%) and two-thirds of juvenile exams (67%). These disclosures reflect information shared before, during, or after the exam. The higher disclosure rate among juveniles is because polygraphs are only used when specific concerns warrant the exam.

- **Exam Type:** Maintenance/Monitoring exams made up most exams (75%). Specific Issue and Instant/Index Offense exams showed the highest Significant Reactions/Deception Indicated rates (40% and 78%), consistent with their use when offense denial is present.

Summary and Implications

The Year 6 review confirms consistent Approved Provider implementation of the *Adult and Juvenile Standards and Guidelines* and continued strong fidelity to the RNR model. Key takeaways include:

- **Consistent Treatment Success and Strong RNR Implementation:** The stabilized 51% successful completion rate, combined with the widespread use of individualized responsivity strategies, suggests consistent implementation of the *Adult and Juvenile Standards and Guidelines*.
- **Ongoing Responsivity Challenges:** Client resistance, lack of motivation, and treatment disengagement remain the most common contributors to unsuccessful discharge. Addressing treatment engagement early—and strengthening motivational, cognitive-behavioral, and acceptance-of-responsibility interventions—remains a priority for improving outcomes.
- **Polygraph as an Accountability Tool:** High rates of clinically significant disclosures support the utility of polygraph testing for monitoring risk and informing supervision and treatment decisions. The higher disclosure rate among juveniles indicates that exams are being used selectively in cases where concerns are highest.
- **Recidivism Monitoring and Public Safety:** New crime data show a stable non-sexual recidivism rate (12.3%) and a slight increase in sexual recidivism (from 4.1% to 5.0%). Ongoing analysis of individual, programmatic, and systemic factors underlying these trends will help guide data-driven refinements to standards and community safety strategies.
- **Data Quality and Provider Support:** Reports of "data fatigue," particularly among polygraph examiners, underscore the need to streamline PDMS processes. Maintaining high-quality data is essential for preserving the longitudinal value of the dataset and supporting meaningful evaluation over time.

The PDMS remains an essential, evidence-supported tool for ongoing system evaluation and improvement. Provider comment entries—documenting individualized treatment approaches, polygraph disclosures, and intervention strategies—give the SOMB real-time insight into implementation successes and challenges. Year 6 findings will directly inform policy revision and targeted training and technical assistance. Overall, PDMS data continue to strengthen provider fidelity, guide evidence-informed decision-making, and enhance public safety outcomes statewide.

Section 2: Relevant Policy Issues and Recommendations

Determinate Sentence Parole Guideline Revision Workgroup

The Determinate Sentence Workgroup was established to fulfill the mandate of Senate Bill 23-164, requiring the SOMB, in collaboration with the State Board of Parole, to revise the parole release guideline instrument for individuals convicted of sex offenses who are serving determinate sentences. The revised guideline must incorporate RNR principles, maximize flexibility for accessing necessary programs, and explicitly prohibit denying parole solely due to an offender's inability to access treatment during incarceration.

Key Progress and Framework Selection

- **Timeline:** The statutory deadline of December 1, 2023, was initially met by the SOMB/DOC Treatment Solutions Workgroup, which developed updated release guideline criteria. However, fully operationalizing those criteria required additional work. To advance this effort, the Determinate Sentence Workgroup was established in 2024 to develop the necessary instrument, resolve operational barriers, and guide implementation.
- **Model Selection:** The workgroup completed Phase II, selecting Structured Decision-Making (SDM) as the most appropriate evidence-based model. SDM aligns with statutory mandates requiring consideration of the "totality of the case" by integrating actuarial data, dynamic risk, and protective factors.
- **Relevance:** Colorado's initiative to develop an SDM tool specifically tailored to determinate-sentence sex offense cases is unique and strongly supported by statutory and empirical considerations.

Foundational and Design Accomplishments (Phases I & II)

- **Risk Mitigation:** The workgroup discussed removing the Department of Corrections Sex Offender Treatment Management Program (DOC SOTMP) completion as a determinant of parole suitability and explored how to develop a more robust, transparent guideline for parole decisions that does not rely on this previously central factor.
- **Instrument Development:** SOMB staff began drafting a new SDM instrument to assess both risk indicators (Part A) and reentry and protective factors (Part B), such as housing, employment, and social support.
- **Data Challenges:** A key challenge identified was the lack of necessary information and document access for Parole Board members to accurately score the instrument, highlighting the need for improved data collaboration.

Current Status and Next Steps (Phase III)

The project is currently in Phase III: Testing & Finalization.

- **Testing:** Initial validity and usability testing of the draft instrument has been initiated by the CDOC SOTMP Administrator and a Parole Board member, with expansion to other members planned.
- **Guideline Development:** A Community Treatment Guideline is being developed to be used alongside the SDM instrument—parole candidates will be scored on the SDM tool, and the guideline will then provide structured recommendations regarding suitability for community-based treatment. It is anticipated that the guideline will utilize the five-level risk and needs classification system currently under review by the SOMB.
- **Future Focus:** Phase IV (2026) will focus on Implementation Readiness, including development of a comprehensive training package and an implementation plan for full system rollout in 2027.

Victim Advocacy Training Initiative and Standardization

The Victim Advocacy Training Initiative addresses critical challenges in supporting the mandated role of Victim Representatives within adult Community Supervision Teams (CSTs) and juvenile Multidisciplinary Teams (MDTs), which are central to the SOMB's victim-centered sex offender management framework.

Core Mandate and Role

- **Statutory Requirement:** Colorado law and the SOMB *Adult and Juvenile Standards and Guidelines* mandate that victim and community safety must be of paramount consideration in all post-conviction decision-making.
- **Indispensable Function:** The Victim Representative is a mandated core member of every CST/MDT, with a dual role to: (i) Inform and support the victim by communicating information and providing a formal avenue for the victim's concerns; and (ii) Inform the CST/MDT by providing the essential victim perspective and advocating for safety conditions, serving as a critical check and balance to ground decision-making in the victim's physical and psychological safety.

Systemic Challenges Driving the Initiative

The role's effectiveness is undermined by three systemic challenges:

- **Inconsistent Training:** Victim Representatives often receive only informal or ad hoc training, leading to variation in the technical knowledge required for participation (e.g., polygraph interpretation, dynamic risk factors).
- **Workforce Instability:** A 45% decline in federal VOCA funding (Office of Victim Programs, 2023) has severely limited agencies' ability to recruit and retain specialized Victim Representative staff.
- **Unequal Capacity:** The quality and availability of representation vary by jurisdiction, especially in rural areas, leading to unequal victim access to critical post-conviction services.

Victim Advocacy Training Initiative

To build a consistent and sustainable statewide network, the SOMB launched a comprehensive initiative funded by a one-time allocation of $100,000 from the Sex Offender Surcharge Fund. This funding is statutorily appropriate because Victim Representatives are an essential, mandated part of the SOMB's core service structure.

- **Scope 1: Training Program:** Focuses on developing a standardized training curriculum, providing technical assistance, and creating a sustainable network of support, recruitment, and mentoring. The contract was awarded to Colorado Coalition Against Sexual Assault (CCASA).
- **Scope 2: Program Evaluation:** Provides independent assessment of the training's effectiveness and investigates optimal operational models for Victim Representative involvement to inform future policy. The contract was awarded to Dr. Jamie Yoder, Colorado State University.

The project is currently in Phase 3: Evaluation & Sustainability (May–June 2026), with the goal of delivering a comprehensive evaluation and sustainability plan.

Section 3: Milestones and Achievements

The SOMB achieved significant milestones in 2025, continuing to address the new mandates in the SOMB Reauthorization Bill (**SB 23-164**)) while advancing ongoing work, stakeholder relationships, and strategic issues. Highlights include:

Implementation of SB 23-164 and Standards Updates

- **Standards Compliance Reviews (SCRs):** The SOMB implemented the new statutory requirement to conduct compliance reviews on a minimum of 10% of all Approved Providers every two years, effective September 1, 2024. In 2025, the Application Review Committee (ARC) initiated 16 SCRs (14 of which were random), successfully monitoring 5% of all active listed providers and putting the Board on track to meet the biennial requirement.
- **Treatment Solutions Workgroup:** Launched in August 2023, this workgroup completed its responsibilities in early 2024, submitting the Treatment Solutions Report to the Joint Judiciary Committee on February 1, 2024. Key actions resulting from the report were implemented in 2024, and were reported in the SOMB 2025 Annual Legislative Report.
- **Policy Revisions:** Several revisions to the *Adult and Juvenile Standards and Guidelines* have been made to align with SB 23-164, and have completed the full policy-revision process. Any remaining required revisions are currently in progress.
- **Determinate Sentence Workgroup:** As detailed in Section 2, the SOMB continues to advance revisions to the parole release instrument for individuals convicted of sex offenses who are serving determinate sentences.

Strategic Planning and Future Direction

The SOMB conducted a Strategic Planning Initiative in August 2025 as a foundational step toward establishing the Board's future direction and priorities in advance of the 2028 legislative Sunset Review.

- **Data Collection:** Preparation involved gathering critical information, including a Provider Survey and Stakeholder Interviews, to inform the planning process.
- **Key Themes:** The planning retreat focused on four strategic themes: (i) Collaboration; (ii) Training, Tools, and System Modernization; (iii) Emerging Trends and Innovation; and (iv) Systemic Improvements.
- **Next Steps:** The Board will refine the identified priority areas and produce a final strategic planning report in 2026.

Provider Workforce and Stakeholder Outreach

The SOMB focused on strengthening its provider workforce and community engagement.

- **Provider Recruitment Strategy:** The SOMB continued a multi-phase recruitment project to strengthen and expand the pipeline of Approved Providers and address the recent downward trend in provider numbers. In 2025, the project developed and piloted recruitment tools—including a provider video and a customizable slide deck.

- **Community and Stakeholder Outreach:** The SOMB held four statewide roundtables in 2025 (Fort Collins, Boulder, Montrose, and Weld County) to improve collaboration between teams and gather feedback from Approved Providers and community members. The Board also facilitated comprehensive annual training for key partners including Judicial staff and the Parole Board.
- **Training Delivery:** The SOMB provided 32 trainings in 2025, including the annual ODVSOM conference, collectively reaching over 1,400 attendees. Training emphasized implementation of core standards as well as specialized topics such as working with high-risk individuals and reducing provider burnout.
- **Provider Applications and Listings:** The Application Review Committee (ARC) received 335 applications in 2025 (a 23% increase over 2024) for initial listings, status upgrades, and renewals. By year's end, 256 applications were approved and 81 remained pending. A point-in-time count showed 325 individual providers on the Approved Provider list overall.
- **Complaints:** The SOMB received 22 complaints against 17 Approved Providers in 2025. By year-end, 7 were founded, 8 were unfounded, and 1 was dismissed, with the remaining complaints still under review.

Organization and Standards

- **Individually Responsive Care:** The SOMB invested in efforts to advance individually responsive care, strengthening *Adult and Juvenile Standards and Guidelines* language to require that treatment be responsive to a client's full range of characteristics (e.g., race, culture, sexual orientation). The Board also hosted training on working with LGBTQ+ clients, female offenders, cultural humility, and intergenerational trauma.
- **ODVSOM Shared Services Model:** The ODVSOM continued to operate its shared services model, centralizing administrative and research functions to provide unified, professional staff support for both the SOMB and the DVOMB.
- **Committees:** The SOMB staffed 16 active committees and workgroups throughout 2025 to carry out statutorily mandated duties and review sections of the *Adult and Juvenile Standards and Guidelines*. All committee and workgroup meetings are open to stakeholders.

Introduction

This annual report presents findings from the **Sex Offender Management Board (SOMB)** regarding best practices for the treatment and management of adults convicted and juveniles adjudicated for sexual offenses. Pursuant to Section 16-11.7-109 (2), C.R.S., the SOMB must submit a written report to the judiciary committees of the Senate and the House of Representatives, or any successor committees, on or before **January 31 of each year**. This report fulfills that mandate by summarizing emerging research and evidence-based practices and reviewing policy issues that may warrant legislative consideration. In addition, the report documents the SOMB's accomplishments and activities in 2025.

Established in 1992, the SOMB was created to enhance community safety and support victims through standardized practices for individuals who have committed sexual offenses. In 1996, the Board originally issued the ***Standards and Guidelines for the Assessment, Evaluation, Treatment and Behavioral Monitoring of Adult Sex Offenders*** (hereafter referred to as the *Adult Standards and Guidelines*). In 2003, the Board published the ***Standards and Guidelines for the Evaluation, Assessment, Treatment and Supervision of Juveniles Who Have Committed Sexual Offenses*** (hereafter referred to as the *Juvenile Standards and Guidelines*). Both sets of *Standards and Guidelines* establish an evidence-based framework for assessment, treatment, and long-term management. They are regularly revised to reflect current research and professional practices, with real-time updates available since 2017 on the SOMB website.

The *Adult and Juvenile Standards and Guidelines* are implemented through coordinated multidisciplinary teams. Community Supervision Teams oversee adults, while Multi-Disciplinary Teams oversee juveniles. These teams typically include a supervising officer, treatment provider, victim representative, and polygraph examiner, who together develop individualized treatment and supervision plans. This interagency approach is intended to promote accountability, reduce risk, and support long-term success while prioritizing public and victim safety.

Both sets of *Standards and Guidelines* are based on **research and best practices** and are periodically updated to reflect advancements in the field based on **new empirical findings**. This continuous refinement process is largely driven by the SOMB's active committees:

- Executive Committee
- Best Practices Committee
- Application Review Committee
- Adult Standards Revisions Committee
- Juvenile Standards Revision Committee
- Victim Advocacy Committee
- Training Committee
- Sex Offender Surcharge Allocation Committee

Report Organization

This legislative report is organized into four sections:

1. Key research and evidence-based practices informing the *Standards and Guidelines*
2. Policy issues affecting the field of sex offender management
3. Accomplishments and activities of the SOMB in 2025
4. Future goals and priorities for the coming year

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.

This mandate is operationalized through 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*). The primary aim of both sets of *Standards and Guidelines* is to prevent reoffending and to enhance the protection of victims and potential victims. To ensure the *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 2025 to fulfill its statutory mandate to **evaluate the effectiveness of its *Standards and Guidelines***:

1. First, a literature review that **synthesizes empirical findings** on **treatment effectiveness for adults convicted of sexual offenses** and examines how outcomes are moderated by three critical factors: (1) individual risk level, (2) dynamic risk and protective factors, and (3) treatment setting (e.g., community vs. prison).[1]

2. Second, a report from the multiphase SOMB sexual **recidivism and desistance study**[2] that examines **post-discharge recidivism outcomes** among **adult male community treatment clients** as a function of risk-need level (RNR framework) and selected responsivity characteristics.[3]

3. Third, a summary of **2025 data** collected through the SOMB Provider Data Management System (PDMS) concerning evaluations, treatment, and polygraph examinations for individuals under the purview of the *Adult and Juvenile Standards and Guidelines*.

[1] **Risk factors** for reoffending are generally classified as **static** (historical, unchangeable characteristics like prior offenses) or **dynamic** (current, changeable characteristics such as substance abuse or pro-criminal attitudes; also referred to as criminogenic needs). **Protective factors** are positive conditions or strengths (e.g., stable relationships, pro-social support) that reduce the likelihood of offending or promote sustained desistance.

[2] **Desistance** is understood as the **sustained, long-term process** through which an individual reduces and eventually ceases criminal activity and identity. This is distinct from **recidivism**, which is typically defined as a **discrete event** or failure—a subsequent criminal offense following intervention or release.

[3] **Responsivity characteristics** are the individual traits (such as cognitive abilities, motivation, and cultural background) that must be considered when **tailoring interventions** to maximize an offender's engagement and treatment effectiveness.

Treatment Effectiveness

Introduction and Purpose

Effective treatment for individuals who have committed sexual offenses is essential for advancing **public safety**, supporting **rehabilitation**, and ensuring the **efficient use of criminal legal system resources**. While sexual recidivism rates are *lower* than for other offense types, even a small number of reoffenses carries significant consequences—for victims, communities, and public trust. Research also shows that many individuals convicted of a sexual offense later engage in non-sexual reoffending, involving violent or general criminal behavior. These patterns of harm underscore the need for **comprehensive, evidence-based** treatment.

Over the past two decades, a substantial empirical literature—including multiple large-scale meta-analyses—has examined whether treatment reduces reoffending. Across studies, **psychosocial interventions consistently produce 10–30 percent reductions in sexual recidivism** compared with untreated groups. The strongest and most reliable results emerge from **cognitive-behavioral, Risk-Need-Responsivity (RNR)–aligned programs**, which outperform other educational or deterrence-driven models (Hanson et al., 2009; Schmucker & Lösel, 2015).

At the same time, treatment effects vary across **people** and **settings**. Three interconnected domains are especially important for interpreting outcomes and informing the *Adult Standards and Guidelines*:

- **Risk Level:** Higher-risk individuals benefit most from intensive, targeted services, whereas over-treating low-risk participants can have minimal or negative effects.
- **Dynamic and Protective Factors:** Programs that address changeable risk factors (e.g., atypical sexual interests, intimacy deficits, and antisocial attitudes) while strengthening protective factors (e.g., social support, coping skills, and prosocial goals) yield more durable change.
- **Treatment Setting:** Community-based programs generally show stronger, more consistent effects than institution-only programs, particularly with continuity of care and when skills can be practiced in real-world environments.

This review synthesizes major findings from contemporary studies to assess the **effectiveness of treatment** for adults convicted of sexual offenses and to illustrate how outcomes differ based on risk level, dynamic and protective factors, and treatment setting.

Risk Level as a Moderator of Treatment Effectiveness

Across decades of research, the Risk Principle—that **treatment works best when matched to an individual's risk for reoffending**—has emerged as a foundational principle of effective correctional rehabilitation. The RNR model predicts that higher-risk individuals require more intensive, targeted interventions, while over-treating low-risk individuals can produce minimal benefits or even cause modestly adverse effects.

Three major meta-analyses[4] provide converging, substantial evidence that risk meaningfully shapes treatment outcomes:

- **Hanson et al. (2009):** Programs adhering to a greater number of RNR principles showed greater reductions in sexual and general recidivism. The data indicated a strong trend that programs serving higher-risk individuals tended to demonstrate larger treatment benefits, particularly when using structured, CBT-based, needs-focused approaches.

- **Schmucker & Lösel (2015):** Treatment yielded an overall **26% reduction** in sexual recidivism, with risk as a clear moderator. Programs serving **medium- and high-risk** groups showed substantial benefits, while **low-risk** groups showed **no measurable reduction in recidivism.**

- **Holper et al. (2023):** In a meta-analysis of nearly 30,000 individuals, treatment produced a **31.6% reduction** in sexual recidivism. Crucially, effects were significantly stronger in programs serving **medium- and high-risk individuals**. An increase in sexual recidivism among low-risk programs was linked to a single large outlier study.

Together, these analyses strongly support the **Risk Principle**: individuals assessed as higher risk experience the largest gains from intensive, structured, and needs-based interventions.

Nonetheless, it is important to recognize methodological limitations to avoid misinterpretation, especially regarding lower risk groups. In these meta-analyses, "risk level" reflected broad categories derived from largely static actuarial scores.[5] As Holper et al. (2023) note, these should be treated as **rough indicators of average risk** which are not standardized across studies. Further, none tested how people at different risk levels respond to different *intensities* of treatment. Instead, they compared programs that happened to serve different risk profiles. The limited benefits observed for low-risk groups indicates that **low-risk individuals gain little from *high-intensity* programs—not that they would fail to benefit from appropriately matched, lower-intensity services**.

Within this context, the **tiered, risk-responsive system** in the *Adult Standards and Guidelines* remains consistent with the broader evidence base and principles of effective correctional rehabilitation.

Treatment for Low-Risk Individuals

Weak or absent treatment effects for low-risk groups are sometimes interpreted as evidence that intervention is unnecessary. However, their already-low rates of sexual recidivism leave little statistical room for measurable improvement—a likely baseline limitation (floor effect) rather than true ineffectiveness.[6] A narrow focus on recidivism also obscures meaningful gains in functioning, coping, reintegration, and prosocial engagement (Farmer et al., 2015), all of which support long-term desistance and help explain why a small minority of low-risk individuals still reoffend (Helmus et al., 2021).

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[4] **Meta-analysis** is a "study of studies" that uses statistical methods to combine results from multiple independent studies, producing a more reliable estimate of an overall effect.

[5] **Static scores** derive from historical and unchangeable risk factors (e.g., age at first offense or prior convictions); as opposed to **dynamic scores** that are current and changeable. **Actuarial scores** are statistical calculations of risk based on empirical research; they differ from structured or subjective professional judgment, which relies on clinical experience rather than data-driven prediction.

[6] **Baseline limitation (floor effect)** refers to a situation where rates are already so low that further meaningful reduction is difficult to detect or achieve.

Short, lower-dosage services can address practical needs such as housing, employment, family reunification, and child-contact decision-making, where structured assessment and documentation are essential for safety and stability (Digiorgio-Miller, 2002; Lee et al., 2016; Rydberg et al., 2022; Willis & Grace, 2008). Some individuals also experience situational stressors, emerging problems, or denial-related barriers that warrant brief monitoring or intervention (Wakeling et al., 2012). Importantly, some studies comparing treated and untreated low-risk groups show small but meaningful reductions in sexual recidivism (e.g., Carr & Willis, 2021: 2.3% vs. 4.1%; Olver et al., 2020a: ~4–4.6% vs. 7.7%).

At the same time, concerns about over-intervention are justified. Lovins et al. (2009) found that intensive residential programming improved outcomes for medium- and high-risk participants but **worsened outcomes for low-risk clients**, increasing reincarceration by 27%. Together, these findings reinforce the central RNR principle: intensive services benefit those at higher risk, whereas lower-risk individuals do best with proportionate, focused interventions matched to their needs.

Within this framework, brief services for low-risk individuals can serve several functions:

- Refining risk assessments by examining dynamic and protective factors (Carr & Willis, 2021)
- Supporting reintegration and supervision planning
- Reinforcing accountability and responsibility-taking (Koss, 2014)
- Identifying emerging concerns—such as stress, substance use, or relationship instability—that, if unaddressed, may increase risk (Chiu et al., 2021; Harris & Hanson, 2010)

When applied responsively and in moderation, such engagement aligns with the RNR model and maintains public and victim confidence that all individuals receive meaningful rehabilitative oversight. It also makes clear that “low risk” does not mean “no intervention” and that individualized approaches are preferable to one-size-fits-all systems.

Dynamic Risk and Protective Factors as Moderators of Treatment Effectiveness

A substantial body of research shows that both **dynamic risk factors** and **protective factors** play critical roles in moderating treatment effectiveness for individuals who have committed sexual offenses. Dynamic risk factors predict recidivism, change meaningfully during treatment, and treatment-related improvements consistently predict reduced reoffending (Eher et al., 2020; Lasher & McGrath, 2017; McPhail & Olver, 2020; Olver et al., 2013, 1018, 2020b; van den Berg et al., 2018). Protective factors, although historically less emphasized, also contribute unique predictive value and help explain why some individuals succeed in treatment and maintain stable, prosocial lives (Burghart et al., 2023; Nolan et al., 2022; Willis et al., 2020). Together, these constructs offer a **comprehensive framework** for understanding the mechanisms through which treatment reduces sexual and general recidivism and how positive change can be meaningfully monitored over time.

Dynamic Risk Factors

Seto et al. (2023) provide the strongest synthesis of dynamic risk evidence to date, identifying four core domains:

1. **Atypical Sexuality** (sexual preoccupation, paraphilic interests)
2. **Self-Regulation Problems** (impulsivity, emotional dysregulation, lifestyle instability)
3. **Antisocial Cognitions** (hostility, offense-supportive attitudes, noncompliance), and
4. **Relationship Problems** (intimacy deficits, emotional congruence with children, negative peer associations)

These domains align closely with the broader empirical literature. For example, factor-analytic studies across commonly used tools (e.g., Static-99R, STABLE-2007, VRS-SO, SOTIPS) show that risk items cluster into a small set of underlying criminogenic propensities (Brouillette-Alarie et al., 2016, 2018, 2023). Static (historic, unchangeable) items reflect the historical imprint of these propensities, while dynamic items capture their current expression and potential for change. This helps clarify why treatment works: by targeting the dynamic expressions of these propensities—reducing sexual preoccupation, challenging cognitive distortions, strengthening emotional and behavioral regulation, and decreasing antisocial orientation—treatment directly alters the pathways through which risk is expressed.

Responsivity factors further shape this process by influencing *how well* individuals are able to engage with and benefit from treatment. Clients who develop insight, motivation, and cognitive-behavioral skills tend to make larger improvements in these dynamic domains, and these improvements translate into better long-term outcomes (Olver et al., 2021, 2022). In other words, responsivity helps explain why individuals with similar risk profiles may benefit differently from the same or similar interventions.

Taken together, these findings converge on a clear conclusion: **dynamic risk factors (or criminogenic needs)—and the extent to which they improve in treatment—are key mechanisms through which programming reduces reoffending.** For this reason they yield more clinically meaningful estimates of posttreatment risk than static factors alone.

Protective and Strength-Based Factors

Although historically overshadowed by risk, research increasingly shows that protective factors—strengths, resources, and circumstances that buffer against reoffending—contribute meaningfully to treatment outcomes and desistance. Including protective factors in assessment improves predictive accuracy, provides a more balanced picture of reintegration potential, and enhances engagement in evaluation and release decisions (de Vries Robbé et al., 2015). Protective factors complement dynamic risk: reductions in risk reflect decreased criminogenic propensities, whereas increases in strengths reflect growing capacities and supports that promote stability.

Protective factors are commonly grouped into two domains (Thornton et al., 2017): **external supports** (e.g., employment, prosocial networks, structured activities) and **internal capacities** (e.g., interpersonal competence, problem-solving, secure attachment, prosocial beliefs). A meta-analysis of the Structured Assessment of Protective Factors (SAPROF; Burghart et al., 2023) found that protective factors (1) moderately to strongly predict the *absence* of recidivism, (2) show meaningful treatment-related improvements that forecast reduced reoffending even after controlling for baseline risk, and (3) add incremental predictive validity when combined with static and dynamic risk tools.

The SAPROF-SO adapts this approach for sexual offense populations (Willis et al., 2020; Nolan et al., 2022), assessing strengths in three clusters: **Resilience**, **Adaptive Sexuality**, and **Prosocial Connection and Reward**. An optional Professional Risk Management scale evaluates treatment participation, motivation, supervision supports, and external controls. Emerging evidence indicates that SAPROF-SO scores are reliable and meaningfully associated with sexual recidivism outcomes.

Finally, Seto et al. (2023) identified **positive social support** as the most consistently demonstrated protective factor associated with reduced sexual recidivism, a finding supported across multiple studies (Farmer et al., 2012; Farrington, 2015; Lasher & McGrath, 2017; Walker et al., 2020). This evidence highlights that some strengths—particularly stable, prosocial relationships—function as especially powerful buffers against reoffending and may amplify the benefits of treatment. Strengthening social support, coping, and goal-directed behavior, therefore, represents a distinct and empirically grounded pathway through which protective factors contribute to long-term community adjustment and desistance (Willis & Grace, 2008, 2009).

Treatment Setting: Prison Versus Community

A third line of inquiry examines whether treatment is more effective in prison or in the community. Across major meta-analyses, the pattern is consistent: **both settings can reduce recidivism**, but **community-based programs tend to produce larger and more reliable effects**, especially in higher-quality studies. Earlier reviews (Hanson et al., 2002, 2009) could not fully assess setting differences, but recent rigorous analyses show a clear trend. Schmucker and Lösel (2015) found that community, outpatient, and hospital-based programs showed significant reductions in sexual recidivism, whereas prison-based programs had smaller and generally non-significant average effects. Holper et al. and Kim (2016) reached the same conclusion, with Kim noting that recent meta-analyses "demonstrate that community-based treatments…have a larger effect in reducing recidivism."

Larger multisite analyses reinforce this pattern while demonstrating that both settings retain value. Gannon et al. (2019), analyzing more than 55,000 individuals in programs for sexual, domestic, and general violence, found significant reductions in both prison and community contexts. Their findings highlight that prison-based treatment can be effective, yet **community programs often achieve equal or stronger effects**. Complementing this, a comprehensive review of rehabilitation pathways in Queensland, Australia, found that sex offending treatment programs for medium and high risk individuals were most effective when institutional treatment was followed by a structured community-based reintegration program (McKillop et al., 2019, 2022). This combined pathway produced the lowest return-to-custody rates and the longest survival times, underscoring the importance of continuity of care for higher risk individuals.

Reentry research helps explain these patterns: stable housing, employment, transportation, treatment access, and prosocial support all contribute to lower recidivism (Kruttschnitt et al., 2000; Lee et al., 2016; Rydberg et al., 2022; Willis & Grace, 2008, 2009). **Community-based programs are uniquely positioned** to address these needs and help clients apply and generalize the skills learnt in treatment into daily living, behaviors, and decisions.

Overall, the evidence suggests that the key issue is not simply *where* treatment occurs but *how* it is delivered and whether gains are supported during reentry. Community-based programs are particularly effective at helping individuals maintain progress, build prosocial supports, and address practical reintegration needs. Prison-based programs remain important—especially for higher-risk individuals—because incarceration provides immediate community and victim safety through removal from the community, while also offering an opportunity for structured intervention in preparation for a potential return to the community. However, in terms of treatment effectiveness and long-term risk reduction, **the most durable reductions in recidivism occur when institutional treatment is followed by structured, skills-focused aftercare in the community**. Across studies, the consistent message is that **continuity of care and coordinated transitions**, rather than reliance on prison-only treatment, are essential for long-term success.

Summary and Policy Implications

Across multiple high-quality meta-analyses and independent studies, treatment for adults convicted of sexual offenses is consistently associated with meaningful reductions in reoffending. Cognitive-behavioral, RNR-informed programs reduce sexual recidivism by roughly **10–30%**, with comparable or larger reductions in violent and general criminal reoffending.

Three overarching conclusions emerge:

1. **Risk level is a central moderator of treatment impact.** Higher-risk individuals derive the greatest benefit from intensive, structured, needs-focused interventions. In contrast, low-risk individuals show limited added value—and sometimes adverse effects—when exposed to high-intensity programming. Evidence supports risk–dosage matching, not uniform treatment requirements.

2. **Dynamic criminogenic needs and protective factors drive treatment-related change.** Dynamic risk factors (e.g., atypical sexual interests, self-regulation problems, antisocial cognitions, relationship difficulties) reliably predict reoffending and change meaningfully during treatment. Reductions in these domains are directly linked to long-term decreases in sexual and violent recidivism. Protective factors—especially positive social support, adaptive coping, and goal-directed prosocial behavior—add incremental predictive value and help explain why some individuals maintain desistance following treatment.

3. **Treatment setting influences the magnitude and durability of outcomes.** Both prison- and community-based programs reduce recidivism, but community and outpatient programs consistently show stronger and more reliable effects. Community settings are particularly effective at supporting skill generalization, addressing responsivity needs, and building prosocial supports. Prison-based programs remain important, especially for higher-risk individuals serving custodial sentences, but are most effective when linked to structured community aftercare and continuity of care.

Policy Implications

Overall, the research reviewed here strongly affirms the core structure and principles already embedded in the SOMB *Adult Standards and Guidelines*. The emphasis on risk-informed, needs-focused, responsivity-aware, and continuity-of-care practices is well supported by contemporary empirical evidence. The findings from this review therefore point not to fundamental changes, but to opportunities to enhance consistency, implementation quality, and system-wide coordination.

1. Reinforce risk-based treatment matching and proportionality

The *Adult Standards and Guidelines* already require that treatment intensity align with assessed risk. The research reviewed here reinforces this principle and highlights the importance of **consistent application across providers and supervision teams**. Strengthening implementation—through clearer expectations for proportionality, continued training on risk interpretation, and routine fidelity checks—would help ensure that risk classifications reliably guide dosage decisions.

2. Strengthen integration of dynamic and protective factors into assessment and review

The *Adult Standards and Guidelines* emphasize ongoing assessment and progress monitoring. Current research supports this approach and underscores the value of **systematically incorporating dynamic risk, responsivity factors, and protective strengths** into case planning. Enhancing consistency in the use of validated tools, strengthening documentation of change over time, and more explicitly integrating strengths into case discussions would further improve alignment with evidence-based practice.

3. Prioritize continuity of care and community-based intervention

The *Adult Standards and Guidelines* already require coordinated transitions and recognize the importance of community-based interventions for those completing the DOC Sex Offender Treatment and Management Program (SOTMP). The evidence suggests opportunities to further reinforce these practices, including improving information-sharing between institutional and community providers, building clearer reentry pathways, and emphasizing the role of community-based programs in skill generalization, housing and employment support, and prosocial connection.

4. Calibrated approaches for the lowest risk individuals

The *Adult Standards and Guidelines* appropriately discourage over-intervention with low-risk clients and require individualized, risk-responsive treatment planning. Research affirms this direction and suggests opportunities to strengthen practice by **expanding access to brief, targeted services**, and promoting early identification of emerging concerns—all while avoiding unnecessary or high-intensity programming.

5. Enhance data systems to support ongoing evaluation

The SOMB PDMS already provides an essential foundation for monitoring risk, dosage, and treatment progress. Enhancing data completeness and consistency, improving user training, and expanding analytic capabilities would help ensure the system fully supports **continuous quality improvement, program evaluation, and evidence-informed policy adjustments**.

SOMB Recidivism and Desistance Study: Risk Levels and Responsivity Factors

Introduction

In 2016, through the SOMB sunset review process, the General Assembly recognized the need for consistent collection of client-level service data to ensure that the *Adult and Juvenile Standards and Guidelines* remain evidence-based (**§16-11.7-103(4)(e), C.R.S.**). House Bill 16-1345 directed the SOMB to develop a statewide data collection plan, which led to implementation of the Provider Data Management System (PDMS) on January 1, 2020. Since that time, Approved Providers have submitted de-identified information on evaluation, treatment, and polygraph services, with court record linkage for long-term recidivism analysis permitted when client consent is provided.

The **SOMB Recidivism and Desistance Outcomes Project** constitutes the next phase of this work. Last year's SOMB Annual Report described the creation of the recidivism dataset and record-matching procedures. That initial analysis described the post-treatment discharge recidivism rates at 1 and 3 year fixed follow periods by treatment discharge type. To access a detailed description of the overall project design, statutory foundation, and methodology see the SOMB 2025 Annual Legislative Report.

This year's report builds on that foundation by examining **post-discharge recidivism among adult male clients who received sex offense-specific treatment in community settings**. Analyses focus on **recidivism outcomes by risk-need level**—an essential component of the RNR framework—and selected responsivity characteristics. This phase illustrates the types of outcome analyses that will become possible as the dataset grows and follow-up periods lengthen.

Study Overview

Sample and Case Selection

The sample includes adult male clients treated in the community whose PDMS records could be matched to Colorado criminal history data (n = 831). Individuals identifying as female or another gender (n = 27) were not included due to their small sample size and extremely low recidivism counts. In addition, given the distinct gender-specific pathways and treatment needs for these groups, findings for men should not be generalized to non-male clients.

Between October 2019 and January 1, 2024, the PDMS contained **2,527** treatment records. As described in last year's report, the data-cleaning and matching process involved removal of duplicates, exclusion of cases without a release of information consent, removal of records missing discharge dates, and matching against statewide court data. This resulted in **1,004** matched cases: 858 adult community clients, 101 DOC clients, and 45 juveniles. Only adult male community clients are included in the present analyses. Comparisons conducted during last year's report showed the matched dataset was broadly similar to the full PDMS cohort in demographics, risk levels, and discharge types.

Recidivism Data

Recidivism Definitions: Recidivism was defined as any new misdemeanor or felony charge occurring after the treatment discharge date across three categories. Although last year's report presented both charges and convictions, this year's analyses rely on **new charge filings** as the more inclusive and timely measure of reoffending. Consistent with SOMB purview and Division of Criminal Justice (DCJ) (CDPS) reporting, offenses were categorized as:

- **Sexual Recidivism:** New sexual offense under §16-11.7-102(3), C.R.S.
- **Violent Recidivism (including sexual recidivism):** New person-violent offense under §18-1.3-406(2), C.R.S.
- **Any Recidivism (including sexual and violent recidivism):** Any new misdemeanor or felony offense other than petty or misdemeanor traffic offenses; includes Failure to Register as a Sex Offender.

Criminal Justice Record Matching: Recidivism events were identified through the Judicial Department's ICON case management system and Denver County Court records. Matching was conducted by the DCJ Office of Research and Statistics (ORS) using PDMS unique identifiers for clients who granted consent. The most recent record extraction occurred on **September 23, 2024**.

Follow-Up Timeframe: The follow-up period for each client began on the **treatment discharge date** and ended on the follow-up cut-off date of September 23, 2024. The sample had wide variation in time-at-risk, ranging from 0.75 years to 6.3 years, with an average of **2.6 years**. Recidivism was analyzed using a cumulative incidence approach, which measures the percentage of clients who recidivated during their respective follow-up periods. This method does not adjust for differences in time-at-risk, meaning clients discharged earlier had more time to potentially reoffend than those discharged later. Nonetheless, **cumulative incidence is a standard method** for preliminary analyses and for examining relationships between predictor and recidivism outcome.

Due to initial data limitations, any time spent incarcerated after discharge was not removed from the follow-up window, which may slightly overestimate true community time-at-risk. Work is underway to refine follow-up calculations using DOC data and to extend the follow-up period for more accurate, time-adjusted recidivism estimates.

Risk and Responsivity Measures

Risk-Need Levels: Reflected the Approved Provider assessments at treatment entry ("Beginning Risk") and at discharge ("End Risk"). Levels were classified as **Low, Low-Moderate, Moderate, Moderate-High,** or **High**, which was converted to an ordinal scale of 1-5 for some analyses. In accordance with the *Adult Standards and Guidelines*, Approved Providers rely on validated static and dynamic risk assessment instruments within an overall comprehensive assessment; thus, these classifications reflect evidence-based practices.

Responsivity Factors: Client characteristics that may influence treatment engagement and outcomes (e.g., developmental or intellectual disability, barriers to progress, or the need for adjunctive mental health or substance use treatment).

Overview Summary

This study:

- Focuses on adult male community clients (N = 831).
- Examines post-discharge recidivism across sexual, violent, and any recidivism categories.
- Uses charge filings as the measure of recidivism, with an average follow-up period of 2.6 years.
- Includes both risk-need levels (at intake and discharge) and selected responsivity factors.
- Provides insight into how risk and responsivity characteristics relate to post-treatment recidivism.

Main Findings

Risk-Need Level and Post-Discharge Recidivism

Analyses of post-discharge outcomes showed a clear and consistent pattern: **as risk-need levels increased, so did the likelihood of violent and general recidivism**, while sexual recidivism remained low across all groups. These patterns were evident in both the beginning (initial) risk ratings assigned at treatment entry and in the end risk ratings assigned at discharge.

Beginning (Initial) Risk-Need Classification: Table 1 shows post-discharge recidivism rates by clients' beginning risk level. Adult community males assessed at higher risk levels demonstrated higher rates of reoffending, particularly for violent and general criminal behavior. While uncommon, sexual recidivism also showed a slight upward trend across increasing risk levels. Statistical tests confirmed that violent and any recidivism were significantly associated with beginning risk classifications, and regression analyses showed that the likelihood of reoffending increased steadily with each step up in the risk scale (see Appendix A.1 and A.2 for statistical results). These findings affirm that **initial risk assessments function as intended**, distinguishing groups with meaningfully different reoffense rates.

Table 1. Post-Treatment Recidivism Rates For Each Initial (Beginning) Risk Classification

Beginning Risk-Need Level	Total (Count)	Sexual Redivism (Count)	Sexual Recidivism Rate (%)	Violent Redivism (Count)	Violence Recidivism Rate (%)	Any Redivism (Count)	Any Recidivism Rate (%)
Low	206	0	0.0%	7	3.4%	23	11.2%
Low-Moderate	155	2	1.3%	9	5.8%	28	18.1%
Moderate	243	4	1.6%	19	7.8%	62	25.5%
Moderate-High	113	2	1.8%	13	11.5%	36	31.9%
High	113	3	2.7%	13	11.5%	33	29.2%
Total	**830**	**11**	**1.3%**	**61**	**7.3%**	**182**	**21.9%**

End Discharge Risk-Need Classification: Table 2 shows post-discharge recidivism rates by clients' risk level at treatment discharge. A stronger relationship with recidivism outcomes was evident; clients rated at a higher end-of-treatment risk level had substantially higher rates of violent and general recidivism. Sexual recidivism again remained uncommon but showed a slight gradient across risk levels. Although the low-moderate group had a slightly higher sexual recidivism rate (2.1%) than the moderate (0%) and moderate-high (0.9%) groups, this finding should be interpreted cautiously given the very small number of cases (2, 0, and 1, respectively). Single cases can exert a disproportionate impact when base rates are low. All three recidivism types were significantly associated with end risk, and regression analyses showed that **each increase in end risk level corresponded to a sizable increase in recidivism likelihood** (see Appendix A.3 and A.4 for statistical results). This suggests that end-of-treatment risk ratings may be especially informative because they reflect **dynamic change during treatment**, not just static baseline characteristics.

Table 2. Post-Treatment Recidivism Rates For Each Final (End) Risk Classification

End Risk-Need Level	Total (Count)	Sexual Redivism (Count)	Sexual Recidivism Rate (%)	Violent Redivism (Count)	Violence Recidivism Rate (%)	Any Redivism (Count)	Any Recidivism Rate (%)
Low	304	1	0.3%	9	3.0%	29	9.5%
Low-Moderate	96	2	2.1%	7	7.3%	24	25.0%
Moderate	115	0	0.0%	9	7.8%	26	22.6%
Moderate-High	112	1	0.9%	6	5.4%	35	31.3%
High	203	7	3.5%	30	14.8%	68	33.5%
Total	**830**	**11**	**1.3%**	**61**	**7.4%**	**182**	**21.9%**

Combined Beginning and End Risk Levels: When both beginning and end risk were evaluated simultaneously, **end risk emerged as the stronger and more reliable predictor** of violent and general recidivism. Beginning risk did not add unique predictive value in these combined models. For sexual recidivism, neither variable was significant—likely due to the small number of cases (see Appendix A.5 for statistical results). Thus, across violent and any recidivism, the findings indicate that **risk levels at discharge capture clinically meaningful change and serve as a better indicator of post-treatment recidivism than initial assessments alone**.

Risk-Recidivism Summary

Taken together, these preliminary results show that:

- **Higher assessed risk-need predicts higher recidivism**, particularly for violent and general offending. Risk classifications collected through the PDMS appear to operate as intended: as assessed risk increases, so does the likelihood of reoffending.
- **End-of-treatment risk is the strongest predictor**, reflecting treatment-related change in dynamic factors and providing the most accurate picture of post-discharge outcomes.

- **Most clients remained offense-free**, even in higher-risk categories. This reinforces a key principle: risk assessment differentiates groups, not individuals; elevated risk increases the probability of reoffending but does not predetermine outcomes for any one person.
- **System responses to treatment non-compliance may help contain or redirect risk.** The analysis presented in the 2025 Annual Report highlighted higher rates of post-discharge recidivism among unsuccessfully discharged clients. An unsuccessful discharge typically triggers an immediate system response—revocation, incarceration in response to new filings, heightened supervision, or referral to supplemental services. These interventions may interrupt escalating risk, stabilize clients, or redirect them into more appropriate levels of treatment and supervision. In this sense, unsuccessful discharge often functions as a proxy for elevated risk *and* activates mechanisms designed to mitigate that risk. Given that unsuccessful discharge is also typically associated with a shorter length of treatment, the inadequate dosage of treatment may be another factor in the higher recidivism rates for this group.

Overall, the findings confirm that the **risk-need-responsivity framework is operating as expected** within Colorado's PDMS data: assessed risk corresponds to meaningful differences in reoffending outcomes, and improvements in risk from intake to discharge are reflected in lower recidivism rates.

Responsivity Issues and Post-Discharge Recidivism

To examine how **responsivity factors relate to post-discharge recidivism outcomes**, several PDMS variables were analyzed based on their established relevance in the literature (e.g., cognitive limitations, treatment-interfering behaviors, mental health concerns). **Table 3** shows the factors that had significant associations with violent and any recidivism; **none were significantly associated with sexual recidivism** (see Appendix A.6 for statistical results).

Importantly, the PDMS responsivity fields capture both client characteristics and the treatment adjustments providers make in response to them. When providers indicate a responsivity barrier that may hinder treatment engagement—such as cognitive limitations, mental health symptoms, or behavioral challenges—they are required by the *Adult Standards and Guidelines* to modify treatment to reduce the impact of that barrier. Therefore, the presence of a responsivity barrier does **not** mean treatment was provided without accommodation. Rather, when a barrier remains associated with recidivism after discharge, it most likely reflects: (i) residual effects of the underlying difficulty despite intervention; (ii) challenges that contributed to an unsuccessful discharge, which is itself linked to higher recidivism; or (iii) it signals broader co-occurring problems (e.g., mental health issues may also reflect housing instability or substance use may indicate involvement with criminogenic peers). For these reasons, significant associations should be understood as markers of ongoing clinical complexity, not evidence of inadequate responsivity-based treatment.

Overall, several responsivity factors showed significant associations with violent and any recidivism, including developmental or intellectual disabilities (DDID), higher denial at treatment discharge, substance use–related barriers, and the need for adjunctive mental health or substance use treatment. Other factors—such as lack of community engagement, or the need for trauma or grief services—were not associated with post-discharge recidivism.

Table 3. Treatment Responsivity Factors and Violent and Any Recidivism (Count 831)

Responsivity Barrier	Association Violent Recidivism	Association Any Recidivism
Developmental Disability/Intellectual Disability	✓	✓
Denial Level: Treatment Start (1-4 scale)	✗	✓
Denial Level: Treatment Discharge (1-4 scale)	✓	✓
Barriers to Progress: Lack of Social Support	✓	✗
Barriers to Progress: Client Factors	✗	✓
Barriers to Progress: Substance Abuse	✓	✓
Barriers to Progress: Lack of Engagement in Community	✗	✗
Any Current Adjunct Treatment for Comorbid Problems	✗	✓
Current Adjunct: Mental Health Treatment	✓	✓
Current Adjunct: Trauma Treatment	✗	✗
Current Adjunct: Substance Abuse Treatment	✓	✓
Current Adjunct: Grief Treatment	✗	✗
Current Adjunct: Other Treatment	✗	✗

To assess the independent effects of these responsivity factors, significant predictors were entered into a series of logistic regression models. When all significant responsivity variables were included together, two factors were independently predictive of violent recidivism: **DDID** (developmental or intellectual disability) and **higher denial at treatment discharge** (see Appendix A.7 for statistical results). For any recidivism, **DDID**, **discharge denial level**, and **current substance abuse treatment** remained significant (see Appendix A.8 for statistical results).

However, when the end-treatment risk level was added to the models a consistent pattern emerged. **End-treatment denial was no longer a significant predictor**, while **DDID**, **substance use treatment**, and **end-treatment risk level** all remained significant (see Appendix A.9 and A.10 for statistical results). This indicates that much of the variance previously attributed to denial reflects broader dynamic risk captured by the end-of-treatment risk rating. In short, **end risk level is the more robust and clinically meaningful predictor of violent and general recidivism**, with DDID and substance use–related needs contributing additional explanatory value.

Responsivity-Recidivism Summary

Preliminary analyses show that DDID, higher denial at discharge, and substance use were associated with elevated rates of violent and general recidivism. These factors likely reflect barriers to treatment engagement and broader lifestyle instability; however, many clients with these challenges did **not** recidivate, suggesting that responsivity needs can be accommodated effectively within treatment.

Data collected from SOMB Providers through the PDMS (see following section) also show that providers are actively implementing treatment modifications, supporting tailored, individualized approaches rather than broad, one-size-fits-all responses.

DDID appears to highlight the need for more structured, longer-term support and may also relate to higher detection rates stemming from closer supervision. Denial at discharge seems to function within a broader constellation of dynamic risk rather than as an independent predictor. Substance use needs commonly co-occur with criminogenic instability—such as housing, relationship, or financial stress—which may contribute to the observed associations. Overall, these preliminary findings reinforce the value of individualized, coordinated interventions for clients with responsivity barriers, while underscoring that elevated responsivity needs do not predetermine negative outcomes.

Study Limitations

Risk Levels and Responsivity Factors should be **interpreted as preliminary** in light of several methodological and measurement constraints. The average follow-up period of 2.6 years (range, 0.75 to 6.3) is short for evaluating sexual recidivism and desistance, which typically require longer observation windows due to low base rates. In addition, the cumulative incidence approach did not adjust for differences in time-at-risk, and community exposure may have been slightly overestimated because time spent incarcerated after discharge could not be removed. The study included only adult male community clients, as the small number of non-male clients prevented meaningful analysis; thus findings cannot be generalized beyond adult men. Recidivism was measured using new charge filings rather than convictions, offering a timely but potentially inflated indicator of reoffending.

Interpretation of risk and responsivity findings also requires caution. Responsivity indicators recorded in the PDMS reflect both client characteristics and provider adjustments, meaning significant associations likely indicate persistent clinical complexity rather than shortcomings in responsivity-based intervention. Some responsivity factors—such as substance use treatment needs—may also represent broader, unmeasured criminogenic needs (e.g., housing instability, antisocial peers), making causal interpretation difficult. Finally, the finding that end-of-treatment denial lost significance when end-of-treatment risk was added to the model suggests meaningful overlap among predictors, which can obscure the unique contribution of individual variables.

Study Implications

Across both the risk and responsivity analyses, several consistent themes emerge about post-discharge outcomes for **male adults participating in sex offense-specific treatment in the community**.

1. **Risk and responsivity matter, but they do not determine outcomes.** Higher risk levels and certain responsivity barriers—such as DDID, substance use needs, and elevated denial at discharge—were associated with increased violent and general recidivism. These patterns reflect core RNR principles: clients with more complex profiles face greater challenges after discharge. Yet most clients in every category, including those rated high risk, did **not** recidivate during the average 2.6-year follow-up period, indicating that elevated risk increases probability but does not predetermine behavior.

2. **Dynamic indicators at discharge are especially informative.** End-of-treatment risk was the strongest and most consistent predictor of recidivism. Denial at discharge ceased to be predictive once end risk was included, suggesting that dynamic risk captures broader treatment progress (or lack of progress) more effectively than any single responsivity factor.

3. **Responsivity barriers signal treatment complexity, not treatment failure.** Responsivity issues remained associated with recidivism despite provider efforts to accommodate them. This likely reflects the challenges clients bring into treatment (e.g., cognitive limitations, co-occurring mental health or substance use issues) rather than shortcomings in service delivery, and points to subgroups who may benefit from more specialized or extended support.

4. **System responses may help mitigate risk.** Previous findings showed that clients with unsuccessful discharges have higher recidivism rates; however, unsuccessful discharge typically triggers coordinated system action—revocation, increased supervision, or additional services—that can interrupt risk escalation. This likely contributes to the finding that many higher-risk or treatment-challenged clients still did not reoffend.

5. **Treatment, supervision, and monitoring appear to be working for most clients.** Sexual recidivism was uncommon, and violent and general recidivism remained relatively low. These results suggest that community-based treatment and supervision—when informed by ongoing risk assessment and responsivity considerations—support long-term public safety. At the same time, any instance of reoffending represents a serious concern and reflects areas where the system can continue to learn, adapt, and strengthen interventions.

6. **Continued investment in high-quality data is essential.** These insights are possible because of the PDMS and consistent data submission from providers and justice agencies. Continued investment in data quality, fidelity, and coordination will strengthen Colorado's ability to monitor outcomes, refine standards, and sustain evidence-informed practice statewide.

SOMB Data Collection Analysis

Introduction

CDPS developed the **SOMB PDMS** following recommendations from the 2016 SOMB Sunset Review. This reflected a consensus among the SOMB, General Assembly, and stakeholders that gathering client service data is essential for evaluating the efficacy of SOMB policies. The PDMS was established under the mandate of HB 16-1345, which requires all SOMB Approved Providers to submit service information related to evaluation, treatment, and polygraph examinations upon the completion of each service, regardless of the outcome. This data collection aligns with the statutory requirement that the *Adult and Juvenile Standards and Guidelines* be evidence-based (§ 16-11.7-103 (4) (e), C.R.S.).

The PDMS was officially implemented on **January 1, 2020**. Approved Providers enter client and service information in a **de-identified format**, omitting personal details like names and dates of birth. Providers seek **Release of Information (ROI) consent** from clients to allow for future matching of criminal recidivism data via a linked unique court case identifier. When consent is denied, providers may, as an option, submit service information without the unique identifier, allowing the SOMB to account for overall service provision without using all the data in future recidivism studies.

To **expedite data entry** when consent is denied, an option is provided for Approved Providers to skip entering certain service information details.[7]

The SOMB regularly updates its data collection process, incorporating modifications to the *Adult and Juvenile Standards and Guidelines*, committee input, and provider feedback to ensure ongoing improvement. The SOMB supports correct system usage by offering training and technical assistance. While the SOMB cannot identify who submitted specific entries, it can track which providers have not entered data over a given reporting period. Compliance with the PDMS requirement has improved over time through the use of regular and targeted reminders. As of the November 1 deadline for the 2025 reporting period, fewer than **40 providers** had outstanding data entries, a figure that included new providers who had not yet discharged clients.[8]

Research Questions

The PDMS data collection serves multiple purposes. Initially, the system's objectives were twofold: (i) to **assess overall provider adherence** to the *Adult and Juvenile Standards and Guidelines*, and (ii) to **match client records with recidivism data** to evaluate longer-term outcomes. 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, and has been instrumental in informing revisions to the *Adult and Juvenile Standards and Guidelines* and shaping policy positions.

The current 2025 PDMS data report provides a 12-month overview of clients who were discharged from evaluation, treatment, and polygraph examination between **November 1, 2024, and October 31, 2025**. This overview provides an assessment of the degree to which these services:

- Adhere to the *Adult and Juvenile Standards and Guidelines*.
- Are implemented as required by the *Adult and Juvenile Standards and Guidelines*.
- Are consistent with the RNR Principles—as outlined in the *Adult and Juvenile Standards and Guidelines*—and individualize services to client risk, need, and responsivity characteristics.

Methodology

During the sixth year of data collection providers entered a total of 3,117 records: 348 evaluation, 625 treatment, and 2,144 polygraph exam records. After filtering for missing data, the final counts included **348 evaluation, 624 treatment, and 2,093 polygraph exams**. Similar to prior years, three separate data surveys were employed to capture the distinct service types: evaluation, treatment, and polygraph. Different versions of these surveys correspond to clients subject to the *Adult Standards and Guidelines* and the *Juvenile Standards and Guidelines*.

Table 4 summarizes the total number of client records entered by service type for adults and juveniles. In this report, client classification as juvenile or adult is determined by the **court of adjudication or conviction**, **not the client's age** at the time of service.

[7] This option was particularly targeted at reducing the data entry demands for Approved Polygraph Examiners, who may conduct up to four exams per day—a significantly higher volume than typical treatment discharge or evaluation completion.

[8] For comparison, the number of providers not entering data was **63 in 2023** and **20 in 2024**.

Specifically, **juvenile clients** were adjudicated in a juvenile court and are subject to the *Juvenile Standards and Guidelines*, while **adult clients** were convicted in an adult court and are subject to the *Adult Standards and Guidelines*. Of note, several factors beyond current age, determine which court and set of *Standards and Guidelines* apply. These include the client's age when the offense was committed, their age at the date of adjudication or conviction, and whether the case is processed in an adult or juvenile court. It is also possible that some young adults may be subject to **both** the *Juvenile and Adult Standards and Guidelines* if they were adjudicated in juvenile court for a sex offense and later received a subsequent adult criminal court conviction for a non-sex offense.

Table 4. Evaluation, Treatment, and Polygraph Records by Adult and Juvenile Clients, 2025

Court Type	Count of Evaluation Clients	% of Evaluation Clients	Count of Treatment Clients	% of Treatment Clients	Count of Polygraph Clients	% of Polygraph Clients
Adult Criminal Court	268	77.0%	584	93.6%	2,072	99.0%
Juvenile Court	80	23.0%	40	6.4%	21	1.0%
Total	**348**	**100%**	**624**	**100%**	**2,093**	**100%**

Table 5 presents the number of adult clients who provided a ROI consent to participate in data collection involving future matching of criminal recidivism data. As indicated, more than half of the adult clients agreed to future data matching, a slight overall decrease compared to 2024. **Table 6** shows the corresponding number of juvenile clients who agreed to participate in data collection with future recidivism matching, an overall stable rate with 2024.

Table 5. Consent Rates for Adult Evaluation, Treatment, and Polygraph Clients, 2025

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	163	60.8%	432	74.0%	1,029	49.7%	**55.5%**
No	105	39.2%	152	26.0%	1,043	50.3%	**44.5%**
Total	**268**	**100%**	**584**	**100%**	**2,072**	**100%**	**100%**

Table 6. Consent Rates for Juvenile Evaluation, Treatment, and Polygraph Clients, 2025

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	59	73.8%	10	25.0%	14	66.7%	**58.9%**
No	21	26.3%	30	75.0%	7	33.3%	**41.1%**
Total	**80**	**100%**	**40**	**100%**	**21**	**100%**	**100%**

Client Characteristics

Figure 1a and 1b shows the **referral sources** for adult and juvenile evaluation, treatment, and polygraph clients. Probation was the major source of evaluation and polygraph referrals for adult and juvenile clients, while also a significant referral source for treatment—alongside Parole/TASC for adults and County DHS/DYS for juveniles. Screen-reader tables for all figures are provided in Appendix B.

Figure 1a. Referral Sources for Adult Evaluation, Treatment, and Polygraph Clients, 2025. Data table, Appendix B.1a

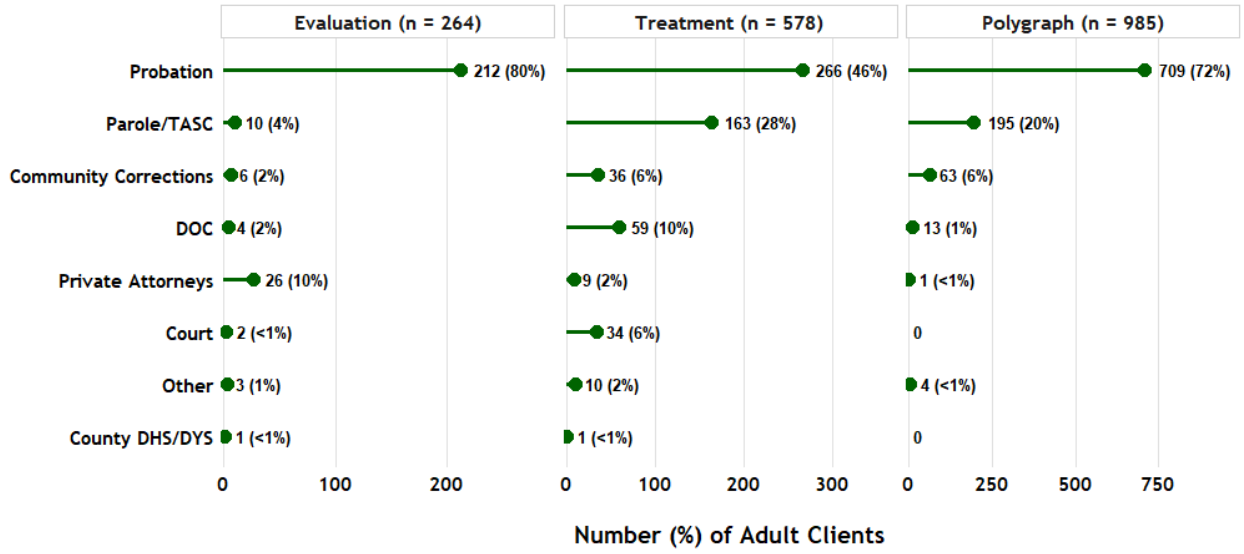


Figure 1b. Referral Sources for Juvenile Evaluation, Treatment, and Polygraph Clients, 2025. Data table, Appendix B.1b

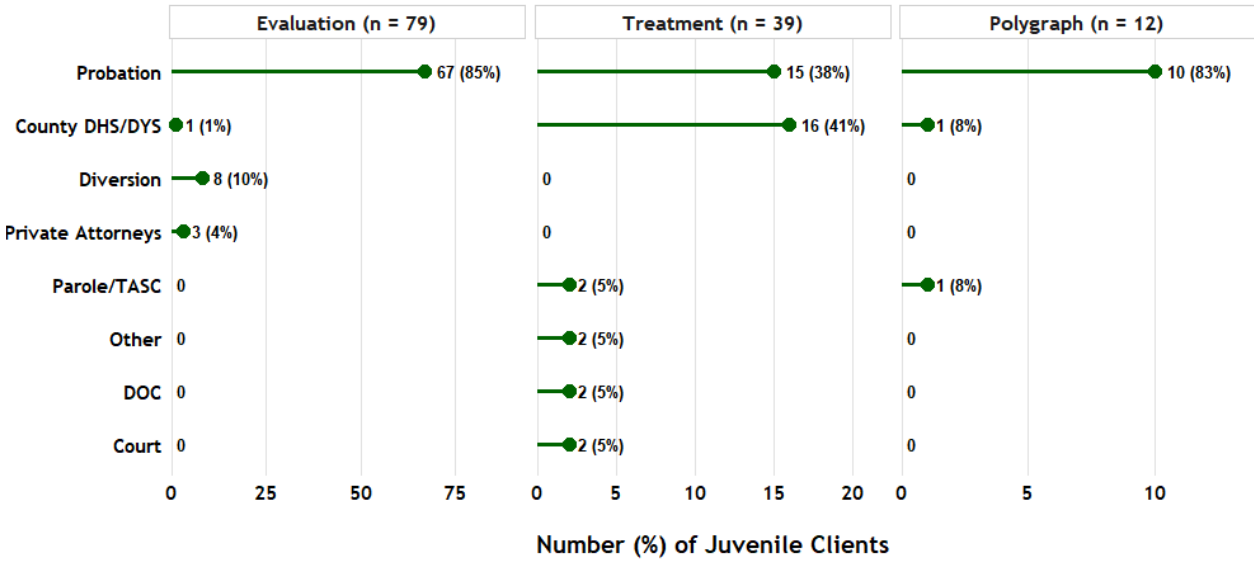


Figure 2a and 2b shows the offense types among adult and juvenile evaluation and treatment clients**.** The majority of adult and juvenile clients had felony contact sex offenses. A third of adult evaluation clients and 9% of juvenile evaluation clients had **previously been in sex offense-specific treatment**. Whereas 47% of adult treatment clients and 43% of juvenile treatment clients had prior sex offense-specific treatment. Data collection regarding clients **lifetime supervision** and **Sexually Violent Predator (SVP) status** began in March 2024. Initial data indicates that approximately **32%** of clients were under lifetime supervision and **4%** had SVP status.

Figure 2a. Offense Types for Adult Clients, 2025. Data table, *Appendix B.2a*

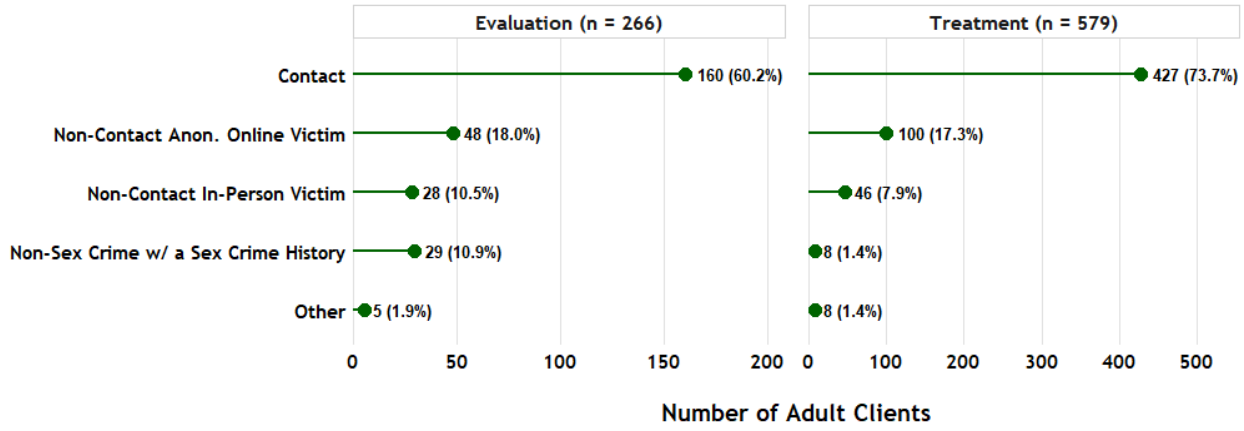
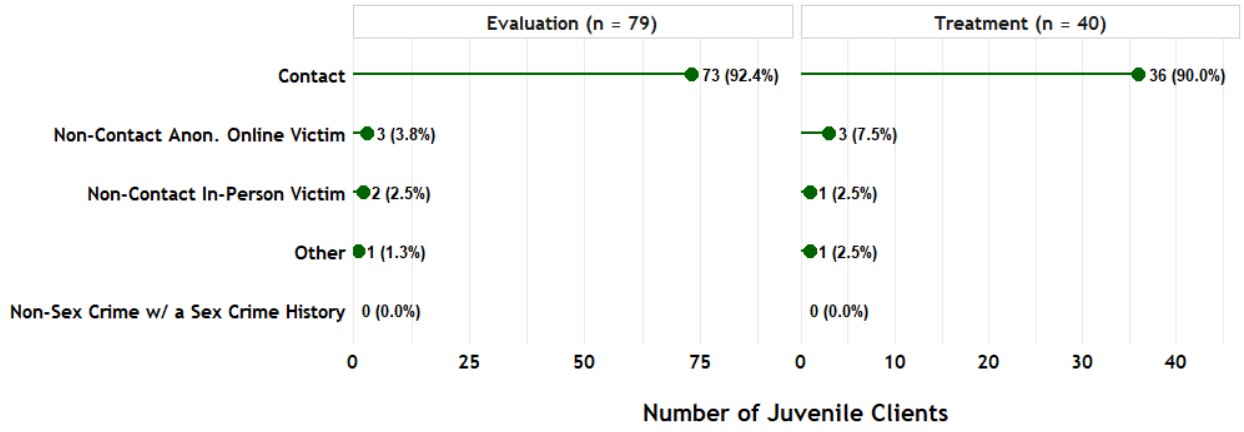


Figure 2b. Offense Types for Juvenile Clients, 2025. Data table, *Appendix B.2b*



Tables 7a and 7b summarize the demographic characteristics of adult and juvenile evaluation, treatment, and polygraph clients. The population was overwhelmingly male (>95%). Among adults, mean age ranged from 38.8 years for evaluations to 44 years for treatment, and most were over 18 at the time of conviction (94% of evaluation clients and 98.3% of treatment clients; not shown in Table 7a). For juveniles, mean ages ranged from 16.7 years for evaluations to 18.5 years for treatment; 20% of evaluation clients and 15% of treatment clients were 18 or older at adjudication, with the remainder under 18 (not shown in Table 7b). Most clients identified as White, followed by Hispanic or Latino. Adult clients typically reported having a high school diploma or higher, whereas juvenile educational attainment was understandably lower.

Table 7a. Demographics for Adult Evaluation, Treatment, and Polygraph Clients, 2025. Data table, Appendix B. Table 7a

Adult Client Characteristics	Evaluation (Count 268) n (%) / Mean (Range)	Treatment (Count 584) n (%) / Mean (Range)	Polygraph (Count 1,000) n (%) / Mean (Range)
Gender			
Male	250 (95.8%)	554 (95.8%)	976 (97.2%)
Female	10 (3.8%)	17 (2.9%)	14 (1.4%)
Other	*	7 (1.2%)	*
Missing	7	6	8
Race/Ethnicity**			
White	167 (62.5%)	363 (62.2%)	613 (61.6%)
Hispanic or Latino	64 (24%)	130 (22.3%)	276 (27.7%)
Black or African American	31 (11.6%)	90 (14.4%)	76 (7.6%)
Asian or Pacific Islander	8 (3%)	11 (1.9%)	15 (1.5%)
Native American or American Indian	6 (2.2%)	14 (2.4%)	15 (1.5%)
Other	*	*	*
Unknown	*	5 (0.9%)	1 (0.1%)
Missing	1	0	5
Age***			
Mean (Range)	38.8 (18-85)	44 (20-82)	43 (19-83)
Missing	3	0	9
Developmental/Intellectual Disability			
Yes	17 (6.4%)	35 (6%)	25 (2.5%)
No	250 (93.6%)	549 (94%)	975(97.5%)
Missing	1	0	0
Education****			
Less than high school degree	57 (21.3%)	76 (13%)	–
High school degree or equivalent	119 (44.6%)	313 (53.6%)	–
Some college but no degree	49 (18.4%)	100 (17.1%)	–
Associate degree	20 (7.5%)	32 (5.5%)	–
Bachelor degree	15 (5.6%)	46 (7.9%)	–
Graduate degree	7 (2.6%)	17 (2.9%)	–
Missing	1	0	–

*Data is suppressed for identifiable demographic categories with fewer than five cases.
**Race/Ethnicity reporting allows for multiple category selection, meaning percentages will not total 100%.
***Age for each column reflects age at time of evaluation, time of offense, and time of polygraph exam. For evaluation data two cases with extreme ages were coded as missing to reduce impact and protect client identity.
****Education questions are not included in the polygraph exam survey.

Table 7b. Demographics for Juvenile Evaluation, Treatment, and Polygraph Clients, 2025. Data table, Appendix B. Table 7b

Juvenile Client Characteristics	Evaluation (Count 80) n (%) / Mean (Range)	Treatment (Count 40) n (%) / Mean (Range)	Polygraph (Count 12) N (%) / Mean (Range)
Gender			
Male	78 (97.5%)	38 (97.4%)	12 (100%)
Female	*	*	0
Other	*	0	0
Missing	0	1	0
Race/Ethnicity**			
White	47 (58.8%)	27 (67.5%)	8 (66.7%)
Hispanic or Latino	22 (27.5%)	11 (27.5%)	4 (33.3%)
Black or African American	12 (15%)	6 (15%)	0
Asian or Pacific Islander	1 (1.3%)	0	0
Native American or American Indian	0	1 (2.5%)	0
Other	*	*	0
Unknown	0	0	0
Missing	0	0	0
Age***			
Mean (Range)	16.7 (12-28)	18.5 (14-25)	18 (16-20)
Missing	2	3	0
Developmental/Intellectual Disability			
Yes	3 (3.8%)	4 (10%)	0
No	16 (96.2%)	36 (90%)	12 (100%)
Missing	0		
Education****			
Less than high school degree	61 (76.3%)	17 (42.5%)	–
High school degree or equivalent	16 (20%)	17 (42.5%)	–
Some college but no degree	2 (2.5%)	6 (15%)	–
Associate degree	0	0	–
Bachelor degree	1 (1.3%)	0	–
Graduate degree	0	0	–
Missing	0	0	–

*Data is suppressed for identifiable demographic categories with fewer than five cases.
**Race/Ethnicity reporting allows for multiple category selection, meaning percentages will not total 100%.
*** Age for each column reflects age at time of evaluation, time of offense, and time of polygraph exam. For evaluation data one case with an extreme age was coded as missing to reduce impact and protect client identity.
**** Education questions are not included in the polygraph exam survey.

Evaluation Results

Providers entered **348 evaluation records** over the 12-month reporting period, with the majority submitted for adult clients (77%). Screen-reader accessible tables for figures are provided in **Appendix B** and a full listing of assessment and individualized recommendations is provided in **Appendix C**.

Assessment and Individualized Treatment Recommendations

The evaluation survey asks providers about the methods used to **assess and individualize treatment recommendations** to align future sex offense-specific treatment with the **RNR treatment model** defined in the *Adult and Juvenile Standards and Guidelines*. Nearly all providers reported that they reviewed previous records (98%) and collateral information (94%). Other strategies were consulting the Community Supervision Team (CST) for adult clients and Multidisciplinary Team (MDT) for juvenile clients (33%), and discussing the client's needs with their support systems (23%).

The **top five** recommendations most frequently made to **match treatment to client risk level** were:

- Adjunct non-sex offense-specific treatment (62%)
- Adjustments to community access (e.g., level of restrictions) (39%)
- Adjustments in frequency of treatment services (23%)
- Type of placement, length of stay, or step-down (19% vs.24% last year)
- Adjustments to types of groups (24% vs. 20% last year)

The **top five** recommendations most frequently made to address client **criminogenic and non-criminogenic needs** identified during evaluations were:

- An individualized treatment plan (79%)
- Increased support (51% vs. 46% last year)
- Increased resources (49% vs. 44% last year)
- Implement modification to treatment modality (16%)
- Modify supervision conditions (14%)

The **top six** recommendations most frequently made to address **treatment responsivity barriers** were:

- Use of mental-health related adjunct therapy (62% vs. 65% last year)
- Use of external supports (47% vs. 49% last year)
- Feedback from the client (42% vs. 37% last year)
- Adjustments in frequency or modality of treatment services (23%)
- Use of specialized resources (22%)
- Assessment of intellectual/cognitive functioning with additional testing (22%)
- Interventions to increase motivation for treatment (22%)

The **top three** recommended treatment settings for adult clients were a **community provider (69%)**, marking a notable increase from 60% last year; **community corrections (15%)**, representing a 6% decrease from the previous year; and the **Department of Corrections (9%)**, a decrease from 12% last year. For juvenile clients, treatment with a community provider was recommended for the vast majority **(91%)**, also reflecting an increase from 83% last year.

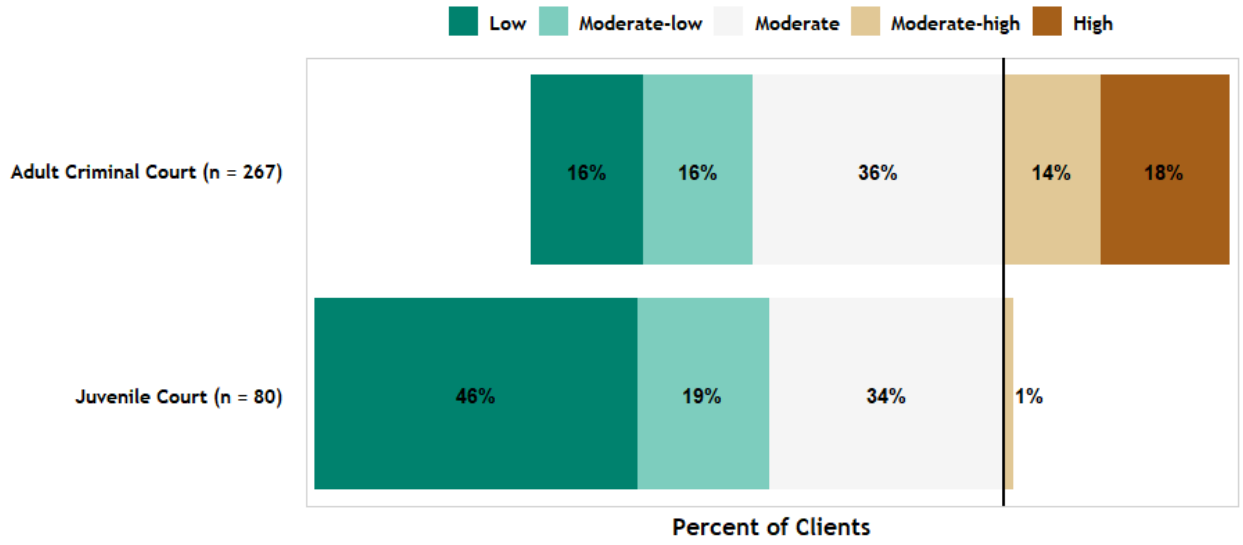
For a full list of individualized treatment recommendation options and frequency, see Appendix C.

Risk Classification

Evaluations include the use of standardized and validated risk assessment instruments. **Most evaluators indicated using 3 or 4 instruments before reaching the final risk assessment classification**. The Sex Offender Treatment and Progress Scale (SOTIPS), Static-99R or Static-2002R, and the Vermont Assessment of Sex Offender Risk (VASOR or VASOR-2) were the most commonly used instruments for adult evaluations. The Juvenile Sex Offender Assessment Protocol-II (J-SOAP-II) was the most commonly used instrument for juvenile evaluations.

Figure 3 displays the distribution of client risk classifications for both adult and juvenile clients. As shown, the majority were classified as **Low, Low-Moderate, or Moderate** risk. Notably, juvenile clients had a **Low-risk level classification (46%)** more often than adult clients **(16%)**.

Figure 3. Risk Level for Evaluation Clients by Court (Count 347). Data table, Appendix B.3



Treatment Completion

Providers entered **624 treatment records** during the 12-month reporting period. The vast majority were for adult clients (**93.6%**), with few records for juvenile clients (**6.4%**). Screen-reader accessible tables for figures are provided in **Appendix B** and a full listing of assessment and individualized treatment strategies is provided in **Appendix C**.

Assessment and Individualized Treatment Strategies

The treatment survey asks providers about the methods utilized to **assess and individualize treatment** concerning client treatment needs and responsivity barriers.

To determine **treatment needs**, the most frequently indicated sources were **self-report (98%)**, discussion with the **CST** for adult clients or the **MDT** for juvenile clients **(91%)**, and a **review of records and collateral data (91%)**. Less common methods included discussion with support systems (41%) and "other ways" (8%), such as consultation with prior providers or conducting collaborative risk assessments and treatment planning.[9] Regarding **responsivity barriers**, nearly all providers reported assessing **client feedback (99%)**, while others used topics raised in treatment sessions **(81%)**, collateral contacts **(45%)**, and less commonly, other channels **(10%)**, including discussion with parole, probation, or the Community Supervision Team (CST).

The top five frequently utilized strategies and resources **to individualize treatment and address client needs** were:

- An individualized treatment plan (95%)
- Increased support (51% vs. 42% last year)
- Modified assignments (48% vs. 44% last year)
- Flexible scheduling (42% vs. 34% last year)
- Increased resources (42%)

The **top five most frequent barriers to treatment progress** identified by providers were:

- Client-related factors (62%)
- Lack of motivation for treatment (37%, a slight increase from 34% last year)
- Lack of support systems (36%, an increase from 29% last year).
- Client's mental health/trauma needs (29%)
- Finances (26%)

To adjust treatment to address client responsivity factors, the **top five** most frequently reported methods were:

- Utilizing client feedback (76%)
- Adjusting frequency or modality of treatment services (56%)
- Using interventions to increase motivation for treatment (36% vs. 32% last year)
- Using external supports (36% vs. 26% last year)
- Using mental-health related adjunct therapy (31% vs. 28% last year)

For a full list of individualized treatment options and frequency, see Appendix C.

[9] When the "other"option is selected, providers can enter comments to indicate what sources of information were used.

Acceptance of Responsibility and Accountability

Providers assess the level of responsibility which reflects the degree to which a client **accepts responsibility and accountability for the current sex offense**. Previously referred to as **level of denial,** this measure was updated midway through the reporting period—per *Section 3.500 of the Adult Standards and Guidelines* and *Section 3.130(7) of the Juvenile Standards and Guidelines*—to support a more constructive and strengths-based approach to addressing this responsivity barrier. **Figures 4a and 4b** show the proportion of adult and juvenile clients, respectively, at each responsibility level at the beginning and end of treatment. Clients who begin treatment taking **no responsibility (categorical denial)** are referred to an **Accountability Intervention** to build readiness for offense-specific treatment, while **all others directly enter** sex offense-specific treatment.

Figure 4a. Acceptance of Responsibility for Adult Treatment Clients, 2025 (Count 583). Data table, Appendix B.4a

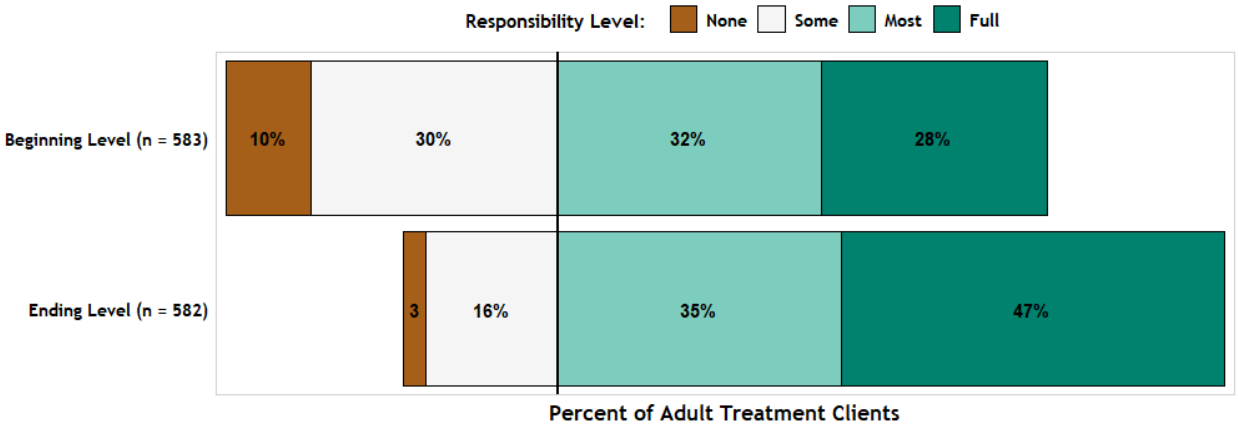
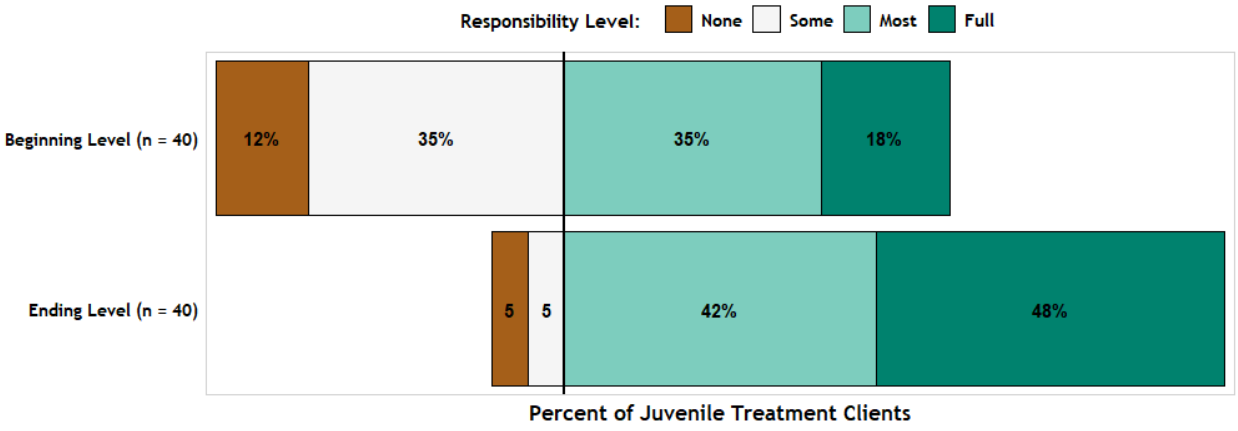


Figure 4b. Acceptance of Responsibility for Juvenile Treatment Clients, 2025 (Count 40). Data table, Appendix B.4b



Figures 5a and 5b show the percentage of adult and juvenile clients, respectively, whose acceptance of responsibility increased, remained the same, or decreased from the beginning of treatment to discharge. Overall, the **majority of clients demonstrated an increase in acceptance of responsibility** over the course of treatment. Notably, 75% of adult clients who began treatment in categorical denial increased their responsibility-taking and progressed into offense-specific treatment, while 80% of juveniles moved out of categorical denial. This pattern is consistent with the low proportion of adults and juveniles who maintained no acceptance of responsibility at discharge (see **Figures 4a and 4b**). Conversely, very few clients showed a decrease in responsibility-taking, which may reflect more accurate assessment of their beliefs as treatment progressed.

Figure 5a. Change in Acceptance of Responsibility During Adult Treatment, 2025 (Count 582). Data table, Appendix B.5a

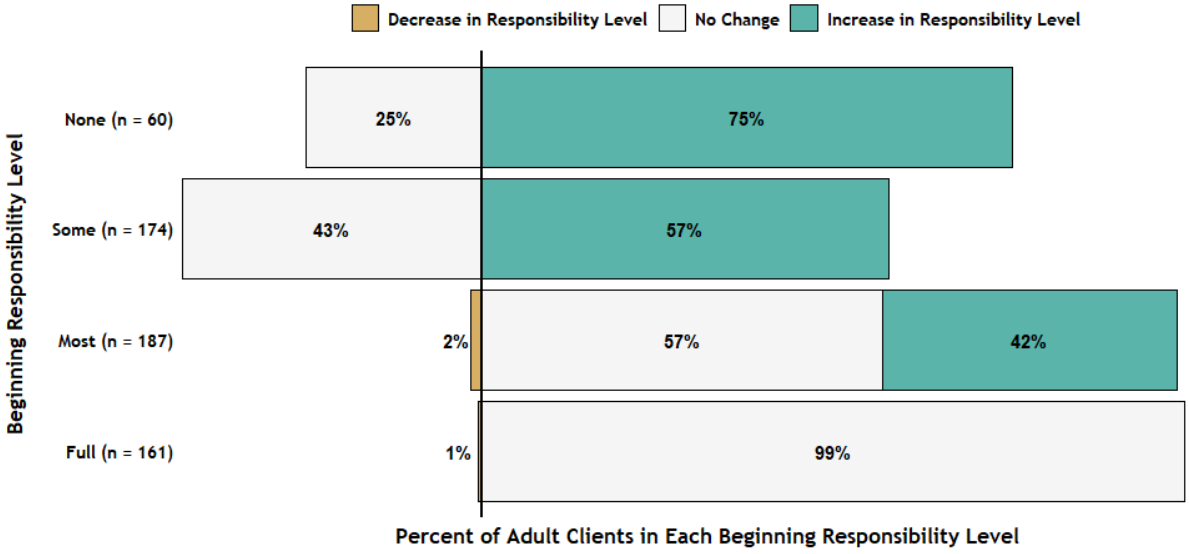
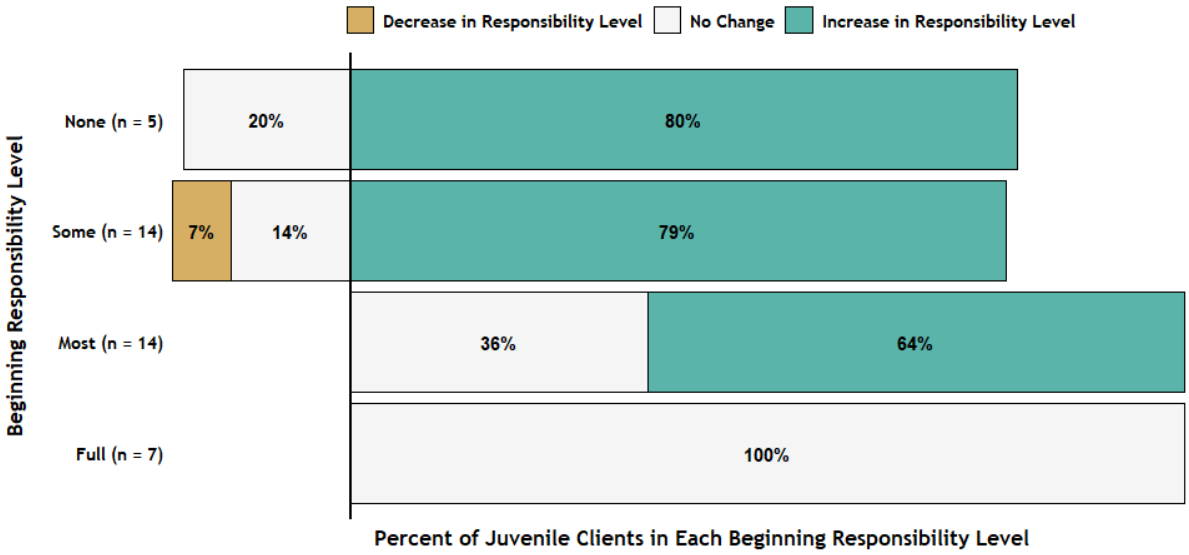


Figure 5b. Change in Acceptance of Responsibility During Juvenile Treatment, 2025 (Count 40). Data table, Appendix B.5b



Risk Classification

Treatment requires that clients be assigned a risk classification level at the beginning and end of treatment. As shown in **Figure 6**, the majority of both adult and juvenile clients were classified as **Low, Low-Moderate, or Moderate risk** at the beginning of treatment. Proportionally, more juvenile clients were classified as Moderate-High risk **(20%)** than adult clients **(12%)**. Conversely, a larger percentage of adult clients were classified as High risk **(13%)** than juvenile clients **(8%)**.

Figure 7 displays the overall **aggregate distribution of risk** among clients at the end of treatment, which remained relatively consistent with the initial classification. A slight decrease was observed in the number of clients classified as Moderate-High or High risk at the end of treatment among both adult and juvenile clients.

Figure 6. Beginning Risk Level for Treatment Clients by Court (Count 623). Data table, Appendix B.6

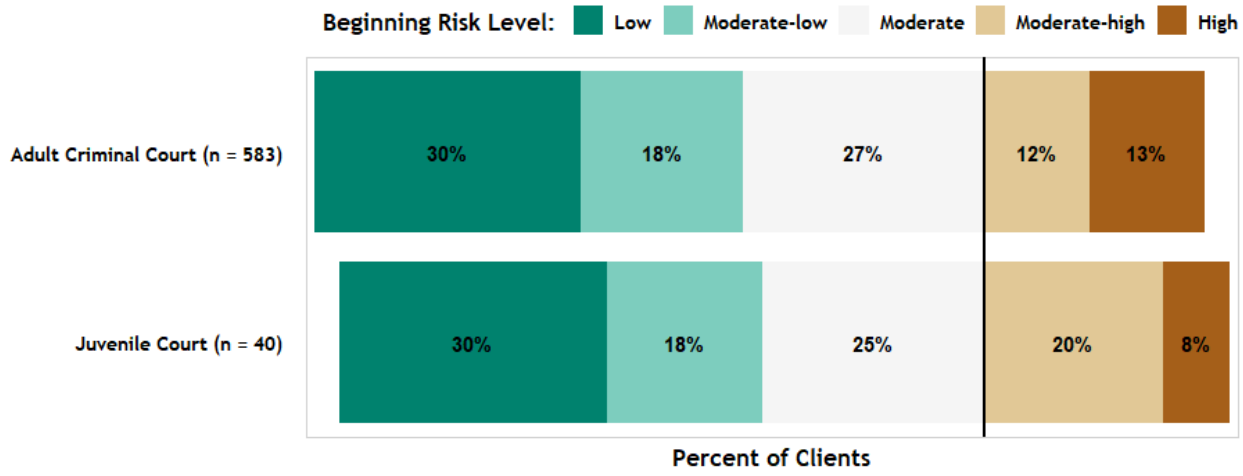


Figure 7. End Risk Level for Treatment Clients by Court (Count 622). Data table, Appendix B.7

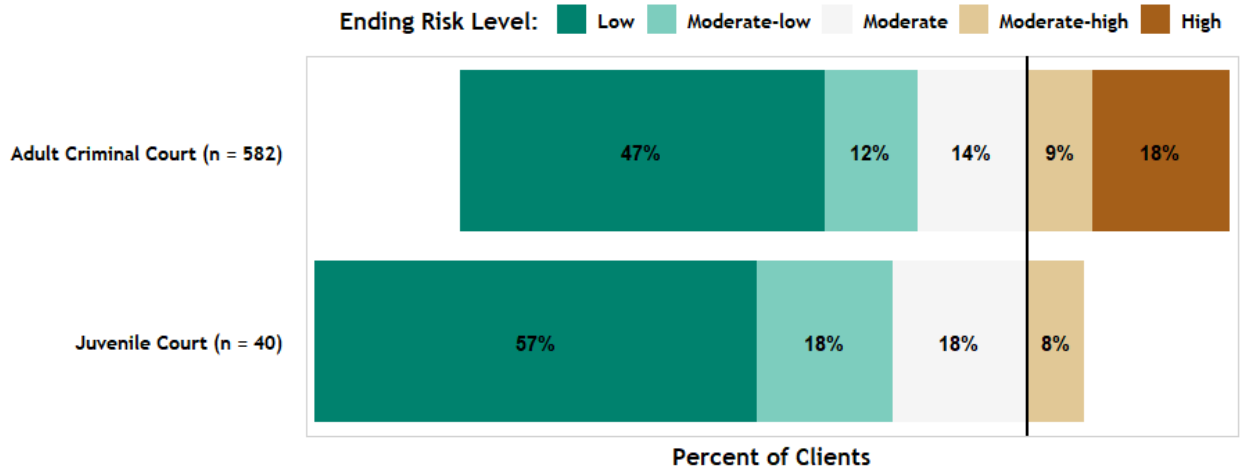
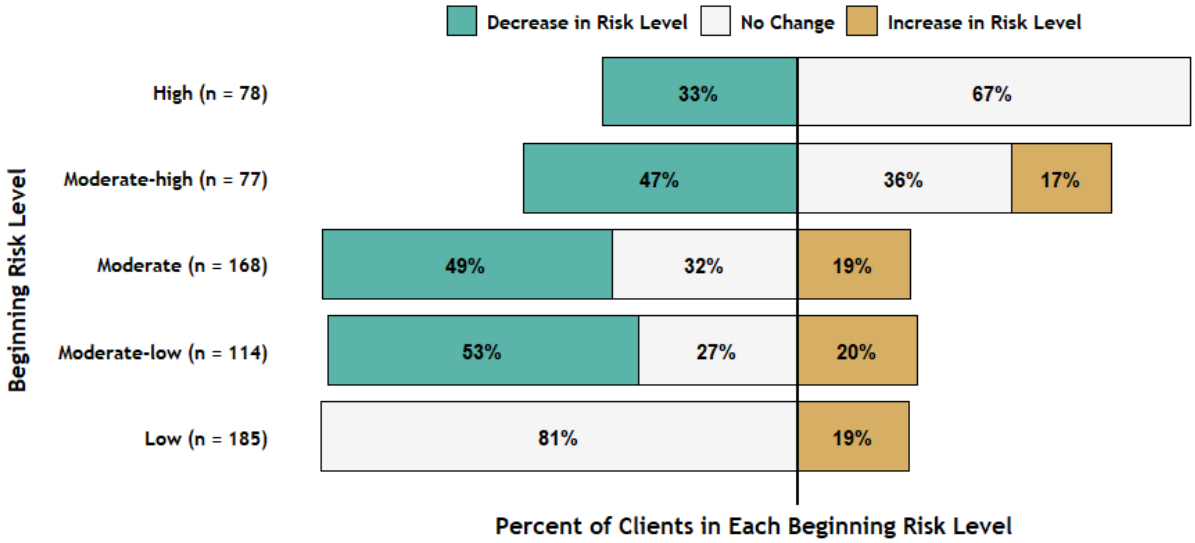


Figure 8 shows the percent of clients whose risk classification decreased, stayed the same, or increased from the beginning of treatment until discharge. Due to the small sample size of juvenile treatment clients, this figure presents the combined data for both adult and juvenile clients. Approximately half of all clients classified as Low-Moderate **(53%)**, Moderate **(49%)**, or Moderate-High **(47%) risk** at the beginning of treatment **decreased their risk level** by the end of treatment. This percentage was lower **(33%)** for clients who began treatment with a High risk level. Unlike **Figures 6** and **7**, which present overall group distributions at intake and discharge where individual increases and decreases cancel each other out, **Figure 8 highlights individual-level change**.

Figure 8. Change in Risk Level During Treatment (Count 622). Data table, Appendix B.8



Discharge Outcomes

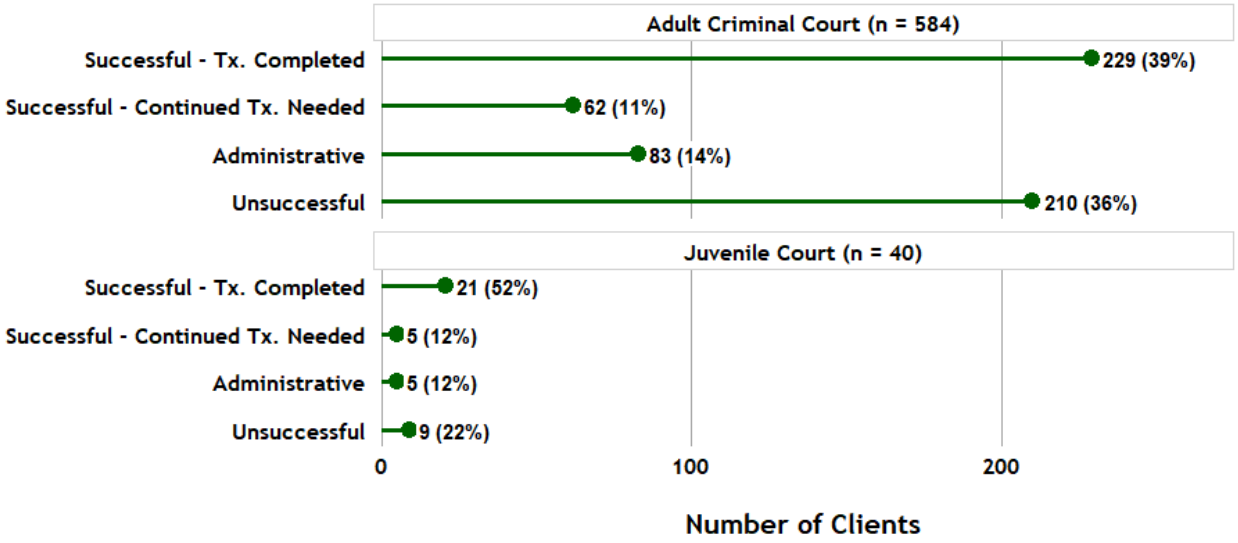
Figure 9 illustrates the specific discharge outcomes for clients categorized by their court of jurisdiction (adult and juvenile).[10] Overall, **51% of clients successfully completed treatment**, a rate consistent with the previous two years. Specifically, 291 adult clients (50%) and 26 juvenile clients (64%) successfully completed treatment.

A notable change in the data collection system was the separation of successful discharges into two categories: **treatment still needed (67 clients, 11%)** and **treatment completed (250 clients, 40%)**. This is particularly relevant for clients completing treatment in the Department of Correction who still require additional treatment in the community to meet the requirements of the *Adult Standards and Guidelines*.

Conversely, **219 clients** exhibited unsuccessful or non-compliant discharge types, accounting for **36% of adult clients** and **22% of juvenile clients**.

[10] **Successful discharge** occurs when the client meets treatment goals, shows overall clinical improvement, and demonstrates sustained use of treatment tools. Clients may be discharged regardless of time remaining under supervision. **Administrative discharge** occurs when circumstances outside the client's control prevent the client from continuing treatment (e.g., medical issues, approval to transfer provider, relocation, etc.). **Unsuccessful discharge** occurs when a client is no longer appropriate for treatment due to non-compliance, re-offending, or failure to engage or progress in treatment.

Figure 9. Treatment Discharges Outcomes by Court (Count 624). Data table, Appendix B.9



When providers document unsuccessful or non-compliant discharges they must record at least one reason per client. **Table 9** shows discharge reasons for the 219 clients in this category. Most reasons were related to **treatment resistance, lack of engagement in treatment goals**, or **violation of treatment contract and supervision conditions**. Regarding recidivism, **37 (17%) clients were discharged due to new crimes**: 27 (12.3%) for a new non-sexual offense and 11 (5.0%) for a new sexual offense, with one client cited for both. For comparison, in **2024** there were 9 discharges (12.2%) involving a new non-sex crime and 3 (4.1%) involving a new sex crime, while in **2023** there were 35 (17.9%) and 11 (5.6%), respectively.

Provider comments further elaborated on the "other" reasons for unsuccessful discharges and indicated they generally centered on **high-risk behaviors and non-compliance**. Examples included engaging in high-risk activities (such as illegal drug use), criminal or inappropriate behavior toward females or minors, revocation of parole or probation, hostility towards treatment providers or other clients, failure to engage with the program, and multiple violations of program terms or conditions of supervision.

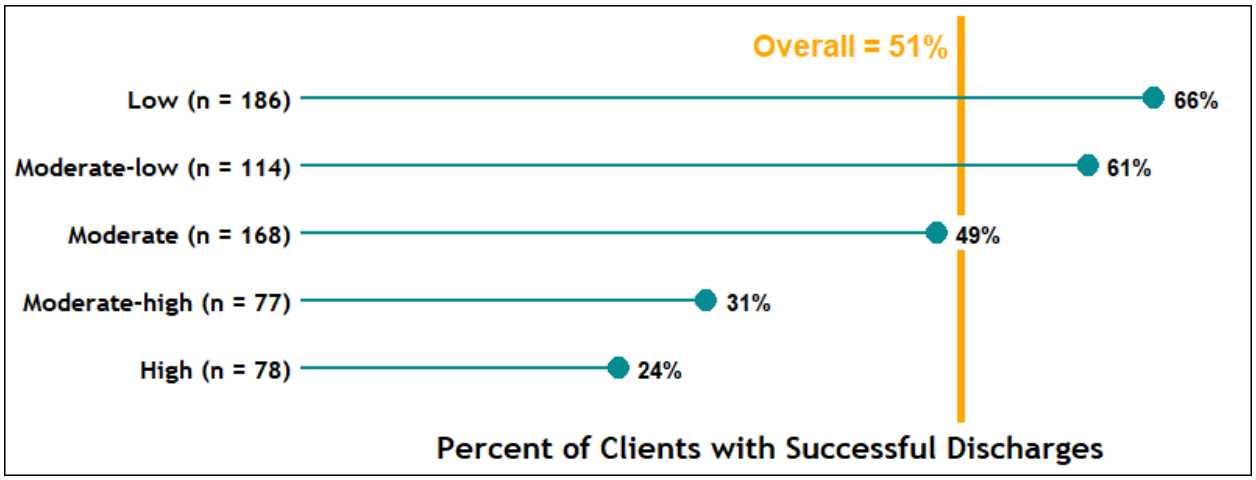
Table 9. Reasons for Unsuccessful/Non Compliant Discharges, 2025* (Count 219)

Discharge Reasons	Count*	Percent (%)*
Client resistant to treatment/Lack of investment in treatment goals	117	53.4%
Violation of treatment contract or terms and conditions of supervision	75	34.2%
Lack of Attendance	52	23.7%
New non-sexual crime	27	12.3%
New sex crime	11	5.0%
Other	69	31.5%

*Totals do not equal 100% as clients could have more than one discharge reason.

Figure 10 shows an expected relationship between risk level and discharge: **Higher-risk clients had lower rates of successful discharge than Lower-risk clients**. Because the juvenile sample is small, data from adult and juvenile clients are combined.

Figure 10. Successful Discharges by Beginning Risk, 2025 (Count 623). Data table, Appendix B.10



Treatment Length

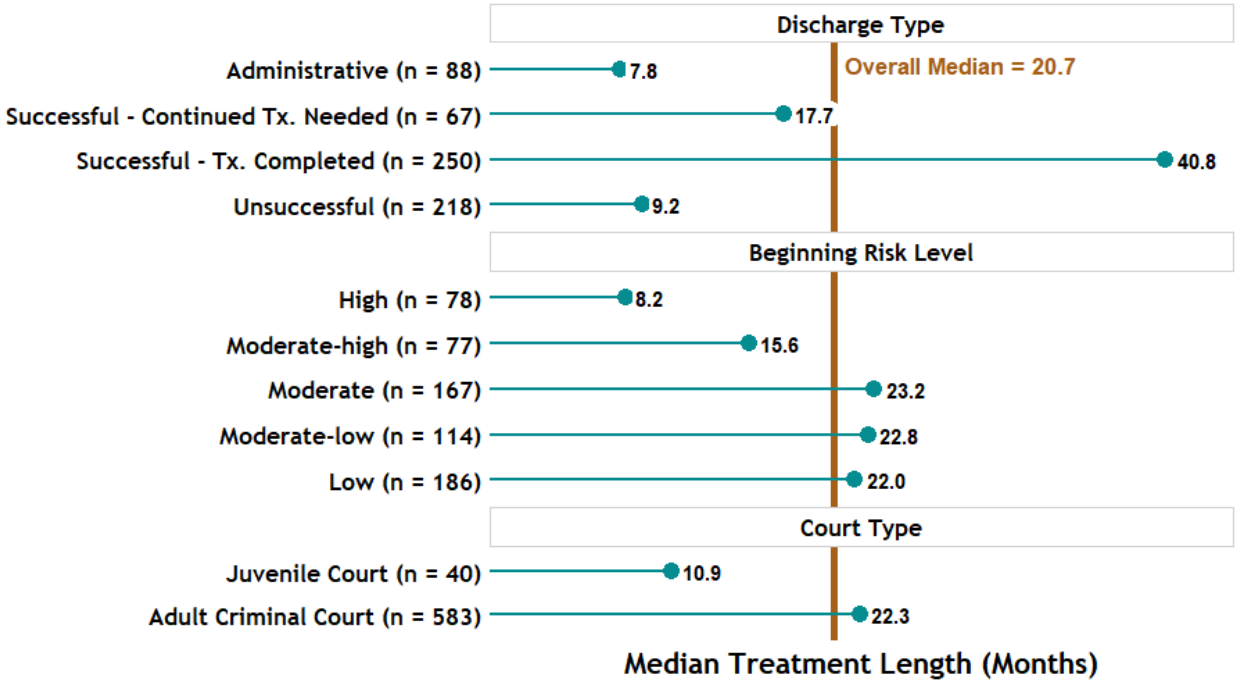
The median treatment length for clients was **20.7 months**, indicating half of clients spent less than 20.7 months in treatment and half spent more. This is an increase from the 17.9 months observed in 2024 and 19.1 months in 2023. As shown in **Figure 11,** successful completion of treatment is associated with longer treatment duration: clients with successful discharges had a median treatment length of **29.3 months** in treatment, compared to **7.8 months** for administrative discharges and **9.2 months** for unsuccessful discharges.

Risk classification also relates to treatment length. Clients in the Moderate-High and High risk categories had **shorter** median treatment durations (15.6 and 8.2 months, respectively) than those in lower risk groups (≥ 22 months). This pattern should not be interpreted as higher-risk clients requiring less treatment; rather, it likely reflects **higher rates of unsuccessful discharge** among these groups, which shortens overall time in treatment.

Within the lower risk categories, the Moderate, Moderate-Low, and Low risk groups all showed **similar** median treatment lengths (approximately 22 months). Because these averages are not disaggregated by discharge type, they represent a mix of successful completions and early terminations. As shown previously in **Figure 10**, successful discharges are more common in the Low-risk group (66%) than in the Moderate-risk group (49%), suggesting the Low-risk median is a more accurate indicator of typical treatment duration, while the Moderate-risk median is likely reduced by a **higher proportion of administrative and unsuccessful discharges**. This limits interpretation of treatment duration by risk level. Future analyses in the upcoming year will examine average treatment length for successful discharges by risk level to provide a clearer estimate of expected treatment duration.

Adult clients had a substantially longer median treatment length (**22.3 months**) than **juvenile clients** (**10.9 months**). However, this difference may be influenced by the lower proportion of juvenile clients classified as High risk and the smaller sample size.

Figure 11. Treatment Lengths by Discharge, Beginning Risk, and Court, 2025 (Count 623). Data table, Appendix B.11



Polygraph Assessment

A total of **2,093 polygraph records** were included in the data analysis. The vast majority of these records were for **adult clients (2,072, or 99.1%)**, with a small number attributed to **juvenile clients (21, or 0.9%)**. To reduce data entry obligations, the SOMB allows Approved Polygraph Examiners the option to skip certain non-essential fields, resulting in detailed demographic and referral data being available for only a smaller subsample of **1,012 record** (see Tables 7a and 7b).

Polygraph Exam Types

Table 10 displays the number of each exam type conducted, categorized by adult and juvenile clients. Most were **initial exams (1,576, or 75%)**, while **517 (25%)** were retests. Retests are administered when clarification or resolution is needed following an initial exam typically due to:

- **Significant Responses Indicative of Deception (SR/Deception):** Results strongly suggest the client was untruthful.
- **No Opinion/Inconclusive Results (NO/Inconclusive):** The initial test did not produce a definitive conclusion.
- **Attempted Manipulation:** Evidence indicates the client used countermeasures to attempt to influence or distort the test results.

The prevalence of countermeasures remained similar to last year: approximately **2% (18 cases)** involved **confirmed use** and **5% (54 cases)** involved **suspected use**.

Table 10. Polygraph Exams Conducted by Court, 2025 (Count 2,042)

Exam Types	Count of Adult Criminal Court Clients*	% of Adult Criminal Court Clients (Count 2,021)	Count of Juvenile Court Clients*	% of Juvenile Court Clients (Count 21)
Maintenance/Monitoring Exams	1,471	72.8%	13	61.9%
Sex History Exam	467	23.1%	4	19.0%
Specific Issue	51	2.5%	2	9.5%
Instant/Index Offense Exams	33	1.6%	3	14.3%
Child Contact Screening Exam	4	<1%	NA	NA
Other	1	<1%	NA	NA

*** Counts and percentages will not sum to 100% as providers can select multiple exam types per client.**

Polygraph Exam Outcomes

A substantial portion of polygraph exams resulted in clinically significant disclosures (multiple disclosures can be made during a single exam) either in the pre-test, during the test, or in the post-test. As detailed in **Table 11**, the percentage of exams with disclosures increased for both client groups compared to the prior year:

- **adult clients: 49%** (up from 43% last year)
- **juvenile clients: 67%** (up significantly from 36% last year)

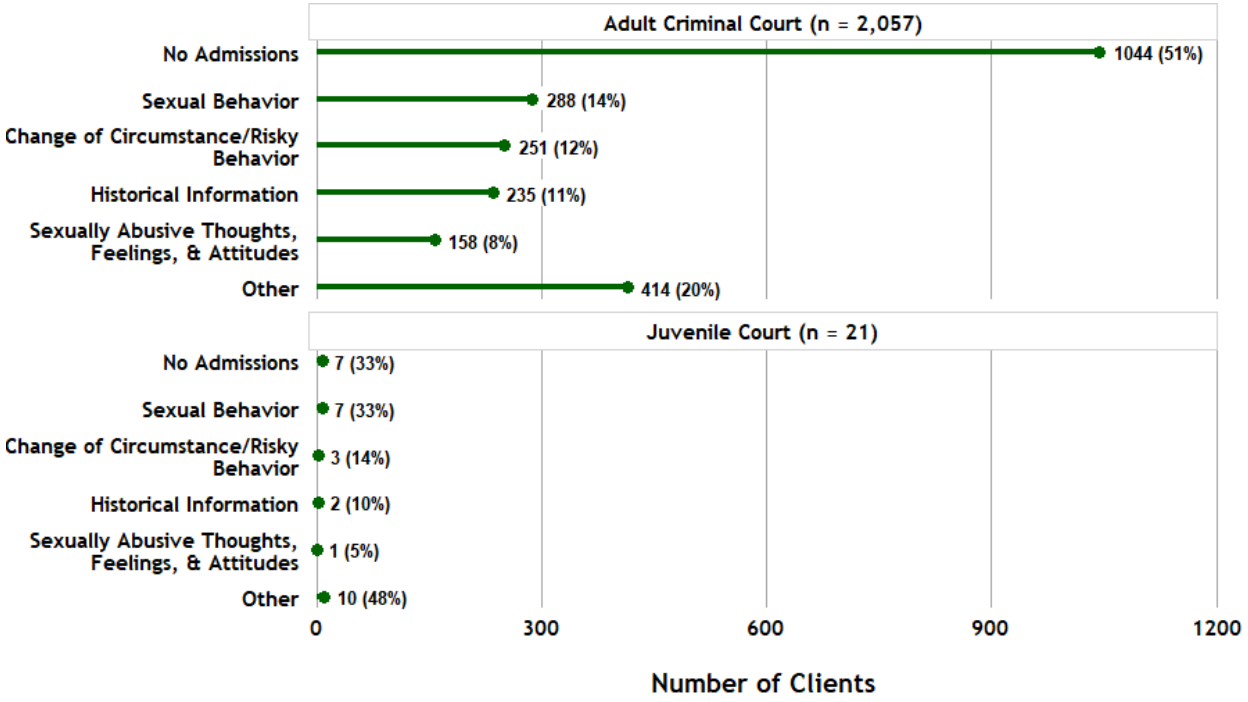
Table 11. Polygraph Exam Clinically Significant Disclosures, 2025 (Count 2,078)

Disclosure Type	Count of Adult Criminal Court Clients	% of Adult Criminal Court Clients (Count 2,057)	Count of Juvenile Court Clients	% of Juvenile Court Clients (Count 21)
Disclosure Made*	1,013	49.0%	14	67.0%
No Disclosure Made	1,044	51.0%	7	33.0%
Total	2,057	100%	21	100%

*Polygraphers can select multiple disclosures such as sexually abusive thoughts, feelings, and attitudes or sex behavior (e.g., use of pornography) or historical information (e.g., admitting an unknown offense) or change of circumstance/risky behavior (e.g., increased access to children) or other disclosures.

The **specific types of clinically significant disclosures** clients made are detailed in **Figure 12.** Approximately half of all adult polygraphs led to some form of disclosure, while the rate was higher for juvenile polygraphs. This disparity in disclosure rates must be interpreted cautiously as it likely reflects that these exams are used sparingly for juveniles only when clear, elevated concerns exist.

Figure 12. Types of Disclosures Made During Polygraph Exams, 2025* (Count 2,078). Data table, Appendix B.12



* Percentages may exceed 100% because multiple disclosure types can be recorded during a single polygraph examination.

Figure 13 shows the four major polygraph examination results, which provide a breakdown of exam outcomes. Overall, **1,486 (71%)** polygraph exams were classified as **No Significant Response (NSR)/Non-Deceptive**. This broad classification includes results categorized as both 'No Deception Indicated/No Significant Response' and 'No Deception Indicated/No Opinion'. In contrast, Significant Responses (SRs)/Deception Indicated results occurred in 23% of adult exams and 43% of juvenile exams. As outlined above, this disparity is likely influenced by polygraphs being used only with juveniles when significant concerns exist.

Figure 14 shows exam outcomes by exam type. Specific Issue exams and Index Offense exams had the greatest rates of Significant Response (SR)/Deception Indicated results. This finding is expected, as these exams are most often used when there is denial of the offense for which the client was convicted. The SR/Deception Indicated responses were slightly higher among repeat exams as compared to initial exams (32% vs. 20%).

Figure 13. Outcomes of Polygraph Exams by Court, 2025 (Count 2,092). Data table, Appendix B.13

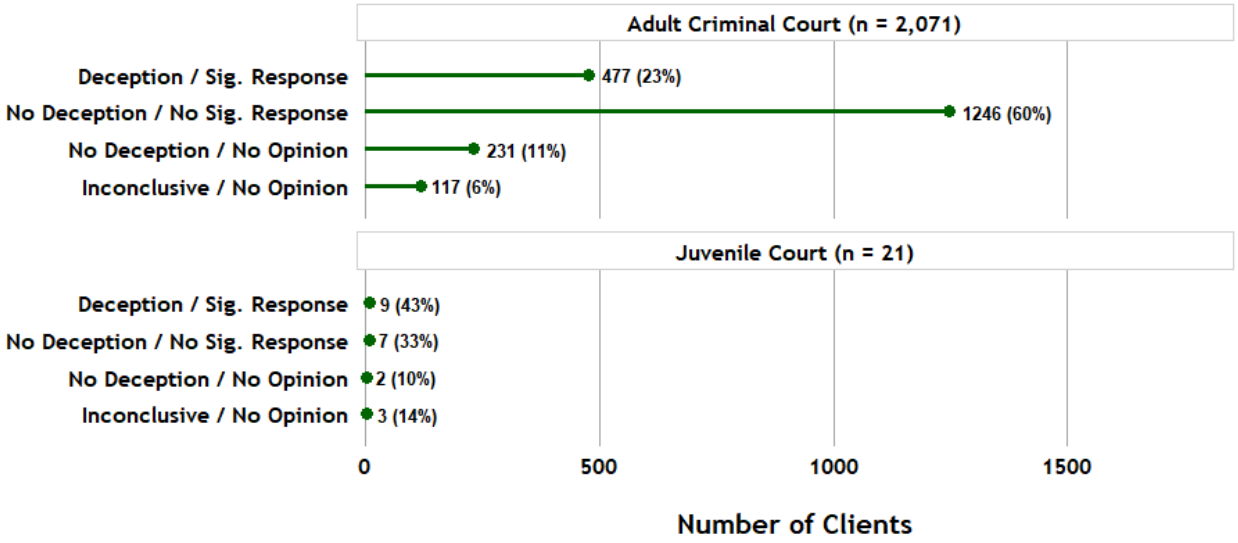
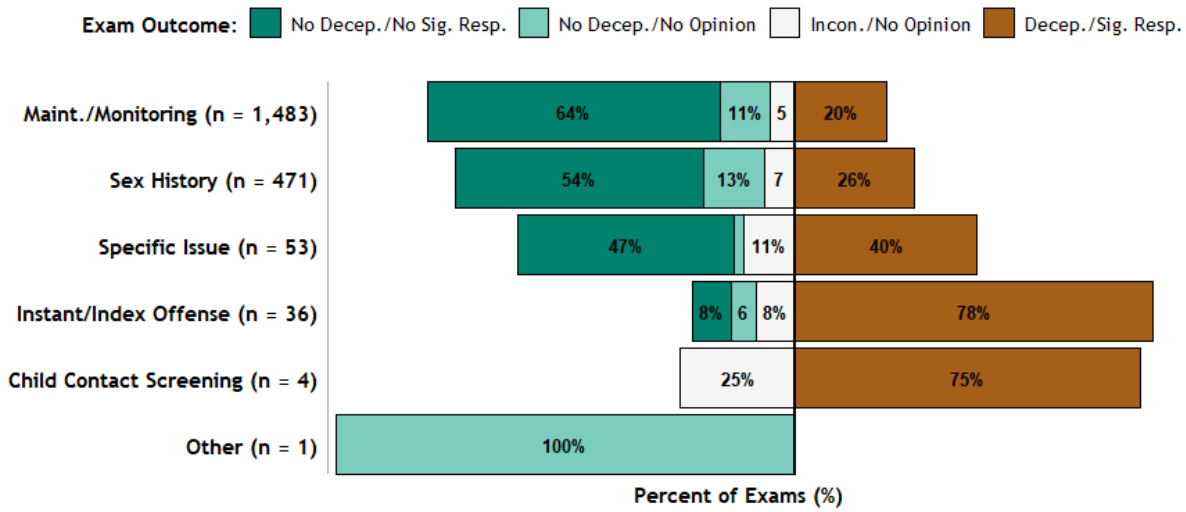


Figure 14. Outcomes of Polygraph Exams by Exam Type, 2025 (Count 2,092). Data table, Appendix B.14



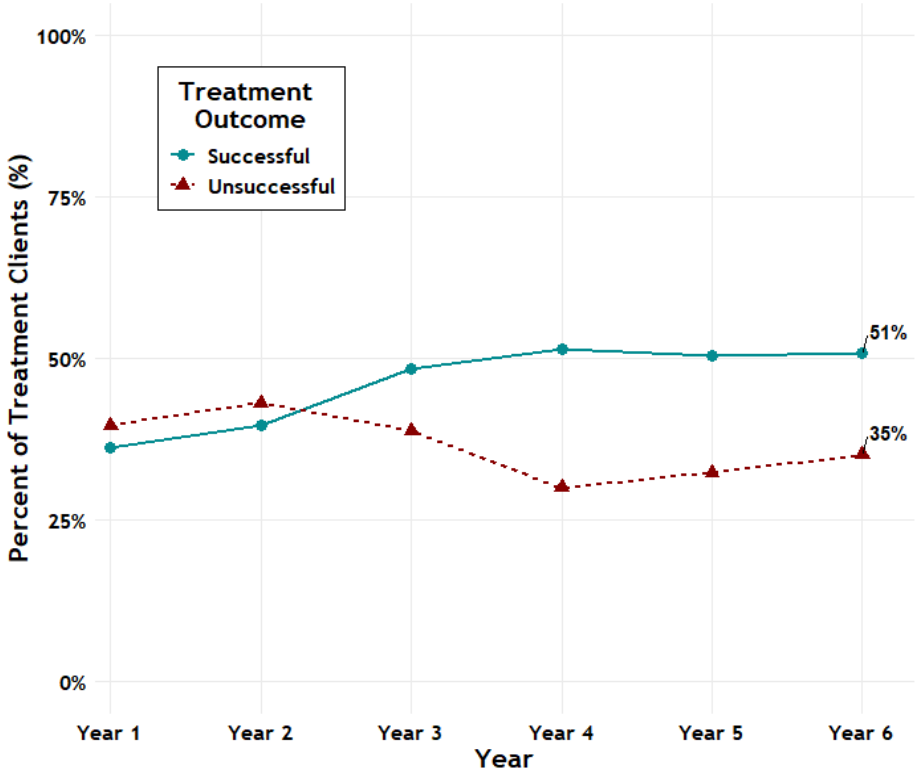
Comparing Results Across the Six Years of Data Analyses

Across six years of data, results support that Approved Providers are adhering to the *Adult and Juvenile Standards and Guidelines* and applying Risk-Need-Responsivity (RNR) principles in evaluation and treatment. As displayed in **Table 12**, service volumes have largely stabilized in recent years, suggesting consistent delivery of evaluation, treatment, and polygraph services. As shown in **Figure 15,** successful treatment discharge rates show a long-term upward trend, increasing through Year 4 and plateauing at approximately 51%, indicating stable program effectiveness over time.

Table 12. Total Records Entered, Years 1-6

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 Year 6	Count of Records Total
Evaluation	383	670	427	486	401	348	**2,715**
Treatment	411	836	539	650	514	625	**3,575**
Polygraph	4,950	3,743	2,992	3,142	2,829	2,144	**19,800**

Figure 15. Successful and Unsuccessful Discharge, Years 1-6. Data table, Appendix B.15



Limitations

The data collected for this review provide a uniquely comprehensive resource, offering multi-year insight that supports trend analysis, policy development, and ongoing system improvement. However, the findings should be interpreted with an awareness of several methodological considerations:

- **Completeness of participation:** A small number of Approved Providers did not submit data during this reporting period, and instances of missing information affect the completeness of the overall dataset. To improve coverage, the SOMB allows providers to report service information without a unique identifier when clients decline ROI consent. This approach allows the SOMB to better account for overall service delivery and continues to be refined.

- **Consistency of data entry:** Because data is submitted by a diverse group of providers, there may be differences in how terms are understood and how information is documented. While procedures continue to improve to support fidelity in data entry, the potential for variation may introduce inconsistencies across records.
- **Design and evolution of the database:** The system was initially approved nearly 10 years ago, with development occurring well before implementation on January 1, 2020. Now in its sixth year of active data collection, the database has undergone periodic updates as the *Adult and Juvenile Standards and Guidelines* have evolved. As a result, when interpreting results—particularly across multiple years—changes in data definitions, shifting priorities, and emerging practices may affect comparability and the ability to fully assess long-term trends.
- **Integration across service types:** The system's original design did not anticipate current needs for linking data across the full continuum of services, from initial evaluation to final discharge. Consequently, service records are stored separately rather than combined at the client level. Analyses therefore focus on individual service types instead of full service pathways that include evaluation, treatment, and polygraph results. As a result, multi-service patterns and cumulative outcomes may not be fully captured in the current findings.

Overall, these considerations do not diminish the value of the data; rather, they provide important context for interpreting findings and continuing to refine data collection and reporting practices.

Summary and Conclusions

The Year 6 review of the PDMS provides compelling evidence of **continued Approved Provider fidelity** *to the Adult and Juvenile Standards and Guidelines,* demonstrating a **sophisticated, data-informed approach** to service delivery. A significant volume of data, particularly from treatment providers, confirms the commitment across providers to **evidence-based practice** and system improvements.

- **Consistent Treatment Conpletion & Strong RNR Implementation:** The successful treatment completion rate has **stabilized at 51% overall**, supported by a clearer classification system. Providers are actively implementing **RNR principles**, evidenced by increases in strategies like increased support (51%) and flexible scheduling (42%) to individualize treatment.
- **Challenges in Client Responsivity:** The most frequently identified barriers to client progress were **resistance or lack of investment in treatment goals (53.4% of unsuccessful discharges)** and general **lack of motivation (37%)**. These challenges are well-recognized across offender rehabilitation and reflect both individual and systemic influences. Continued attention to **engagement and motivation-enhancing practices** within the *Adult and Juvenile Standards and Guidelines* will help support providers in addressing these ongoing responsivity concerns.
- **Polygraph Examination Utility:** Polygraphs continue to be a **vital tool for monitoring and accountability**, resulting in clinically significant disclosures in **49% of adult** and **67% of juvenile exams**. The notable increase in disclosures for juvenile clients (up from 36% last year) suggests polygraphs are being strategically used in cases of elevated concern.

The PDMS remains an **essential, evidence-based tool** that supports continuous enhancement of the *Adult and Juvenile Standards and Guidelines*. Provider comment entries—describing individualized treatment approaches, polygraph exam conditions, client disclosures, and intervention strategies—offer the SOMB a **real-time mechanism** for monitoring implementation challenges and successes.

Key priorities emerging from Year 6 findings include:

- **Treatment Engagement and Early Responsivity Supports:** Unsuccessful discharge continues to correlate with new criminal activity and risk-related behaviors; however, **client resistance** or **lack of investment in treatment goals** has now surpassed violations of supervision conditions as the most common reason for unsuccessful discharge. Continued refinement of the *Adult and Juvenile Standards and Guidelines* related to **early engagement**, **acceptance of responsibility**, and **motivational interventions** may help providers reduce this persistent barrier to treatment completion.
- **Recidivism Monitoring and Public Safety Analysis:** Recidivism data reflect a **stable non-sexual crime rate (12.3%)** and a slight increase in the **sexual crime rate (from 4.1% to 5.0%)**. Because these trends have direct implications for community safety and victim well-being, the SOMB will continue **rigorous monitoring** and pursue deeper analysis of individual, programmatic, and systemic factors that contribute to reoffending.
- **Data Quality, User Experience, and Provider Support:** Reports of "**data fatigue**," particularly among polygraph examiners, emphasize the need to ensure PDMS data entry remains **streamlined**, **intuitive,** and **minimally burdensome**. Ongoing stakeholder feedback will be essential to maintain complete, high-quality data and to preserve the integrity of the multi-year dataset.

Overall, the Year 6 review shows that Approved Providers are consistently implementing services aligned with the *Adult and Juvenile Standards and Guidelines* and **utilizing RNR principles to tailor evaluation and treatment**. The PDMS continues to provide the SOMB with a robust, **longitudinal evidence base** to support **data-driven decision-making**, enhance provider fidelity, and strengthen public safety outcomes.

Section 2: Relevant Policy Issues and Recommendations

Beginning in 2011, as part of the SOMB Sunset renewal, the SOMB was tasked with providing policy recommendations in addition to implementing the *Adult* and *Juvenile Standards and Guidelines*. To support this role, the annual legislative report highlights relevant developments, such as policy recommendations informed by current research, summaries of court cases that may influence SOMB practices, and emerging topics of interest to the legislature. This section offers context on issues shaping the SOMB's work and highlights information that may be useful for future policy discussions.

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, the Office of State Planning and Budgeting, the Colorado Department of Public Safety, or other state agencies.

Revision of the Determinate Sentence Parole Guideline

Senate Bill 23-164 reauthorized the SOMB and directed that, in collaboration with the **State Board of Parole**, the SOMB revise the parole release guideline instrument for individuals convicted of sex offenses who are serving determinate sentences. Under § 17-22.5-404(4)(c)(II), C.R.S., the revised guideline must:

- Incorporate Risk-Need-Responsivity principles or another evidence-based correctional model.
- Be as flexible as possible to ensure that necessary programs can be accessed in a timely manner to prevent the offender from harming victims or potential victims.
- Consider the intersection of the guideline instrument with the factors outlined in the parole statute, **§ 17-22.5-404(4)(a), C.R.S.**, which includes considering the totality of the circumstances and a list of required factors.[11]
- **Not deny parole solely due to** the offender's inability to access treatment during incarceration, when determined eligible for treatment.

The legislation further directs the Boards to consider current research, information, and data regarding:

- The offender's individual **static and dynamic risk factors,** and whether participation in treatment while incarcerated will significantly reduce risk prior to release.

[11] **§ 17-22.5-404(4)(a), C.R.S.,** requires the State Board of Parole to consider the totality of the circumstances, including victim input, actuarial risk of reoffense, criminogenic needs, treatment and program participation, institutional conduct, adequacy of the parole plan, any threats or harassment of victims, aggravating or mitigating case factors, support from prospective sponsors, prior absconding or escape attempts, and educational progress made during incarceration.

- The most **effective use of limited treatment resources** within the DOC.
- The **availability or lack of availability of treatment during incarceration** for otherwise release-eligible individuals serving determinate sentences.
- The **effectiveness of treatment** delivered as a condition of community supervision on parole.

Evidence-Informed Parole Decision-Making

In developing the new guideline, it is essential to anchor decision-making in contemporary parole research. The Robina Institute's *Modernizing Parole Statutes: Guidance from Evidence-Based Practice* (McVey et al., 2018) remains one of the most comprehensive syntheses of empirical guidance in this area. This report strongly endorses **structured decision-making (SDM)** informed by validated risk and needs assessments for parole decisions. Together, these help parole boards:

1. Identify criminogenic needs and match individuals to appropriate programming.
2. Distinguish between **low-risk individuals—who should be released at the earliest safe opportunity—from those requiring additional intervention**.
3. Include consideration of treatment engagement, institutional behavioral conduct, and reentry preparation as indicators of **release readiness**.
4. Increase fairness, transparency, and defensibility in decision-making while allowing necessary flexibility.

The report also underscores the importance of **interagency collaboration** so that treatment, risk-reduction programming, and reentry planning begin well before parole eligibility. It further highlights the value of **trauma-informed, forward-looking victim input** that focuses on safety planning, rehabilitation, and readiness for supervised release rather than punishment. Finally, the report emphasizes tailoring parole conditions to individual risk and needs—minimizing requirements for low-risk individuals, applying more targeted and intensive conditions for higher-risk individuals (especially early in supervision), and using **swift, proportionate responses** to both compliance and violations.

Selecting the Most Suitable Decision-Making Model for Colorado

Determining the most appropriate model for Colorado requires assessing the strengths and limitations of available decision-making approaches. **Unstructured professional judgment** has been consistently shown to be less accurate and less consistent than structured or actuarial methods, especially in complex, high-stakes, and low-feedback environments such as parole decision-making (Grove & Meehl, 1996; Hanson & Morton-Bourgon, 2009; Helmus et al., 2021). Although actuarial approaches are strong predictors of recidivism risk, **no single actuarial instrument captures the full range of factors relevant to parole release**, and many tools—especially those assessing **dynamic risk factors**—require clinical training beyond what Parole Board members can reasonably obtain. Static actuarial tools provide important information but are insufficient for assessing **treatment gains, behavioral change, reentry readiness, or protective factors**.

Structured decision-making (SDM) offers the most **balanced, evidence-based approach.** SDM:

- **Integrates** actuarial assessments where appropriate and available.
- Incorporates dynamic risk and protective factors, institutional behavior, treatment engagement, and reentry planning, **based on research-derived domains and guidance**.
- **Reduces variability** across assessors, aiding consistency and transparency.
- A**ligns closely with statutory mandates** requiring consideration of the "totality of the case."

Experience from other jurisdictions reinforces the legitimacy of this model. The Structured Parole Decision-Making Framework (SPDMF; Serin et al., 2022) is used across multiple **U.S. states** (e.g., California, Connecticut, Michigan, Ohio) and **the Parole Board of Canada**. This model integrates a **validated actuarial anchor** (where available), empirically derived domains (e.g., criminal history, self-control, institutional conduct, offender change, release planning), and **structured professional judgment** to classify information as aggravating, neutral, or mitigating. Research consistently demonstrates that the SPDMF improves **consistency, transparency, and predictive validity** relative to unstructured judgment (Serin et al., 2022; Wardrop et al., 2019).

A national review shows that most states **do not develop structured decision-making instruments or guidelines for sex-offense-specific cases**; instead, sex-offense cases are handled within the same SPDMF used for all applicants (e.g., Watts et al, 2018). Where distinctions exist, they typically involve operational or eligibility requirements—such as completion of sex-offense-specific treatment, incorporation of specialized risk assessments, or addressing issues established in statutes. Colorado has historically been unique in maintaining a separate guideline for individuals serving sex-offense sentences. Utah is the other exception as it uses a distinct sex-offense matrix to guide sentencing, release, and supervision, though it emphasizes static and severity factors.

Summary

- **SDM is the prevailing evidence-based model** for parole decision-making across jurisdictions.
- **Sex-offense-specific SDM tools are extremely rare;** Utah is the only notable exception.
- **Colorado's initiative to develop an SDM instrument tailored to determinate-sentence sex-offense cases is unique and well-supported** by statutory and empirical considerations.
- **SDM best satisfies Colorado's statutory requirements** by integrating actuarial information, dynamic risk and protective factors, treatment progress, and reentry readiness into a transparent and legally grounded process.

Determinate Sentence Workgroup

Senate Bill 23-164 set a statutory target to revise the release guideline instrument by December 1, 2023. The SOMB and State Board of Parole met the **conceptual requirements** of this mandate through the *Treatment Solutions Work Group Report (Appendix B of that report)*.[12] The proposed release criteria relied centrally on an assessment of sexual reoffense risk derived from both static and dynamic factors, as documented in the most recent risk assessment evaluation.

During the Workgroup's foundational review, however, it became clear that significant barriers prevented access to a current and valid reoffense risk score based on combined static and dynamic factors. SOMB offense-specific evaluations are conducted at sentencing—often many years before an individual becomes eligible for parole—and may be outdated because assessment tools and standards evolve over time. In addition, because these evaluations originate in the Judicial system, they are currently inconsistently available in parole files, and obtaining them through records requests can require substantial time, with no guarantee of success. Although the Treatment Solutions Workgroup made important progress in outlining revised criteria, the development of a workable risk-assessment instrument, solutions to information-access obstacles, and the operationalization of these elements within the release guideline remained unfinished.

To move forward, the SOMB—in partnership with the State Board of Parole and the Colorado Department of Corrections—established the **Determinate Sentence Workgroup** in 2024. This workgroup includes representatives from the SOMB, DCJ Office of Research and Statistics (ORS), the State Board of Parole, and the DOC Sex Offender Treatment and Monitoring Program (SOTMP). Their overarching goal is to translate statutory requirements and evidence-based principles into a validated, operationally sound decision-making process. The group has adopted a **structured approach consisting of**:

- **Design:** Creating a robust instrument that addresses operational barriers and systems integration. (*Phases I & II*)
- **Pilot:** Testing the instrument to assess viability and functionality (*Phase III*)
- **Implement:** Full rollout of the new criteria (*Phases IV & V*)

The workgroup has convened **nine public meetings** to date (three in 2024 and six in 2025), supplemented by targeted work sessions. The project is organized into five distinct phases as shown in **Figure 16**.

[12] The Treatment Solutions Workgroup was established in August 2023 to address potential barriers to timely sex offense specific treatment access within DOC SOTMP. Its findings were published in the Treatment Solutions Report (February, 2024) to the Joint Judiciary Committee and outlined in the SOMB 2024 Annual Legislative Report.

Figure 16. Determinate Sentence Release Guideline Revision Project Timeline

Phase I: Foundational Review (Completed in 2024)

The initial meetings in 2024 centered on a comprehensive review of existing processes and the identification of significant systemic barriers.

- **Criteria Review and Revision:** The workgroup discussed shifting from the previous **2011 disqualifier-based criteria** to a broader set of considerations for release suitability. Discussions included integrating **static and dynamic risk assessment scores**, pro-social factors (e.g., housing and employment), and adjunct treatment needs.

- **Information Gaps and Systems Integration:** A critical challenge identified was the **lack of necessary information** for informed release decisions. The group explored leveraging the ongoing **CDOC record management system build-out** for automation and considered seeking an Attorney General's opinion to clarify Health Insurance Portability and Accountability Act (HIPPA)[13] laws regarding required data sharing.

- **Risk Assessment Tool Development:** The workgroup discussed the preference for an automated tool that effectively assesses risk and protective factors consistent with statutory requirements.

- **Treatment Access Barriers:** The group acknowledged the widespread lack of access to SOTMP for determinately sentenced individuals and **the need to remove this barrier** in the revised guidelines.

Phase II: Framework Selection and Instrument Structuring (Completed 2025)

The 2025 meetings and associated work sessions focused on evaluating, selecting, and preparing to implement a structured decision-making framework and developing a structured professional judgment instrument.

- **Evidence Review and Needs Assessment:** To determine the most appropriate release-guideline model and achieve consensus across the workgroup, members **reviewed the empirical evidence** and completed a comprehensive **needs and feasibility survey**.

- **Structured Model Selection:** The SDM model was selected as the most evidence-based and feasible option. Its design aligns directly with the statutory mandates, and it was preferred over maintaining an **unstructured** decision-making process or adopting a **purely actuarial** model. A purely actuarial model was deemed unsuitable because it requires substantial new research, presents significant operational challenges for data capture and scoring, and reliance on static factors would fail to account for the dynamic, protective, and reentry-focused considerations that are central to parole readiness and statutory requirements.

- **Draft Instrument Development:** SOMB staff began structuring a new instrument specific to individuals convicted of sex offenses, designed to assess both risk indicators (part A) and reentry and protective factors (part B). These items were determined after a thorough review of the risk assessment and reentry literature.

- **Initial Document & Data Collaboration:** The workgroup emphasized the importance of key stabilizing factors—such as stable housing, employment, treatment continuity, and social support—in reducing recidivism, and these considerations are reflected in the proposed instrument (part B). Members also identified the need to improve the Parole Board's **access to essential documents and information to accurately score both parts of the drafted instrument**. The absence of essential documents and information would likely result in an inaccurate or unreliable process for formulating decisions by the Parole Board.

[13] HIPPA is a federal law established in 1996 that sets national standards for the protection and confidential handling of patients' health information.

Phase III: Refinement, Pilot Testing, and Guideline Development (In Progress)

This phase involves initial testing of the draft instrument and developing the essential accompanying materials.

- **Targeted Usability Testing:** The **DOC SOTMP Administrator** had staff review the instrument to provide feedback on its **validity** compared with assessed cases using other risk assessment instruments. To test its **usability**, a **Parole Board member** tested the draft instrument with cases to gather real-world feedback on its utility for board decisions initially via **administrative (file) reviews** and since through **cases as they appear for parole hearings**.

- **Instrument Revision and Manual Finalization:** Based on the initial usability testing feedback, the structured decision-making instrument will be **revised, and the scoring manual finalized**.

- **Expanded Usability Pilot:** The usability pilot will be **expanded** to include a select group of other Parole Board members to further test the instrument's utility across different decision-makers. Further refinement to the instrument and manual will occur, alongside efforts to ensure case information is available to support scoring.

- **Community Treatment Guideline Development:** A guideline will be developed to inform decisions about which parole candidates are suitable for community-based, sex offense–specific treatment. This guideline will be grounded in a **comprehensive review of research on treatment effectiveness** (see Section One for a summary of that review). It will also consider the **five-level risk and needs classification system** created by the Council of State Governments (CSG) Justice Center and the National Reentry Resource Center (NRRC). Aligning this work with Colorado's local adaptation of the framework—the **SONICs** (Sex Offending Needs Integrated Classification System) currently under review for implementation—will further promote consistency in risk communication and treatment matching across the SOTMP, parole decision-making, and community providers.

Phase IV: Implementation Readiness and Training (2026 Goal)

This phase constitutes the preparation and roadmap for achieving full system integration and use of the new guidelines.

- **Comprehensive Implementation Planning:** The workgroup will develop a comprehensive implementation plan outlining the necessary **system changes** (e.g., IT needs), procedural adjustments, and resource allocation.

- **Training Package Creation:** A comprehensive **training package** will be created for all users (Parole Board members, CDOC staff) to ensure proficiency in using the new decision-making instrument and understanding the revised guidelines.

- **Stakeholder Training:** This step involves creating targeted resources to ensure understanding by all involved stakeholders.

- **Readiness for Full Implementation:** The goal is to have completed all preparation and be ready for **full system implementation of the new tool and revised guidelines by the end of 2026**.

Phase V: Full Implementation

The final phase constitutes the Parole Board implementing the revised tool and guidelines, with SOMB transitioning primary ownership while continuing to provide general and technical support as needed.

Summary

The Determinate Sentence Workgroup remains on track to complete its **core deliverables in 2026** and have the revised tool and guidelines ready for implementation by the State Board of Parole in 2027. The group has completed foundational analysis, selected the SDM model, and addressed key system barriers—including treatment access and information gaps. The workgroup is now in Phase III, having completed initial usability testing and actively refining the instrument and scoring manual while developing the Community Treatment Recommendation Guideline. In 2026, the project will transition to developing the implementation plan, training materials, and stakeholder resources to ensure operational readiness, culminating in a handoff to the State Board of Parole for full implementation in 2027.

Victim Advocacy Training Initiative and Standardization

Colorado's victim-centered approach requires all team members to possess the requisite training, resources, and ongoing support to ensure victim safety and to function effectively. Victim Representatives play a central role in this multidisciplinary system by facilitating communication with victims, advocating for their needs and concerns, and contributing essential information to decision-making processes. However, gaps in training, variability in practice, and limited access to support structures currently undermine the consistency and effectiveness of this role. This section outlines the critical responsibilities of Victim Representatives, examines the challenges that impede their work, and introduces a comprehensive SOMB initiative designed to enhance training of Victim Representatives and establish sustainable, system-wide support.

Statutory Foundation for a Victim-Centered Approach

Colorado's sex offender management framework is grounded in a clear statutory directive: interventions must **prioritize the physical and psychological safety of victims and potential victims, while addressing the assessed needs of the offender** in all aspects of post-conviction evaluation, supervision, treatment, and decision-making. This directive is established in § 16-11.7-103(4), C.R.S., and reinforced throughout both the SOMB *Adult Standards and Guidelines* and the SOMB *Juvenile Standards and Guidelines*.

Sexual offenses inflict profound and often lifelong trauma, impacting the victim's health, stability, and fundamental sense of safety and self-worth. As defined in **Section 8.000** of the *Adult and Juvenile Standards and Guidelines*, a victim-centered approach mandates that the needs and interests of victims require *paramount attention* from all professionals involved. This requires a proactive commitment to protecting victims, avoiding re-victimization, and maintaining sensitivity to their issues throughout the continuum of offender management.

A victim-centered approach is further codified by the Colorado **Victims' Rights Act (VRA)**, which is enshrined in the **State Constitution (Article II, Section 16a)** and detailed in statute. The VRA guarantees victims the fundamental right to be treated with fairness, respect, and dignity, and the right to be informed, present, and heard at all critical stages of the criminal justice process (**§ 24-4.1-302.5, C.R.S.**). For the post-conviction supervision and treatment phases for individuals convicted or adjudicated of sexual offenses—the very stages where long-term safety planning is executed—this means creating a formalized, reliable mechanism for victim input. This initiative directly addresses that mechanism by ensuring that victim advocacy is grounded in expertise and sustainability, thereby fulfilling both the spirit and the letter of the VRA.

Critical Role of the Victim Representative in the SOMB TEAMS Model

To operationalize this victim-centered mandate, the *Adult Standards and Guidelines* require the formation of a **Community Supervision Team (CSTs)** for adults, and the *Juvenile Standards and Guidelines* require a Multidisciplinary Team (**MDTs)** for juveniles. These teams function collectively under the **TEAMS Model** (Treatment, Engagement, Assessment, Management, and Supervision). The CSTs and MDTs are a collaborative body of professionals—including the supervising officer, the treatment provider, the evaluator, and the polygraph examiner—who coordinate efforts to manage an individual's risk and promote public safety.

Under Section 5.025 of the *Adult Standards and Guidelines* and Section 5.110 of the *Juvenile Standards and Guidelines*, **every CST and MDT must include a Victim Representative as a core member**. Victim Representatives hold a **dual and indispensable function**:

- **To Inform the Victim:** Victim Representatives serve as **essential liaisons and supports**, communicating agreed-upon information to victims who choose to participate regarding offender progress, supervision conditions, and any potential contact planning, including clarification or reunification efforts. They provide victims and their families with a formal, reliable, and sensitive avenue to receive information, ask questions, and have their concerns heard and validated when they elect to engage. This function ensures that victims remain informed, supported, and meaningfully connected to the post-conviction process to the extent they choose.

- **To Inform the CST/MDT:** Victim Representatives ensure that team decision-making remains grounded in the victim's physical and psychological safety. Their role extends far beyond procedural compliance; they function as a **critical check and balance** within the CST/MDT structure, ensuring that the system remains **grounded in the victim's experience and safety needs**. They provide the essential victim perspective, share victim-related information and concerns (when available), and advocate for conditions that prioritize safety and hold the offender accountable. Their presence mitigates "clinical tunnel vision," preventing teams from focusing exclusively on offender rehabilitation at the expense of victim safety.

Guiding Principles in both the *Adult and Juvenile Standards and Guidelines* explicitly affirm that **victim input is valuable information for these teams,** making the Victim Representative an indispensable conduit for effective, risk-informed management. Their expertise in trauma, victim dynamics, safety planning from the victim's perspective, and VRA compliance elevates the entire quality of the CST and MDT's risk management efforts.

Systemic Challenges Undermining the Victim Representative Role

The SOMB has identified three statewide systemic challenges that undermine the function and sustainability of Victim Representatives:

- **Inconsistent Training and Technical Knowledge:** A 2023 SOMB survey revealed notable variation in Victim Representatives' understanding of technical areas required for CST and MDT participation, including clarification protocols, dynamic risk factors, polygraph interpretation, treatment expectations, and CCS processes. Many Victim Representatives receive only localized, informal, or ad-hoc training.

- **Workforce Instability Driven by Marked VOCA Funding Reduction:** As detailed in the 2025 Annual Report, Colorado has experienced a drastic 45% decline in federal VOCA funding (Office of Victim Programs, 2023). This downturn has destabilized the statewide victim-services infrastructure, threatening dozens of programs and severely limiting agencies' ability to train, recruit, or retain specialized staff. Victim Representative functions—already niche and complex—are among the most affected.

- **Unequal Capacity Across Communities:** Smaller and rural agencies face acute staffing constraints, limited professional development resources, and high turnover. Without statewide support, the quality and availability of Victim Representatives vary by jurisdiction, resulting in unequal victim access to critical post-conviction services.

These challenges diminish the State's ability to fulfill statutory mandates, maintain consistent risk-management practices, and uphold victim rights during the most consequential stages of offender management, even as responsibility for victim representation appropriately remains outside the SOMB's statutory authority.

Justification for Statewide Training and Support Initiative

This critical project uses a portion of the **Sex Offender Surcharge Fund** to develop a robust, standardized training and support resource for Victim Representatives involved in sex offense–specific supervision and treatment under the SOMB *Adult or Juvenile Standards and Guidelines*. This essential allocation is supported for three compelling reasons:

- **Statutory Appropriateness:** Pursuant to § 16-11.7-103(4)(c), C.R.S., the SOMB is responsible for developing a plan for the allocation of money deposited into the Sex Offender Surcharge Fund. Given that the Victim Representative is an **essential, mandated member** of the core CST and MDT structure, providing accessible, standardized training for this role is a necessary component of implementing the programs and procedures required under the SOMB's legislative authority. Without trained Victim Representatives, the integrity of the CST and MDT model are compromised, making this allocation both appropriate and essential.

- **Bolstering Victim Services Amid Severe Funding Losses:** Widespread VOCA reductions mean agencies can no longer sustain specialized training, shadowing, mentoring, or ongoing support for Victim Representatives. Without intervention, Colorado faces a risk of system-wide attrition of qualified Victim Representatives. Relying on federal victim service funding streams is no longer sustainable for this highly specialized function. A state-supported, standardized curriculum ensures that:
    - Victim Representatives can continue to serve even when local agencies lack resources.
    - Training quality does not depend on geographic location or agency size.
    - Victims statewide have equitable access to informed, competent representation.
- **Ensuring Quality and Consistency in Risk Management:** The lack of standardized training has resulted in uneven practices, inconsistent victim input procedures, and gaps in technical knowledge. Given the Victim Representative's central function in risk management, inconsistent training jeopardizes:
    - Team decision-making
    - Victim safety planning
    - Compliance with *Adult and Juvenile Standards and Guidelines*
    - The credibility of the TEAMS Model

A statewide curriculum eliminates these disparities by ensuring all Victim Representatives receive **uniform, vetted, and recorded training**, accessible regardless of turnover, geography, or funding fluctuations.

SOMB Solution: A State-Supported, Sustainable Training System

Recognizing the magnitude of the systemic challenges, the SOMB initiated a statewide project in 2025 to strengthen the training, competency, and sustainability of Victim Representatives and to stabilize the long-term infrastructure needed to support their mandated role.

To fund this effort, the SOMB approved a one-time allocation of **$100,000 from the Sex Offender Surcharge Fund**, consistent with its statutory authority under § 16-11.7-103(4)(c), C.R.S., to develop a post-conviction victim training curriculum. This project aims to develop and implement comprehensive training and support systems for victim representatives to ensure that victims' needs are addressed effectively and equitably during the sex offense treatment process. This project is critical to support victim needs post-conviction, an area in which victim needs are often neglected. This funding is intended to secure the long-term infrastructure of the Victim Representative role. The project is divided into two distinct scopes of work and project phases:

Scope 1: Victim Representative Training Program

Following a competitive bidding process, the SOMB awarded Scope of Work 1 to the Colorado Coalition Against Sexual Assault (CCASA). CCASA is tasked with stabilizing the quality of the Victim Representative function regardless of local organizational capacity. Key objectives include:

- **Curriculum Development:** Develop and deliver comprehensive training and technical assistance to victim representatives, covering topics from offender management and treatment standards to victim confidentiality, safety planning, and trauma-informed care.

- **Sustainability:** Support and sustain the victim representative network through training, mentoring, recruitment, retention, communities of practice, and collaboration, while coordinating with the SOMB for standards alignment.

- **Colorado's Diversity of Victim Needs:** Ensure all project deliverables and services are tailored to the diverse needs of communities and victim populations, promoting equitable service delivery and assisting local communities with strategic planning and recruitment.

Scope 2: Program Evaluation and Research

Scope of Work 2 was identified as a separate project to ensure independent analysis and was awarded to Dr. Jamie Yoder with Colorado State University (CSU).

This component focuses on assessing the impact of the training initiatives and researching operational models. Key objectives include:

- **Program Assessment:** Evaluating the effectiveness of the training and support provided to Victim Representatives.

- **Operational Modeling:** Investigating optimal models for Victim Representative involvement to inform future policy.

Project Implementation Phases

The project is proceeding in distinct phases, as outlined in **Table 13**.

Table 13. Victim Representative Training Initiative Implementation Phases

Phase	Dates	Key Deliverables & Outcomes
Phase 1: Curriculum & Design	September – December 2025	Finalization of training curriculum (CCASA) and evaluation design plan (CSU).
Phase 2: Delivery & Data Collection	January 2026 – April 2026	Delivery of training sessions; collection of data on training effectiveness and operational models.
Phase 3: Evaluation & Sustainability	May – June 2026	Comprehensive evaluation report, sustainability plan, and recommendations for future initiatives.

Summary

Colorado's victim-centered approach mandates that victim safety be the paramount consideration in all post-conviction sex offender management. This principle is codified in § 16-11.7-103(4), C.R.S., and the Victims' Rights Act (VRA), which guarantees victims the right to be informed and heard. To operationalize this, the SOMB *Adult and Juvenile Standards and Guidelines* require every CST and MDT to include a **Victim Representative** as a core member. This role is indispensable, serving the dual function of informing and supporting the victim through the process, and informing the CST/MDT to ensure all risk-management decisions are grounded in the victim's physical and psychological safety.

To strengthen this core function statewide, the SOMB has launched a comprehensive training and support initiative funded through a one-time allocation from the Sex Offender Surcharge Fund. The project is designed to build a consistent, sustainable Victim Representative network and ensure high-quality, victim-centered participation in CST and MDT processes. The initiative includes two coordinated scopes of work: Scope 1, led by the Colorado Coalition Against Sexual Assault, focuses on developing a standardized training curriculum, technical assistance structure, and long-term sustainability strategy; and Scope 2, led by Dr. Jamie Yoder (CSU), provides independent evaluation, implementation guidance, and statewide modeling to support consistency, accountability, and continuous improvement through mid-2026.

Section 3: Milestones and Achievements

Overview of 2025 Accomplishments

The Sex Offender Management Board (SOMB) achieved significant milestones in 2025, driven both by the **statutory mandates of the SOMB Reauthorization Bill (SB 23-164)** and by ongoing priorities related to standards development, provider oversight, and statewide system collaboration. Major accomplishments included progress on implementing SB 23-164—most notably the launch of **biennial Standards Compliance Reviews (SCRs)** and the continued advancement of the **Determinate Sentence Workgroup.** The Board also strengthened system capacity through updates to the ***Adult and Juvenile Standards and Guidelines*** and through targeted training and outreach efforts.

These achievements were complemented by broader organizational initiatives focused on long-term system improvement. The SOMB conducted a **foundational Strategic Planning Initiative** to shape future priorities in advance of the **2028 Sunset Review**, informed by provider surveys, stakeholder interviews, and analysis of emerging system needs. The Board continued to invest in workforce and stakeholder engagement through a **multi-phase provider recruitment strategy**, **four statewide roundtables**, and **32 training events** reaching more than **1,400 attendees**. Efforts to enhance **individually responsive care** were advanced through strengthened language in the *Adult and Juvenile Standards and Guidelines* and specialized training focused on culturally responsive, trauma-informed, and identity-affirming practices. Collectively, these accomplishments reflect the SOMB's ongoing commitment to **public safety**, **effective treatment**, and **system-wide collaboration**.

Implementation of SOMB Reauthorization Bill (SB 23-164)

The **SOMB was reauthorized** for an additional five years, extending its mandate through **September 1, 2028**, under SB 23-164, in alignment with the recommendations of the 2022 Department of Regulatory Authority (DORA) Sunset Report. SB 23-164 incorporated the recommendations in the Sunset Report alongside additional statutory mandates (summarized in Appendix D). To strategically address these new and updated requirements, the SOMB has initiated several multi-step projects. **Completed projects** include the **Treatment Solutions Workgroup** and most key **updates to the *Adult and Juvenile Standards and Guidelines***. Meanwhile, **SCRs** are on track and the **Determinate Sentence Criteria Workgroup progress** is reported in Section Two of this report.

Standards Compliance Reviews (SCRs) Implementation Update

Effective **September 1, 2024**, and every two years thereafter, the SOMB is statutorily required to conduct compliance reviews on a minimum of **10%** of all **SOMB Approved Providers**. The SOMB adjusted its existing administrative policies in March 2024 to align with this new biennial requirement, and the first year of implementation is now complete.

The **Application Review Committee (ARC)** administers the SCRs, which can be initiated in three ways:

- **Randomly:** Periodic, randomly chosen checks of compliance. This option was specifically introduced to help meet the 10% minimum threshold.
- **Voluntarily:** A provider self-selects for review.
- **For Cause:** Initiated when a complaint may be filed or when the ARC has a concern alleging non-compliance.

The ARC initiated a total of **16 SCRs in 2025** (see subsection below, Standards Compliance Reviews, for more details). This effort successfully monitored **5% of all active listed providers**, meaning the Board is currently on track to meet the statutory requirement. Of the 16 reviews, **14 were random SCRs.** This high volume of random reviews demonstrates the successful implementation of the administrative and technical resources required to launch the new compliance system. The SOMB will continue to conduct SCRs to achieve the 10% biennial requirement, with a formal review of the process and policies planned after two years of implementation to identify any needed refinements.

Statutory Standards and Policy Updates

In addition to the multi-step projects discussed above, the remaining provisions of SB 23-164 required direct revisions to the *Adult and Juvenile Standards and Guidelines*. As highlighted in **Table 15**, these revisions involved updating terminology, strengthening language concerning treatment responsivity, and clarifying administrative processes to align the SOMB's operational framework with the new statutory mandates.

Table 15. Revisions to Standards and Guidelines for Statutory Alignment with SB 23-164

Statutory Requirement	SOMB Policy Revisions
Supervising Officer Accountability (§16-11.7-106(8)): Officers must follow standards; agencies must develop accountability for non-compliance.	• Developed accountability measures by establishing Memorandums Of Understanding (MOUs) with relevant entities and publishing complaint information on our website.
Provider Selection Flexibility (§16-11.7-105(2),(3)): Repeals limit on provider options; requires specific, comprehensive referrals based on client needs and geographic proximity. Includes requirements for DD/ID referrals and DYS change procedures.	• Amendments to *Adult Standards and Guidelines 5.110, 5.115.* and *5.120*. Approved: April 2025. Effective: July 2025. • Amendments to *Juvenile Standards and Guidelines* 5.201, 5.20, 5.610 and 5.610 DD/ID. Approved May 2025. Effective July 2025.
Administrative Updates (§16-11.7-106(2)): Update fingerprint process (third-party vendor); repeals DORA's list publication duty.	• Updates to *Adult Standards and Guidelines* 4.100. Approved May 2025. Effective July 2025. • Update to DORA requirement action.

Statutory Requirement	SOMB Policy Revisions
Treatment Responsivity (§16-11.7-103(4)(b)(I)): Treatment must be responsive to client's developmental status, race, culture, sexual orientation, etc.	• Amendments to *Adult Standards and Guidelines* 3.163 and 3.164 language, culture, and use of interpreters for treatment providers. Approved: May 2025. Effective: July 2025. • Amendments to *Juvenile Standards and Guidelines* 2.300 and 3.000 regarding language, culture, and use of interpreters for treatment providers. Approved: Fall 2022. Effective: July 2023.
Definition Updates (§16-11.7-102): Updates definitions for adult/juvenile sex offenders; clarifies when a person with a prior offense is classified as a sex offender.	• *Juvenile Standards and Guidelines*. Introduction updated March 2024. • *Adult Standards and Guidelines* update pending.

Strategic Planning Initiative

To establish the Board's future **direction and priorities**, the SOMB conducted a Strategic Planning Initiative centered on a full-day retreat on August 15, 2025. This planning was timely as it anticipates the upcoming 2028 Sunset Review. This retreat was intentionally designed as a foundational step for developing a new strategic plan, not to produce a finalized plan itself. The session was facilitated by consultants, drawing on existing data, provider feedback, and system observations.

Building on Established Frameworks: The strategic themes addressed in this initiative—such as workforce capacity, role clarity, and modernization—are consistent with priority areas previously identified by the SOMB. However, the 2025 retreat represents a distinct evolution in the Board's operational scheme. Following targeted improvements implemented in 2019 and 2023, the Board is now moving beyond isolated adjustments to address the broader framework of these enduring challenges.

This initiative acknowledges that while previous efforts laid the groundwork, a modernization of the approach is required to fully resolve complex issues collaboratively. By strategically centering current insights within the context of past lessons-learned, the goal is to support the SOMB in transitioning to an integrated strategy that solidifies the Board's readiness for the future.

Phase I: Pre-Planning and Data Sourcing

Preparation for the retreat focused on collecting current, critical data from stakeholders to ensure the plan was informed by real-world system challenges:

- **Provider Survey:** The SOMB distributed an online survey to capture the current realities, challenges, and priorities experienced by providers under its purview, ensuring provider perspectives directly informed the strategic planning process.

- **Stakeholder Interviews:** Interviews were conducted with key stakeholder groups (e.g., treatment providers, Board members, etc.) to gather useful and relevant qualitative information, which was then compiled into thematic insights for discussion.

Phase II: Retreat Session and Key Findings

The facilitated session combined presentations with discussions organized around four strategic themes: (i) **Collaboration**, (ii) **Training, Tools, and System Modernization**, (iii) **Emerging Trends and Innovation, and (iv) Systemic Responsiveness**; see **Tables 16-19**. Key issues and future actions to explore under each theme were:

- Collaboration and Engagement

Table 16. Potential Collaboration and Engagement Strategic Issues

Issue	Action to Explore / Investigate
Lack of internal role clarity for Board members, particularly those whose professional roles are external to the sex offense-specific field.	**Investigate** and define roles and responsibilities for all Board members. Examine and improve the onboarding process and succession planning to retain expertise.
Insufficient communication about ongoing committee work.	**Standardize** the Board agenda to include a brief, structured update from each committee at monthly meetings.
Need for increased collaboration and support among providers regarding difficult case issues.	**Explore** restructuring ARC reports to add a focus on common provider struggles and share successful resolutions. Expand ARC's role to include a teaching and implementation support goal.
Lack of continuity of care due to **barriers in interagency record sharing**.	**Investigate** and make recommendations regarding interagency record sharing (e.g., discharge summaries, assessments, police reports) to increase client continuity of care.

Note: ARC is the Application Review Committee.

B. Training, Tools, and System Modernization

Table 17. Potential Training, Tool, and System Modernization Strategic Issues

Issue	Actions to Explore / Investigate
High administrative burden from existing tools (i.e., PDMS, SONICS) serves as a barrier to recruitment and retention.	**Investigate** and implement system streamlining measures for PDMS and SONICS. Develop on-demand video training and an automated certificate upload feature to reduce provider administrative work.
Barriers to provider recruitment and retention persist.	**Explore** grant opportunities or sponsorships for students or interns as a recruitment tool. Identify and address key barriers to retention.
Need for increased accountability and training for Clinical Supervisors.	**Investigate** and implement a requirement for mandatory Clinical Supervisor training.
ARC is viewed as purely **regulatory rather than incorporating a supportive role**.	**Explore** expanding ARC's role to include **teaching as well as regulatory components**. Explore disseminating regular ARC findings on trends (discipline, recruitment, attrition) to increase transparency.

Note: PDMS is the Provider Data Management System; SONICS is the Sex Offending Needs Integrated Classification System; ARC is the SOMB Application Review Committee.

C. Emerging Trends and Innovation

Table 18. Potential Emerging Trends and Innovation Strategic Issues

Issue	Action to Explore / Investigate
SOMB's tendency to be **reactive rather than proactive** regarding research and standards changes.	**Formalize** a process to proactively evaluate, pilot, and potentially integrate new interventions and technologies (e.g., an Innovation Focus Group or clear variance pathway).
Significant gap in the standards regarding **guidance for working with special populations** (e.g., women, LGBTQ+, neurodivergent).	**Identify** supporting research and create guidance or revise standards to clarify how this work fits within SOMB requirements.
Field needs to **adopt emerging risk assessment tools** as they become validated and address additional areas of assessment (e.g., CPORT and SAPROF-SO).	**Explore** how additional risk and protective factor assessment tools can be supported for use by providers. Explore whether additional training on their use is feasible and warranted.
Need to clarify the degree of flexibility allowable in the standards and the **process for integrating innovation**.	**Increase** messaging about standards flexibility and the process for requesting a variance to allow cutting-edge programs to develop.

Note: CPORT is Child Pornography Offender Risk Tool; SAPROF-SO is Structured Assessment of Protective Factors Sex Offender Version.

D. Systemic Improvements

Table 19. Potential Systemic Improvements Strategic Issues

Issue	Action to Explore / Investigate
Strategic Posture and Education of External Stakeholders: Addressing SOMB's reactive stance and identity.	Shift SOMB's operational mode from reactive to proactive concerning emerging trends and statewide policies. This involves SOMB rebranding to clarify its mission, scope, and role, and then using this to educate key stakeholders (e.g., the bench, legislators) to foster understanding rather than defensiveness.
Workforce Capacity (Recruitment, Retention, and Funding): ensuring the sustainability of providers doing this work.	Address the decline in approved providers by exploring strategies for bringing new professionals into the field, such as grants or internships for students and interns to gain experience. Identify and address key barriers to retention, including low pay, rising cost of liability insurance, and increasing risk of burnout. Determine if SOMB can act as an information broker for provider funding opportunities.
Regulatory Burden and Flexibility: Streamlining standards and reducing administrative stress to support providers and teams.	Reduce the regulatory burden providers face from multiple bodies (DORA, SOMB). Review the SOMB Standards to address the over-reliance on "shalls" versus "shoulds" to allow more flexibility. Ensure the ARC both holds providers accountable and supports them through changes.

Issue	Action to Explore / Investigate
Victim Representation and Stakeholder Engagement: Enhancing collaboration and system transparency.	Improve access to victim representation in mandated teams (MDT/CST) by collaborating with regional victim advocacy organizations. Pursue proactive outreach to external stakeholders, including legislators (early engagement) and judicial partners (conference presentations), to address multi-systemic issues. Ensure better dissemination and implementation of information and training on SOMB's actual scope and provider roles.

Note: DORA is the Department of Regulatory Authority; MDT is the Multidisciplinary Team (i.e., treatment provider, supervising officer, victim representative); CST is the Community Supervision Team (i.e., juvenile treatment provider, supervising officer, victim representative).

Phase III: Next Steps and Strategic Priorities

To complete the strategic planning, the SOMB will:

- Clarify and refine the priority areas identified by the workgroups at upcoming Board meetings.
- Produce a final strategic planning report incorporating these findings to guide the Board's work toward the 2028 Sunset Review.

Efforts Toward Individually Responsive Care

The SOMB continues to emphasize individually responsive care as part of implementing a RNR informed model across its operations through policy revisions, training, and organizational commitments.

Standards and policy strengthening included:

- **Mandated Responsiveness:** Language in the *Adult and Juvenile Standards and Guidelines* was strengthened to align with the SB 23-164 mandate, requiring treatment to be responsive to the client's full range of characteristics: **linguistic, cultural, religious, racial, sexual orientation, gender identity, and gender expression**.
- **Interpreter Use:** Revisions were completed to strengthen sections on Language, Cultural, and Ethnic considerations, including amendments regarding the **use of interpreters**.
- **Training Requirement:** All training applications must include how cultural responsiveness will be addressed in the proposed training.

Training and organizational commitments included:

- **Targeted LGBTQ+ Training:** In partnership with the DVOMB, the Board hosted a **two-day training** focused on working with clients who are part of the **LGBTQ+ community**.
- **Annual Conference Sessions:** The ODVSOM conference dedicated sessions to working effectively across the diversity present among client groups, covering topics such as: cultural responsiveness with Native American clients and communities, practising with **cultural humility**, advanced female offender evaluation, understanding the experience of developmentally/intellectually disabled offenders in prison, and **intergenerational trauma**.

- **Cultural Awareness:** Guest speakers were hosted at SOMB meetings to honor **cultural heritage** months and promote responsive interventions.

- **Diverse Recruitment:** The SOMB actively seeks to recruit diverse members whose composition ensures broad representation of experience and thought across the Board and committees. The SOMB in partnership with the DVOMB, has invested in a **provider recruitment strategy** designed to attract providers from a diverse range of identities and cultural backgrounds.

Provider Recruitment Strategy

To address the need for p**rovider workforce sustainability and responsiveness** within the **SOMB** and DVOMB, the **ODVSOM** launched a multiphase recruitment project in **2022** in partnership with Orange Circle Consulting (Orange Circle). This initiative was prompted by a steady decline in approved provider numbers, raising concerns about the l**ong-term stability of the workforce** and its capacity to ensure comprehensive client care. The project supports the priorities of both Boards by pursuing two key goals: (i) building a sustainable pipeline of providers and (ii) recruiting individuals with broad backgrounds and experiences to better reflect and respond to the needs of clients and communities.

Phase One: Research and Insights (2022). This phase focused on **formative research** with potential recruits and current stakeholders. Findings, summarized in the **SOMB 2023 Annual Legislative Report**, guided the development of inclusive recruitment strategies and resources designed to reach a broader pool of candidates and attract providers whose backgrounds reflect the client populations served.

Phase Two: Outreach Strategy Development (2024). Launched in 2024, the second phase centered on developing **targeted outreach strategies**. Orange Circle tested messaging that highlighted the missions of the **SOMB** and **DVOMB**, their role in public safety, and the meaningful impact of provider work with individuals who perpetrate sexual violence and domestic violence. Input from different focus groups with key audiences informed the design of tailored recruitment strategies.

Phase Three: Recruitment Tool Development and Testing (2025). Building on prior research and strategy development, 2025 focused on **producing and piloting recruitment tools**:

- **Provider Video:** Developed with current Approved Providers to showcase clinical work and highlight the benefits of becoming a provider.

- **Customizable Slide Deck:** Designed to promote the work of both Boards and encourage interest in the treatment field.

- **Field Testing:** Both tools were piloted by Board members and ODVSOM staff in graduate-level human services courses, demonstrating effectiveness in academic settings.

- **Supplemental Video:** Featuring diverse providers sharing their experiences, further enriching the recruitment toolkit.

Next Steps: The final phase will train Clinical Supervisors to lead presentations drawing on their own experiences. Colleges and universities with strong student engagement may become partners in developing formal pathways to SOMB or DVOMB approval. SOMB and DVOMB staff will also be encouraged to integrate these resources into existing presentations when appropriate.

Community and Stakeholder Outreach

Round Tables

The SOMB held **four roundtables in 2025** in **Fort Collins** (January), **Boulder** (June), **Montrose** (September), and **Weld** County (October). The Montrose roundtable focused specifically on juvenile providers and MDTs. 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. 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.

Stakeholder Engagement and Training Initiatives

The SOMB also facilitates community outreach and relationship building through a **comprehensive annual training program and accessible meetings**. Training was conducted with a range of key partners, including **Judicial staff**, **Community Corrections Boards and staff**, the **Parole Board**, and **Law Enforcement** throughout the year. These efforts were designed to ensure consistent knowledge of standards, foster cross-discipline understanding, and build stronger working relationships across the field. In addition, all SOMB monthly, committee, and workgroup meetings are explicitly **open to all stakeholders and the public** and offered **online or in a hybrid format** to reduce geographical, time, and logistical barriers to participation, encouraging broader engagement from our community partners.

Policy and Regulatory Work

The **SOMB** executes its core functions, including policy and implementation review, primarily through its network of committees. These committees serve as the primary forum for discussing and reviewing policy and implementation matters. To maximize accessibility, meetings are open to the public and conducted in either an **online or hybrid format**, ensuring broad participation from **appointed SOMB members**, program staff, and relevant **stakeholders**. The committees update the Board about their progress and present proposals to address policy and practice issues at **monthly Board meetings**.

All committees base their policy recommendations on advancements within the **sex offender treatment and management field**. When developing their proposals, they cover a broad spectrum of policy and practice issues. These proposals often involve:

- Recommendations for revisions to the *Adult and Juvenile Standards and Guidelines* and to address emerging research or issues raised by the field.
- Suggestions for **white papers, policy briefs, resource documents, or training initiatives** designed to support best practices.

Crucially, when proposing changes to the *Standards and Guidelines*, the committees support their recommendations with **current research and established best practices**. They also proactively suggest methods for educating providers, CSTs and MDTs, and other stakeholders to ensure the effective implementation of *Standards and Guidelines* across the state.

Committees

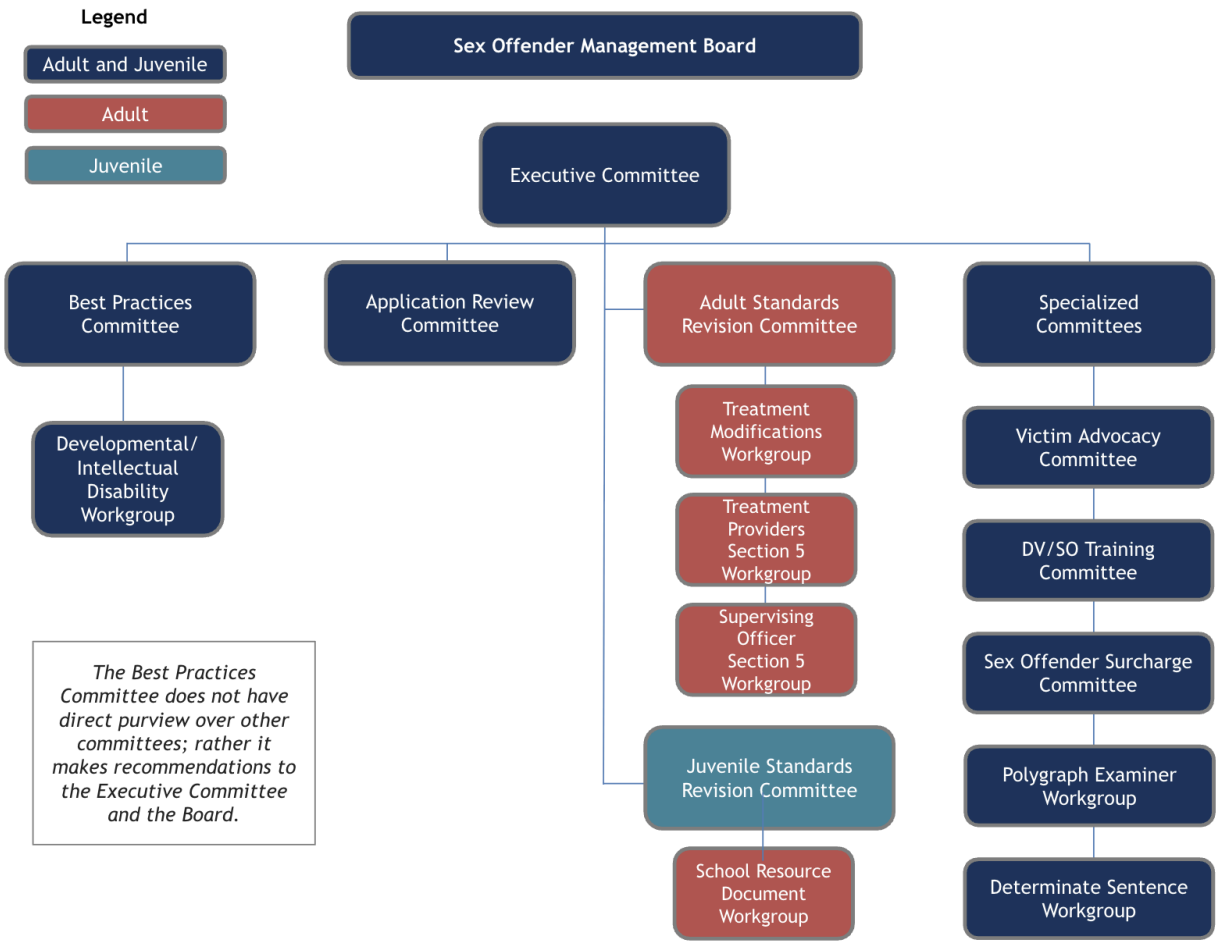
The SOMB staffed **16 active committees and workgroups** during 2025, as shown in **Figure 17**, to work on statutorily mandated duties. All committees were open to all stakeholders.

The committees were:

- Executive Committee
- Best Practices Committee
    a. Developmental Disability and Intellectual Disability Workgroup
- Application Review Committee
- Adult Standards Revisions Committee
    a. Treatment Modifications Workgroup
    b. Treatment Providers Section 5 Workgroup
    c. Supervising/Parole Officers Section 5 Workgroup
- Juvenile Standards Revision Committee
    a. School Resource Document Workgroup
- 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 E provides a summary of the main work of each committee and workgroup in 2025.

Figure 17. SOMB Committees and Workgroups Structure, 2025



Applications for the SOMB Approved Provider List

Sex offense-specific evaluation and treatment require advanced clinical skill, sound professional judgment, and adherence to evidence-based practices. Given the complexity of sexual offending and the importance of community safety, **Approved Providers must demonstrate specialized training, competencies, and experience** in assessment, treatment, and risk management**.** Under **§ 16-11.7-106, C.R.S.**, only **SOMB Approved Providers** may conduct court-ordered or post-conviction sex offense-specific evaluations, treatment services, or polygraph examinations in Colorado.

Provider Qualification Framework

Provider qualification requirements are outlined in **Section 4.0** of the SOMB *Adult and Juvenile Standards and Guidelines*. The SOMB approves three provider types—**treatment providers**, **evaluators**, and **polygraph examiners**—for both adult and juvenile populations. Providers progress through tiered approval levels: **Associate** and **Full Operating** Levels for all provider types, with an additional **Clinical Supervisor** level for treatment providers and evaluators. Specialized approval is required for working with individuals with intellectual and developmental disabilities.

The approval process is grounded in a **Competency-Based Model (CBM)**, which evaluates providers across broad professional practice domains. Providers at the early levels practice under the structured oversight of a **Clinical Supervisor** until they demonstrate sufficient competence and readiness for independent practice. **Placement on the Approved Provider List confirms that a provider has met the required training and competency expectations**; however, this designation is **not a professional license** and **does not mandate a uniformity of provided services** or guarantee of referrals.

2025 Submissions and Outcomes

Table 20 shows that the ARC received **335** applications for initial listings, status upgrades, and renewals—a **23% increase** over the 273 applications submitted in 2024.

The **ARC approved 256 applications** during the reporting period, including both new submissions and applications carried over from the previous year:

- **Initial listings:** 76 (up from 49 in 2024)
- **Status upgrades:** 66 (up from 51 in 2024)
- **Renewals:** 114 (up from 82 in 2024)

At the end of 2025, **88 applications remained pending**. "Pending" refers to applications awaiting completion, staff review, or ARC review due to factors such as recent submission, missing or incomplete information, the need for additional work products, or a provider's request to defer review.

Table 20. Count of SOMB Applications, 2025

Application Type	Number Submitted[a]	Number Approved	Number Pending[b]
Application 1 (Initial Listing)	102	76	23
Application 2 (Status Upgrade)	86	66[c]	24
Application 3 (Renewal)	147	114[d]	41
Total	**335**	**256**	**88**

Source: **SOMB** Provider Data Management System.

a. This includes submitted applications that expired, were missing information, or were denied.
b. Pending refers to applications that are pending completion, staff review, or ARC review.
c. Ten applications were approved with conditions.
d. Two applications were approved with conditions.

Current Availability of SOMB Approved Providers

Colorado's SOMB Approved Provider List includes providers approved to offer treatment, evaluation, or polygraph services for either adult or juvenile populations. Providers may be approved at the Associate or Full Operating Levels and may obtain additional specialty listings, such as Clinical Supervisor or intellectual and developmental disabilities. Because providers can hold multiple listings, the numbers of approved providers in each service area represent **approvals**, not distinct individuals. For example, many adult-approved providers are also approved to work with juveniles, and a single provider may hold up to **eight** different listings.

A **point-in-time (snapshot)** count on November 1, 2025—presented in **Tables 21a and 21b**—shows the number of adult and juvenile Approved Providers by service listing. The snapshot indicated:

- **223** providers were approved for **adult treatment services.**
- **183** providers were approved for **juvenile treatment services.**
- **24** polygraph examiners were approved to work with adults; **12** of whom were also approved for juvenile services.
- **325** individual providers appeared on the list overall (down from **331** in 2024).

Approved Providers also list the counties in which they offer services. **Figures 18 through 23** show the distribution of adult and juvenile Approved Providers across Colorado counties. Providers were located in **all 23 judicial districts** across the state.

Table 21a. Count of SOMB Approved Adult Sex Offender Service Providers in Colorado, 2025

Service Listing	Associate Level	Full Level	Total
Adult Treatment Provider	**88**	**135**	**223**
Treatment Provider DD/ID	*21*	*30*	*51*
Clinical Treatment Supervisor	*N/A*	*75*	*75*
Clinical Treatment Supervisor DD/ID	*N/A*	*18*	*18*
Adult Evaluator	**41**	**62**	**103**
Evaluator DD/ID	*8*	*13*	*21*
Clinical Evaluator Supervisor	*N/A*	*34*	*34*
Clinical Evaluator Supervisor DD/ID	*N/A*	*9*	*9*
Adult Polygraph Examiner	**1**	**23**	**24**
Polygraph Examiner DD/ID	*1*	*11*	*12*

Source: **SOMB** Provider Data Management System.
DD/ID indicates developmental disability/intellectual disability listing.

Table 21b. Count of SOMB Approved Juvenile Sex Offender Service Providers in Colorado, 2025

Service Listing	Associate Level	Full Level	Total
Juvenile Treatment Provider	**48**	**99**	**147**
Treatment Provider DD/ID	*9*	*18*	*27*
Clinical Treatment Supervisor	*N/A*	*55*	*55*
Clinical Treatment Supervisor DD/ID	*N/A*	*13*	*13*
Juvenile Evaluator	**20**	**35**	**55**
Evaluator DD/ID	*2*	*6*	*8*
Clinical Evaluator Supervisor	*N/A*	*18*	*18*
Clinical Evaluator Supervisor DD/ID	*N/A*	*4*	*4*
Juvenile Polygraph Examiner	**2**	**11**	**13**
Polygraph Examiner DD/ID	1	5	6

Source: **SOMB** Provider Data Management System.
DD/ID indicates developmental disability/intellectual disability listing.

Figure 18. SOMB Adult Treatment Providers by County, 2025. Data table, Appendix F.1

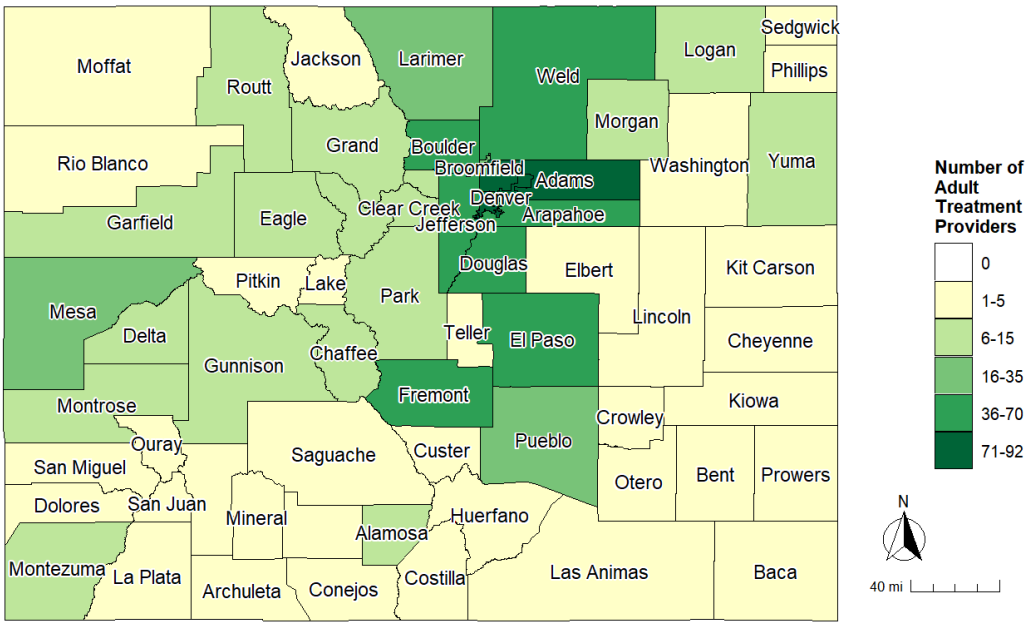


Figure 19. SOMB Juvenile Treatment Providers by County, 2025. Data table, Appendix F.1

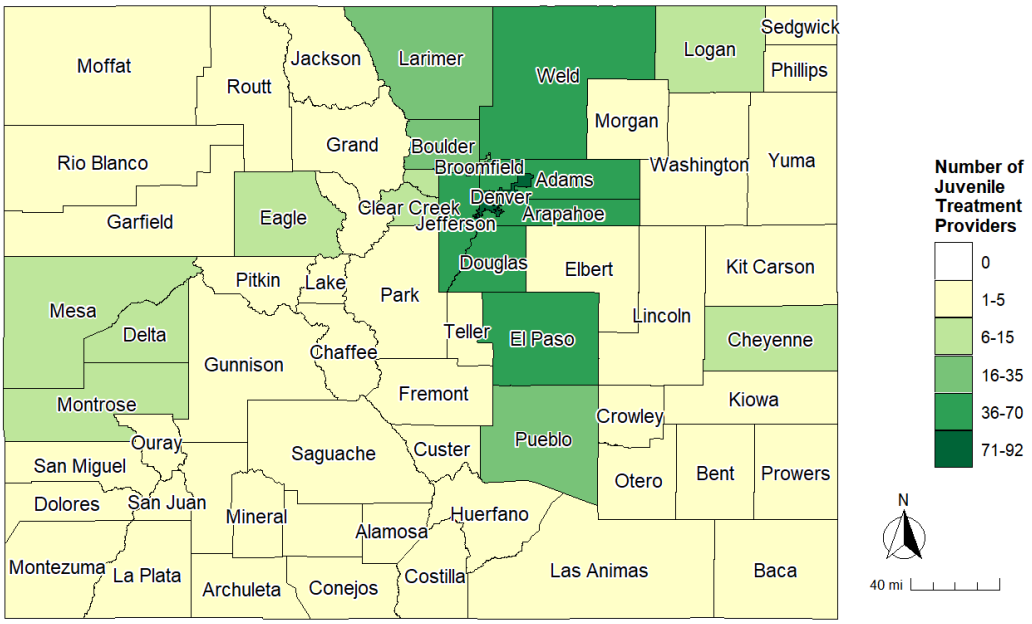


Figure 20. SOMB Adult Evaluators Providers by County, 2025. Data table, Appendix F.1

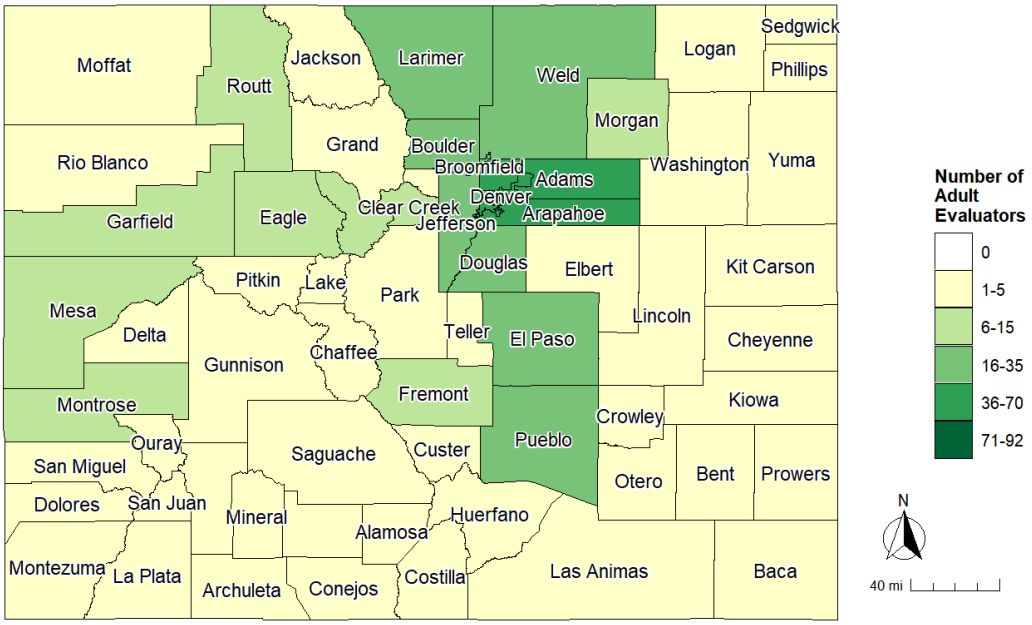


Figure 21. SOMB Juvenile Evaluators by County, 2025. Data table, Appendix F.1

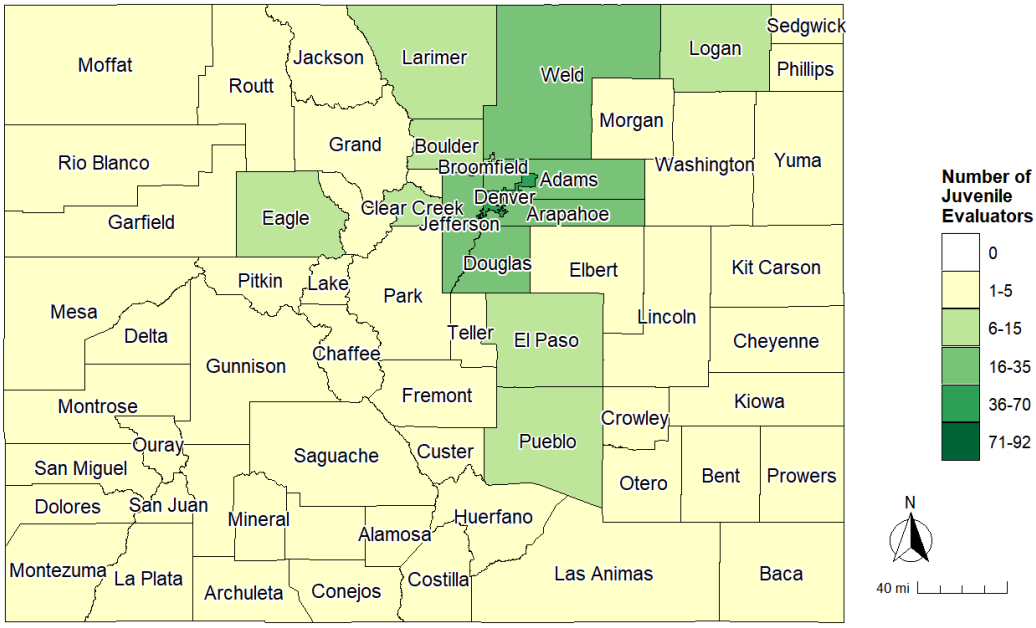


Figure 22. SOMB Adult Polygraphers by County, 2025. Data table, Appendix F.1

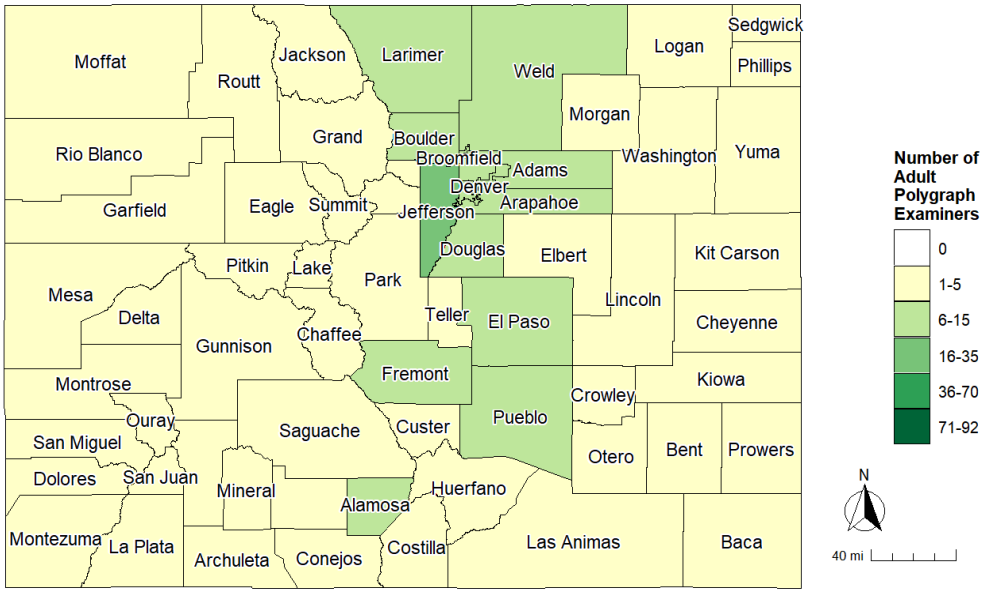
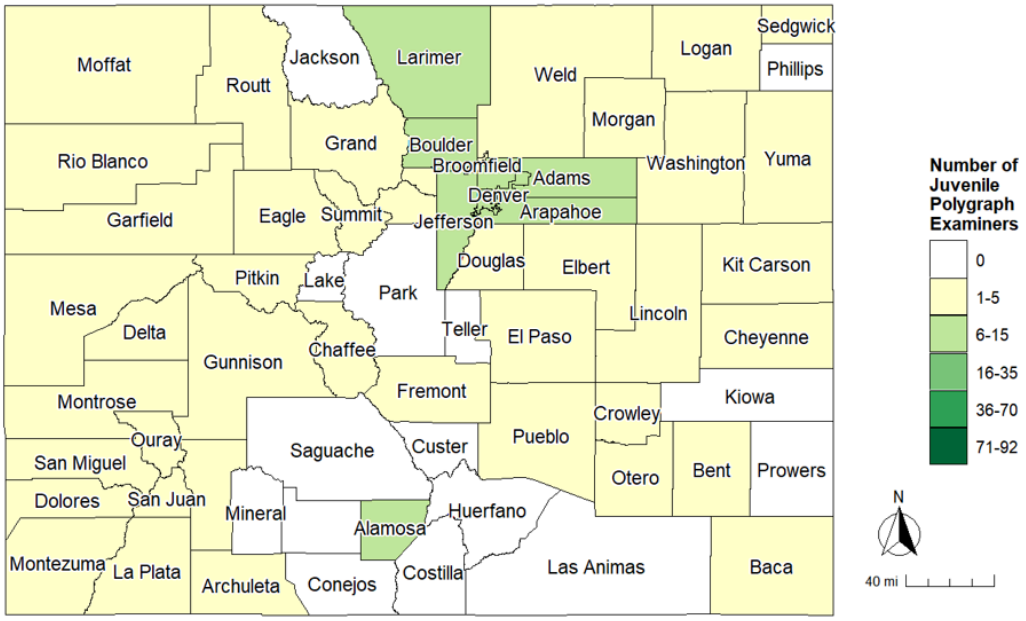


Figure 23. SOMB Juvenile Polygraphers by County, 2025. Data table, Appendix F.1



Complaints Received Against Providers

The *Adult and Juvenile Standards and Guidelines, Appendix A: Administrative Policies, Section C (Complaint Against A Listed Provider)*, establishes the formal process for addressing concerns about Approved Providers. **Complaints may be submitted by various stakeholders** (victims, offenders, probation, community members, etc.) if a provider's conduct is believed to violate the respective *Adult or Juvenile Standards and Guidelines* or professional license requirements. The **SOMB** has statutory authority (**§ 16-11.7-106(7), C.R.S.**) to review complaints through the ARC and must forward them to DORA. The **SOMB's** authority is limited to complaints concerning individuals who were Approved Providers at the time of the alleged violation. All complaint outcomes include a structured process for **reconsideration and appeal**.

Upon review, complaints may be categorized as follows:

- **Dismissed**: A complaint is **dismissed** if it falls **outside the Board's jurisdiction or does not substantially allege a standards violation**. For example, a complaint filed against an individual who is not a **SOMB** Approved Provider, or one related to billing practices rather than a standards violation, would be dismissed.

- **Unfounded**: A complaint is deemed **unfounded** if it is **not supported by evidence**, and no violation is recorded. For example, a complaint alleging that a provider failed to disclose sharing concerns with the supervising agent may be unfounded if the signed treatment contract clearly documents this requirement.

- **Founded**: A complaint is **founded** when **evidence supports the allegation, resulting in formal action and a recorded violation**. For example, a provider who fails to develop a treatment plan is in clear violation of standards, leading to corrective action and a recorded violation.

As shown in **Table 22**, in 2025 the **SOMB** received 22 complaints against 17 Approved Providers. By the end of 2025, 1 was dismissed, 8 were unfounded, **7 were founded**, and 6 were pending review. Additionally, resolution efforts continued on 2 complaints against 2 providers carried over from 2024.

Table 22. Count of SOMB Provider Complaints and Outcomes, 2025

Outcome	Complaints Received in 2025	Complaints from 2024 Resolved in 2025[a]
Dismissed	1	0
Unfounded	8	2
Founded	7	0
Pending	6	0
Total	**22**	**2**

Source: **SOMB** Provider Data Management System.

Standards Compliance Reviews (SCRs)

SCRs are a formal process conducted by the ARC to verify Approved Provider adherence to the respective *Adult and Juvenile Standards and Guidelines*. Pursuant to **§ 16-11.7-103(4)(h.5), C.R.S.**, the ARC is required to conduct compliance reviews **on at least 10%** of SOMB Approved Providers every two years. This requirement was established by the SOMB reauthorization bill (SB 23-164) and became effective on **September 1, 2024**. Accordingly, the current reporting period represents the **first year of implementation** of the biennial SCR requirement.

SCRs can be initiated in three ways:

- **Voluntarily**: A provider self-selects for review.
- **Randomly**: Periodic, randomly chosen, checks of compliance.[14]
- **For Cause**: Initiated when sufficient information or a potential complaint may be filed alleging non-compliance in accordance with Appendix A of the *Standards and Guidelines*.

The intensity of SCRs falls into one of three levels, commensurate with the direction given by the ARC:

- **Level 1, Implementation Verification**: Evaluates administrative, training, or MDT/CST consultation.

[14] Providers who elect a voluntary SCR or are randomly selected, and found to comply with the applicable *Standards and Guidelines*, are exempt from another random selection for the next six years.

- **Level 2, Work Product Review**: Adds the evaluation of written documents, such as offender evaluation summary reports, treatment plans, and discharge summaries.
- **Level 3, Site Visit and File Review**: Adds a comprehensive audit that includes Level 2 requirements plus a review of client files and observation of services.

Upon review, the ARC can reach one of four main determinations, which are communicated to the Approved Provider in writing within 7 days. The outcomes are:

5. **Successful Compliance**: Approval for continued placement with no further action required.
6. **Innovative Practice Identified**: A best or innovative practice identified, potentially leading to an increase in the provider's practice level.
7. **Violations Found**: The provider is typically offered a Compliance Action Plan (CAP) to systemically resolve the issues. The practice level may be retained or temporarily reduced while the CAP is in effect.[15]
8. **Administrative Action**: Failure to comply with a CAP, or inability to resolve the founded violations, can result in further administrative action, including a recommendation that a formal complaint be opened by the **SOMB** and forwarded to **DORA**.

As detailed in **Table 23**, the ARC initiated a total of **16 SCRs in 2025**. This collective effort monitored **5%** of all active listed providers, thereby being on track to meet the biennial statutory requirement to review at least 10% of active providers.

Table 23. Count of SOMB Standards Compliance Reviews Initiated, 2025

SCR Type	2025
Voluntary	0
Random	14
For Cause	2
Total	**16**

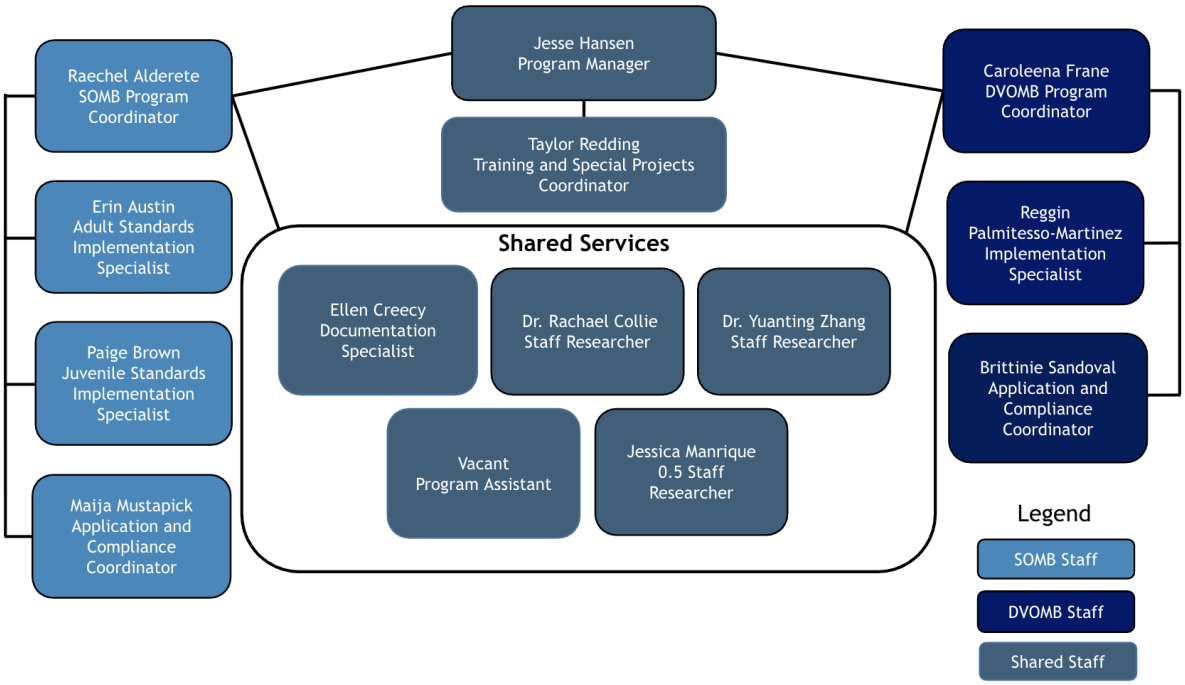
Source: **SOMB** ARC Records.

Update on the ODVSOM Shared Services Model

The ODVSOM provides **unified**, **professional staff support** for both the **SOMB** and the **DVOMB** as shown in **Figure 24**. Staff members, **many holding advanced degrees**, offer specialized expertise crucial for statewide implementation of evidence-based policy, training, and oversight. Formed in **2016** by merging previously separate staff teams, the office aimed to **reduce duplication and improve efficiency** while respecting each Board's distinct legal authority. The model was further refined and implemented in **2023** to address the growth in specialty listings, the increasing complexity of the *Standards and Guidelines*, and additional legislative mandates.

[15] Resolved violations from Voluntary and Random SCRs remain confidential; For Cause SCR violations are public record.

Figure 24. ODVSOM Shared Services and Organizational Chart, 2025. Data table, Appendix F.2



The current **Shared Services Model** (see **Figure 24**) centralizes administrative, planning, and research functions while designating **specialized roles** to ensure accountability to both Boards. Each role leverages advanced professional expertise to enhance efficiency, oversight, and statewide impact:

- **Program Manager** provides executive-level leadership, integrating staff functions, coordinating strategic initiatives, and ensuring consistent and effective support for both Boards in meeting legislative and stakeholder expectations.
- **Program Coordinators** provide high-level administrative and strategic leadership for each Board, maintaining a comprehensive view of operations, ensuring alignment with statutory mandates, and managing stakeholder engagement and Board processes.
- **Implementation Specialists** lead technical revisions to the *Standards and Guidelines*, staff Board committees, and deliver specialized technical assistance to multidisciplinary teams, ensuring fidelity to best practices.
- **Application and Compliance Coordinators** oversee provider application and renewal processes, support the ARC, and manage SCRs to uphold statewide accountability.
- **Training and Special Projects Coordinator** designs and administers professional development initiatives, including coordination of the statewide annual conference, and expands training opportunities for providers and stakeholders.
- **Researchers** manage provider databases, conduct research and special projects, complete literature reviews, and support working groups with analytical and subject matter expertise. They also prepare legislative reports and provide evidence-informed analysis to guide policy and standards development.

- **Administrative Personnel** provide skilled operational support, streamlining record management, refining administrative processes, and ensuring efficient day-to-day functioning of the office.

This **highly qualified and role-specific staffing model** enables the **ODVSOM** to operate as a professional, research-informed, and responsive entity, equipped to support the full scope of Board mandates.

Ongoing Implementation

The implementation process ensures that Approved Providers understand and adhere to the applicable *Adult* and *Juveniles Standards and Guidelines*, while also supporting the effective functioning of the MDTs and CSTs. Implementation is supported through four key elements: **communication**, **training**, **resource development**, and **technical assistance**.

Communication: The SOMB continues to notify Approved Providers, members of the MDTs/CSTs and stakeholders of the Board's work and implications through **monthly Bulletins** and a **Quarterly Newsletter**. To strengthen relationships and gather direct feedback, the SOMB has also launched **statewide roundtable discussions** (see Stakeholder and Community Outreach subsection). These sessions enhance collaboration among providers and MDTs/CSTs and offer valuable insights that inform the Board's ongoing work.

Training and Technical Assistance Hub: A key resource on the website describes core and specialty/advanced training provided by the SOMB, including how to access or request training. The SOMB considers training requests from subject matter experts and stakeholders who identify a need. Pre-recorded webinars are also available.

Training: Regular training is provided through:

- **Introductory Training:** Accessible both in-person and online.
- **Lunch-and-Learn Webinars:** 90-minute sessions offered every two months.
- **Advanced Series:** Full-day training delivered by subject-matter experts.
- **Monthly Technical Assistance Hours:** Opportunities for providers to network and consult with Implementation Specialists.

Website and Documents: Ongoing efforts focus on enhancing the **accessibility of documents** on the SOMB website.

Standards and Guidelines Implementation: The SOMB continues to work on streamlining the implementation timeline for revisions to the *Adult* and *Juvenile Standards and Guidelines*.

Research Support: The SOMB informs the ongoing work of its committees and the Board by providing **research literature reviews** and conducting **research analyses**.

Training Delivery

In 2025, the SOMB provided **32 trainings** including the ODVSOM annual conference, reaching over **1,400 attendees** across Colorado. Over **500 stakeholders attended the ODVSOM annual conference**. 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 or adjudicated of sex offenses.

Training topics included:

- *SOMB 100 Introduction to Colorado Sex Offender Management*
- *SOMB 101* ***SOMB Standards Overview***
- *SOMB 102 Advanced Series: Standards and Policy Implementation*
- *Sexually Violent Predator (SVP) & Community Notification Training*
- SOMB **Accountability and Responsibility** Standards 3.500
- Working Effectively using the **SOMB TEAMS model**
- Individual Supervision Management Plan training (ISMP)
- **SOMB Polygraph Training**
- Peer Recovery Services Within CDOC and In The Community
- SOMB **Informed Supervision**
- SOMB Approved Supervision
- SOMB **Booster Training** for Judicial
- SOMB Roundtable Discussions
- SOMB Juvenile **Roundtable Discussion**
- Internet Use and Electronic Monitoring **Best Practices** for SOMB Providers
- Community Corrections Training: Collaboration for Client Success
- **SVP Training** for Judicial
- SVP Training for **State Parole Board**
- SOMB Supervision and Treatment Presentation for **Law Enforcement**
- Sex Offender Risk Assessment to Guide **Community Corrections** Decisions
- **Reducing Anxiety, Stress, and PTSD** for Counselors and Other Correctional Personnel
- The LATTICES Program for **High-Risk Criminal Clients**
- Sexual Abuser Risk of Sexual Abuse to Children **ROSAC Part 1 and Part 2**
- **Applied Behavior Analysis** Meets RNR: Foundations and Applications
- Ending Violence Against Women

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

Topics included:

- Human Trafficking
- Integrated Treatment for High-Risk Forensic Clients
- **Sexual Assault Awareness Presentation and Panel Discussion**
- From Pain to Purpose: Domestic Violence Awareness
- **DOC Support Education Program**
- Native American Heritage Month: Office of Missing and Murdered Indigenous Relatives

Summary of Year-End Accomplishments

The SOMB achieved significant milestones in 2025, continuing to address the new mandates in the **SOMB Reauthorization Bill (SB 23-164)**, while advancing ongoing work, stakeholder relationships, and strategic issues. Highlights include:

Implementation of SB 23-164 and Standards Updates

The SOMB made substantial progress in implementing the requirements of the reauthorization bill.

- **Standards Compliance Reviews (SCRs):** The SOMB implemented the new statutory requirement to conduct compliance reviews on a minimum of **10% of all Approved Providers every two years**, effective September 1, 2024. In 2025, the ARC initiated **16 SCRs** (14 of which were random reviews), successfully monitoring **5% of all active listed providers** and putting the Board on track to meet the biennial requirement.

- **Treatment Solutions Workgroup:** Launched in **August 2023**, this workgroup completed its responsibilities in early 2024, submitting the **Treatment Solutions Report** to the Joint Judiciary Committee on **February 1, 2024**. Key actions resulting from the report were implemented in 2024, and were reported in the SOMB 2025 Annual Legislative Report.

- **Direct Policy Revisions: Direct Policy Revisions:** Several revisions to the *Adult and Juvenile Standards and Guidelines* have been made to align with SB 23-164 and have completed the full policy-revision process. Any remaining required revisions are currently in progress.

- **Determinate Sentence Workgroup**: As detailed in Section 2, the SOMB continues to advance revisions to the parole release instrument for individuals convicted of sex offenses who are serving *determinate sentences*.

Strategic Planning and Future Direction

The SOMB conducted a **Strategic Planning Initiative** in August 2025, as a foundational step toward establishing the Board's future direction and priorities in advance of the 2028 legislative Sunset Review.

- **Data Collection:** Preparation involved gathering critical data, including a **Provider Survey** and **Stakeholder Interviews**, to inform the planning process.

- **Key Themes:** The planning retreat focused on four strategic themes: (i) **Collaboration**, (ii) **Training, Tools, and System Modernization**, (iii) **Emerging Trends and Innovation**, and (iv) **Systemic Improvements**.

- **Next Steps:** The Board will refine the identified priority areas and produce a final strategic planning report in 2026.

Provider Workforce and Stakeholder Outreach

The SOMB focused on strengthening its provider workforce and community engagement.

- **Provider Recruitment Strategy:** The SOMB continued a multi-phase recruitment project to strengthen and expand the pipeline of Approved Providers and address the recent downward trend in provider numbers. In 2025, the project developed and piloted recruitment tools—including a provider video and a customizable slide deck.
- **Community and Stakeholder Outreach:** The SOMB held **four statewide roundtables** in 2025 (Fort Collins, Boulder, Montrose, and Weld County) to improve collaboration between teams and gather feedback from Approved Providers and community members. The Board also facilitated comprehensive annual training for key partners including Judicial staff and the Parole Board.
- **Training Delivery:** The SOMB provided **32 trainings** in 2025, including the annual ODVSOM conference, collectively reaching over **1,400 attendees**. Training emphasized implementation of core standards as well as specialized topics such as working with high-risk individuals and reducing provider burnout.
- **Provider Applications and Listings:** The ARC received **335 applications** in 2025 (a 23% increase over 2024) for initial listings, status upgrades, and renewals. By year end, **256 applications** were approved and 81 remained pending. A point-in-time count showed **325 individual providers** on the Approved Provider list overall.
- **Complaints:** The SOMB received **22 complaints** against 17 Approved Providers in 2025. By year-end, **7 were founded**, 8 were unfounded, and 1 was dismissed, with the remaining complaints still under review.

Organization and Standards

- **Individually Responsive Care:** The SOMB invested in efforts toward individually responsive care, strengthening the *Adult and Juvenile Standards and Guidelines* language to require that treatment be responsive to a client's full range of characteristics (e.g., race, culture, sexual orientation). The Board also hosted training on working with the **LGBTQ+ clients**, female offenders, cultural humility, and **intergenerational trauma**.
- **ODVSOM Shared Services Model:** The **ODVSOM** continued to operate its shared services model, centralizing administrative and research functions to provide unified, professional staff support for both the SOMB and the DVOMB.
- **Committees:** The SOMB staffed **16 active committees and workgroups** throughout 2025 to work on statutorily mandated duties and review sections of the *Adult and Juvenile Standards and Guidelines*. All committee and workgroup meetings are open to stakeholders.

Section 4: Future Goals and Directions

The SOMB's mission is statutorily centered on **protecting victims and promoting public safety**. To fulfill this mission statewide, the SOMB works to support the **successful rehabilitation** of individuals convicted or adjudicated of sexual offenses through **effective treatment and risk management**, while balancing the needs of victims, their families, and the broader community. Over the past three decades, the knowledge base on sexual offending has evolved substantially. In response, the *Adult and Juvenile Standards and Guidelines*—long acknowledged as living documents—have required ongoing refinement. A core priority of the SOMB continues to be the **periodic revision and enhancement** of these sets of *Standards and Guidelines* to incorporate emerging research, evidence-based best practices, and lessons learned from the field. Revisions are also required to address concerns raised by stakeholders and **respond to legislative, societal, and technological developments**.

Looking ahead, the SOMB will continue to emphasize the central role of the **Risk-Need-Responsivity (RNR) model** in supporting rehabilitation and effective risk management, while also integrating the growing recognition of **protective factors**, the **desistance process**, and the Board's role in supporting **effective reentry and reintegration** to enhance long-term community safety. The SOMB will remain attentive to the unique needs of specialized populations—including individuals with intellectual and developmental disabilities, individuals assessed at the lowest and highest levels of risk, and those with complex trauma histories—by continuously refining **responsivity principles** within the *Adult and Juvenile Standards and Guidelines*. Additionally, the Board will maintain its commitment to **system cohesion and alignment** across SOTMP, community providers, probation, parole, and multidisciplinary partners so that treatment and risk management practices remain consistent across settings.

Strategic Goals and Initiatives

Over the next year, the SOMB will continue prioritizing its **statutory responsibilities** and supporting Approved Providers to implement the *Adult and Juvenile Standards and Guidelines* with fidelity. Key efforts include completing remaining requirements of the **SOMB Reauthorization Bill (SB 23-164)**, particularly the **finalization and implementation of the revised determinate sentence release instrument**, and continuing the rollout of **Standards Compliance Reviews (SCRs)**. A central organizational priority will be advancing and operationalizing the **Strategic Plan** developed through the 2025 strategic planning process. The SOMB will also maintain strong **stakeholder and community engagement** through statewide roundtables and other outreach efforts.

To support **evidence-based policy** and continuous improvement, the SOMB will expand its analysis of **recidivism and desistance data** and continue monitoring emerging research to ensure the *Adult and Juvenile Standards and Guidelines* remain aligned with current knowledge and best practices. This work will inform approaches to **individually responsive care** for diverse client subgroups, which remains a core focus. Finally, the SOMB will implement the resources and tools developed through the multi-phase **provider recruitment strategy** to strengthen the statewide provider workforce and enhance treatment and supervision capacity.

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Appendices

Appendix A: Study Statistical Results

A.1. Chi-Square Test of Association Between Beginning Risk-Need Level and Recidivism Rate (Count 830)

Recidivism Type	$x^2(4)$	p-value	Effect Size (ϕ)
Sexual	4.66	.324	.075
Violent	11.07	.026*	.116
Any	27.12	< .001*	.181

* significant finding

A.2. Logistic Regression Predicting Likelihood of Recidivism Based on Beginning Risk-Need Level (Count 830).

Recidivism Type	Odds Ratio (OR)	95% Confidence Interval	p-value
Sexual	1.59	1.00 - 2.53	.048*
Violent	1.38	1.13 - 1.68	.001*
Any	1.36	1.20 - 1.54	<.001*

* significant finding

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A.3. Chi-Square Test of Association Between End Risk-Need Level and Recidivism Rate (Count 830)

Recidivism Type	$x^2(4)$	P-value (2-sided)	Effect Size (ϕ)
Sexual	11.43	.022*	.117
Violent	25.74	<.001*	.176
Any	49.37	< .001*	.244

* significant finding

A.4. Logistic Regression Predicting Likelihood of Recidivism Based on End Risk-Need Level (Count 830).

Recidivism Type	Odds Ratio (OR)	95% Confidence Interval	p-value
Sexual	1.67	1.08 - 2.60	.021*
Violent	1.46	1.23 - 1.74	<.001*
Any	1.42	1.28 - 1.58	<.001*

* significant finding

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A.5. Logistic Regression Predicting Likelihood of Recidivism Based on Both Beginning and End Risk-Need Levels (Count 830)

Recidivism Type	Predictor	Odds Ratio (OR)	95% Confidence Interval OR	p-value
Sexual	Beginning Risk	1.30	0.74 - 2.12	.409
—	End Risk	1.52	0.92 - 2.49	.100
Violent	Beginning Risk	1.14	0.90 - 1.43	.274
—	End Risk	1.38	1.13 - 1.69	.001*
Any	Beginning Risk	1.14	.98 - 1.31	.084
—	End Risk	1.35	1.20 - 1.52	<.001*

* significant finding

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A.6. Logistic Regression Predicting Likelihood of Recidivism Based on Responsivity Factors

DDID (Count 831)

Recidivism Type	Odds Ratio (OR)	95% Confidence Interval	p-value
Sexual	3.52	0.75 - 16.57	.111
Violent	3.36	1.54 - 7.33	.002*
Any	2.67	1.45 - 4.91	.002*

* significant finding

Denial Level Start of Treatment (Count 831)

Recidivism Type	Odds Ratio (OR)	95% Confidence Interval	p-value
Sexual	1.23	0.68 - 2.32	.463
Violent	1.31	.99 - 1.73	.062
Any	1.23	1.03 - 1.47	.024*

* significant finding

Denial Level Treatment Discharge (Count 830)

Recidivism Type	Odds Ratio (OR)	95% Confidence Interval	p-value
Sexual	1.74	0.90 - 3.36	.100
Violent	1.60	1.18 - 2.17	.002*
Any	1.43	1.17 - 1.75	<.001*

* significant finding

Barriers to Progress: Lack of Social Support (Count 830)

Recidivism Type	Odds Ratio (OR)	95% Confidence Interval	p-value
Sexual	2.15	.65 - 7.10	.211
Violent	1.73	1.01 - 3.00	.046*
Any	1.34	.94 - 1.91	.106

* significant finding

Barriers to Progress: Client Factors (Count 830)

Recidivism Type	Odds Ratio (OR)	95% Confidence Interval	p-value
Sexual	4.02	.51 - 31.61	.186
Violent	1.88	.96 - 3.68	.065
Any	1.54	1.04 - 2.27	.030*

* significant finding

Barriers to Progress: Substance Use (Count 830)

Recidivism Type	Odds Ratio (OR)	95% Confidence Interval	p-value
Sexual	1.00	0.26 - 3.79	.995
Violent	2.10	1.23 - 3.58	.006*
Any	2.22	1.57 - 3.14	<.001*

* significant finding

Barriers to Progress: Lack of Community Engagement (Count 830)

Recidivism Type	Odds Ratio (OR)	95% Confidence Interval	p-value
Sexual	.78	.17 - 3.63	.749
Violent	1.52	.85 - 2.71	.154
Any	1.45	.98 - 2.12	.052

Any Current Adjunct (Count 831)

Recidivism Type	Odds Ratio (OR)	95% Confidence Interval	p-value
Sexual	1.90	.60 - 6.02	.279
Violent	1.58	.94 - 2.65	.084
Any	1.52	1.10 - 2.12	.012*

* significant finding

Current Adjunct: Mental Health Treatment (Count 831)

Recidivism Type	Odds Ratio (OR)	95% Confidence Interval	p-value
Sexual	2.33	.74 - 7.29	.147
Violent	1.74	1.02 - 2.94	.041*
Any	1.59	1.13 - 2.24	<.009*

* significant finding

Current Adjunct Treatment: Trauma (Count 831)

Recidivism Type	Odds Ratio (OR)	95% Confidence Interval	p-value
Sexual	2.36	0.51 - 11.00	.274
Violent	1.27	.52 - 3.06	.600
Any	1.17	.64 - 2.06	.650

Current Adjunct Treatment: Substance Use (Count 831)

Recidivism Type	Odds Ratio (OR)	95% Confidence Interval	p-value
Sexual	1.23	0.34 - 4.68	.736
Violent	2.21	1.28 - 3.84	.005*
Any	2.60	1.80 - 3.75	<.001*

* significant finding

Current Adjunct Treatment: Grief (Count 831)

Recidivism Type	Odds Ratio (OR)	95% Confidence Interval	p-value
Sexual	.000	0.00 - —	.998
Violent	1.45	.55 - 3.79	.454
Any	1.30	.67 - 2.51	.434

Current Adjunct Treatment: Other (Count 831)

Recidivism Type	Odds Ratio (OR)	95% Confidence Interval	p-value
Sexual	0.00	.00 - —	.998
Violent	1.16	.40 - 3.36	.778
Any	.71	.33 - 1.56	.369

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A.7. Model of Significant Predictors of Violent Recidivism: Excluding End Risk Level (Count 830)

Recidivism Type	Odds Ratio (OR)	95% Confidence Interval	p-value
DDID	2.83	1.24 - 6.45	.013*
Discharge Denial Level	1.54	1.13 - 2.12	.007*
Barriers: Lack Social Support	1.26	.71 - 2.23	.429
Barriers: Substance Use	1.48	.78 - 2.84	.233
Current Adjunct: Mental Health	1.41	.79 - 2.49	.243
Current Adjunct: Substance Use	1.57	.79 - 3.13	.197

* significant finding

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A.8. Model of Significant Predictors of Any Recidivism: Excluding End Risk Level (Count 830)

Recidivism Type	Odds Ratio (OR)	95% Confidence Interval	p-value
DDID	2.49	1.32 - 4.69	.005*
Beginning Denial Level	.97	.75 - 1.27	.842
Discharge Denial Level	1.39	1.03 - 1.86	.030*
Barriers: Client Factors	1.31	.88 - 1.97	.187
Barriers: Substance Use	1.50	.99 - 2.27	.059
Current Adjunct: Mental Health	1.23	.85 - 1.79	.279
Current Adjunct: Substance Use	1.94	1.23 - 3.05	.004*

* significant finding

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A.9. Model of Significant Predictors of Violent Recidivism: Including End Risk Level (Count 830)

Recidivism Type	Odds Ratio (OR)	95% Confidence Interval	p-value
End Risk Level	1.31	1.07 - 1.59	.008*
DDID	2.57	1.11 - 5.92	.027*
Discharge Denial Level	1.37	.99 - 1.90	.061
Barriers: Lack Social Support	1.25	.70 - 2.21	.451
Barriers: Substance Use	1.14	.58 - 2.22	.706
Current Adjunct: Mental Health	1.33	.75 - 2.36	.335
Current Adjunct: Substance Use	1.49	.75 - 2.36	.257

* significant finding

A.10. Model of Significant Predictors of Any Recidivism: Including End Risk Level (Count 830)

Recidivism Type	Odds Ratio (OR)	95% Confidence Interval	p-value
End Risk Level	1.30	1.14 - 1.47	<.001*
DDID	2.27	1.19 - 4.32	.013*
Beginning Denial Level	1.04	.80 - 1.36	.752
Discharge Denial Level	1.16	.854 - 1.58	.340
Barriers: Client Factors	1.08	.71 - 1.64	.735
Barriers: Substance Use	1.14	.74 - 1.76	.562
Current Adjunct: Mental Health	1.17	.80 - 1.72	.409
Current Adjunct: Substance Use	1.87	1.19 - 2.95	.007*

* significant finding

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Appendix B. PDMS Screen-Reader Accessibility Tables

B.1a. Referral Sources for Adult Evaluation, Treatment, and Polygraph Clients, 2025

Referral Source	Count of Evaluation Clients (Count 264)	% of Evaluation Clients (Count 264)	Count of Treatment Clients (Count 578)	% of Treatment Clients (Count 578)	Count of Polygraph Clients (Count 985)	% of Polygraph Clients (Count 985)
Probation	212	80%	266	46%	709	72%
Parole/TASC	10	4%	163	28%	195	20%
Community Corrections	6	2%	36	6%	63	6%
DOC	4	2%	59	10%	13	1%
Private Attorneys	26	10%	9	2%	1	<1%
Court	2	1%	34	6%	0	NA
Other	3	<1%	10	2%	4	<1%
County DHS/DYS	1	<1%	1	<1%	0	NA

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B.1b. Referral Sources for Juvenile Evaluation, Treatment, and Polygraph Clients, 2025

Referral Source	Count of Evaluation Clients (Count 79)	% of Evaluation Clients (Count 79)	Count of Treatment Clients (Count 39)	% of Treatment Clients (Count 39)	Count of Polygraph Clients (Count 12)	% of Polygraph Clients (Count 12)
Probation	67	85%	15	38%	10	83%
County DHS/DYS	1	1%	16	41%	1	8%
Diversion	8	10%	0	NA	0	NA
Private Attorney	3	4%	0	NA	0	NA
Parole/TASC	0	NA	2	5%	1	8%
Other	0	NA	2	5%	0	NA
DOC	0	NA	2	5%	0	NA
Court	0	Na	2	5%	0	NA

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B. Table 7a. Demographic Characteristics for Adult Evaluation, Treatment, and Polygraph Clients, 2025

Client Gender

Client Gender	Count of Evaluation Clients (Count 268)	% of Evaluation Clients (Count 268)	Count of Treatment Clients (Count 584)	% of Treatment Clients (Count 584)	Count of Polygraph Clients (Count 1,000)	% of Polygraph Clients (Count 1,000)
Male	250	95.8%	554	95.8%	976	97.2%
Female	10	3.8%	17	2.9%	14	1.4%
Other	*	*	7	1.2%	*	*
Missing	7	NA	6	NA	8	NA

* Data is suppressed for identifiable demographic categories with fewer than five cases.

Client Race/Ethnicity

Client Race/Ethnicity**	Count of Evaluation Clients (Count 268)	% of Evaluation Clients (Count 268)	Count of Treatment Clients (Count 584)	% of Treatment Clients (Count 584)	Count of Polygraph Clients (Count 1,000)	% of Polygraph Clients (Count 1,000)
White	167	62.5%	363	62.2%	613	61.6%
Hispanic or Latino	64	24%	130	22.3%	276	27.7%
Black or African American	31	11.6%	90	14.4%	76	7.6%
Asian or Pacific Islander	8	3%	11	1.9%	15	1.5%
Native American/Am Ind	6	2.2%	14	2.4%	15	1.5%
Other	*	*	*	*	*	*
Unknown	*	*	5	0.9%	1	0.1%
Missing	1	NA	0	NA	5	NA

* Data is suppressed for identifiable demographic categories with fewer than five cases.
**Race/Ethnicity reporting allows for multiple category selection, meaning percentages will not total 100%.

Client Age*

Statistic	Evaluation Clients (Count 268)	Treatment Clients (Count 268)	Polygraph Clients (Count 584)
Client Mean Age (years)	38.8	44	43
Client Age Range (years)	18-85	20-82	19-83
Missing	3	0	9

* Age for each column reflects age at time of evaluation, time of offense, and time of polygraph exam. For evaluation data two cases with extreme ages were coded as missing to reduce the impact and protect client identity.

Client Developmental or Intellectual Disability

Developmental or Intellectual Disability	Count of Evaluation Clients (Count 268)	% of Evaluation Clients (Count 268)	Count of Treatment Clients (Count 584)	% of Treatment Clients (Count 584)	Count of Polygraph Clients (Count 1,000)	% of Polygraph Clients (Count 1,000)
Yes	17	6.4%	35	6%	25	2.5%
No	250	93.6%	549	94%	975	97.5%
Missing	1	NA	0	NA	0	NA

Client Education

Client Education*	Count of Evaluation Clients (Count 268)	% of Evaluation Clients (Count 268)	Count of Treatment Clients (Count 584)	% of Treatment Clients (Count 584)	Count of Polygraph Clients (Count 1,000)	% of Polygraph Clients (Count 1,000)
Less than HS degree	57	21.3)	76	13%	NA	NA
HS degree or equivalent	119	44.6%	313	53.6%	NA	NA
Some college, no degree	49	18.4%	100	17.1%	NA	NA
Associate degree	20	7.5	32	5.5%	NA	NA
Bachelor degree	15	5.6%	46	7.9%	NA	NA
Graduate degree	7	2.6%	17	2.9%	NA	NA
Missing	1	NA	76	13%	NA	NA

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

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B. Table 7b. Demographic Characteristics for Juvenile Evaluation, Treatment, and Polygraph Clients, 2025

Client Gender

Client Gender	Count of Evaluation Clients (Count 80)	% of Evaluation Clients (Count 80)	Count of Treatment Clients (Count 40)	% of Treatment Clients (Count 40)	Count of Polygraph Clients Count 12)	% of Polygraph Clients (Count 12)
Male	78	97.5%	38	97.4%	12	100%
Female	*	*	*	*	0	0.0%
Other	*	*	0	0.0%	0	0.0%
Missing	0	NA	1	NA	0	NA

* Data is suppressed for identifiable demographic categories with fewer than five cases.

Client Race/Ethnicity

Client Race/Ethnicity**	Count of Evaluation Clients (Count 80)	% of Evaluation Clients (Count 80)	Count of Treatment Clients (Count 40)	% of Treatment Clients (Count 40)	Count of Polygraph Clients (Count 12)	% of Polygraph Clients (Count 12)
White	47	58.8%	27	67.5%	8	66.7%
Hispanic or Latino	22	27.5%	11	27.5%	4	33.3%
Black or African American	12	15%	6	15%	0	0.0%
Asian or Pacific Islander	1	1.3%	0	0	0	0.0%
Native American/Am Ind	0	0.0%	1	2.5%	0	0.0%
Other	*	*	*	*	0	0.0%
Unknown	0	0.0%	0	0	0	0.0%
Missing	0	NA	0	NA	0	NA

* Data is suppressed for identifiable demographic categories with fewer than five cases.
**Race/Ethnicity reporting allows for multiple category selection, meaning percentages will not total 100%.

Client Age*

Statistic	Evaluation Clients (Count 80)	Treatment Clients (Count 40)	Polygraph Clients (Count 12)
Client Mean Age (years)	16.7	18.5	18
Client Age Range (years)	12-28	14-25	16-20
Missing	2	3	0

* Age for each column reflects age at time of evaluation, time of offense, and time of polygraph exam. For evaluation data two cases with extreme ages were coded as missing to reduce impact and protect client identity.

Client Developmental or Intellectual Disability

Developmental or Intellectual Disability	Count of Evaluation Clients (Count 80)	% of Evaluation Clients (Count 80)	Count of Treatment Clients (Count 40)	% of Treatment Clients (Count 40)	Count of Polygraph Clients (Count 12)	% of Polygraph Clients (Count 12)
Yes	3	3.8%	4	10%	0	0.0%
No	16	96.2%	36	90%	12	100%
Missing	0	NA	0	NA	0	NA

Client Education

Client Education*	Count of Evaluation Clients (Count 80)	% of Evaluation Clients (Count 80)	Count of Treatment Clients (Count 40)	% of Treatment Clients (Count 40)	Count of Polygraph Clients (Count 12)	% of Polygraph Clients (Count 12)
Less than HS degree	61	76.3%	17	42.5%	NA	NA
HS degree or equivalent	16	20%	17	42.5%	NA	NA
Some college, no degree	2	2.5%	6	15%	NA	NA
Associate degree	0	0.0%	0	0.0%	NA	NA
Bachelor degree	1	1.3%	0	0.0%	NA	NA
Graduate degree	0	0.0	0	0.0%	NA	NA
Missing	0	NA	0	NA	NA	NA

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

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B.2a. Offense Types for Adult Clients, 2025

Offense Type	Count of Evaluation Clients (Count 266)	% of Evaluation Clients (Count 266)	Count of Treatment Clients (Count 579)	% of Treatment Clients (Count 579)
Contact	160	60.2%	427	73.7%
Non-Contact Anonymous Online Victim	48	18.0%	100	17.3%
Non-Contact In-Person Victim	28	10.5%	46	7.9%
Non-Sex Crime w/ a Sex Crime History	29	10.9%	8	1.4%
Other	5	1.9%	8	1.4%

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B.2b. Offense Types for Juvenile Clients, 2025

Offense Type	Count of Evaluation Clients (Count 79)	% of Evaluation Clients (Count 79)	% of Treatment Clients (Count 40)	Count of Treatment Clients (Count 40)
Contact	73	92.4%	36	90.0%
Non-Contact Anonymous Online Victim	3	3.8%	3	7.5%
Non-Contact In-Person Victim	2	2.5%	1	2.5
Other	1	1.3%	1	2.5%
Non-Sex Crime w/ a Sex Crime History	0	0.0%	0	0.0%

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B.3. Risk Level for Evaluation Clients by Court, 2025 (Count 347)

Risk Level	Percent of Adult Clients (Count 267)	Percent of Juvenile Clients (Count 80)
High	18%	0%
Moderate-high	14%	1%
Moderate	36%	34%
Moderate-low	16%	19%
Low	16%	46%

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B.4a. Acceptance of Responsibility for Adult Treatment Clients, 2025 (Count 583)

Responsibility Level	% of Adult Clients at Each Beginning Level (Count 583)	% of Adult Clients at Each Ending Level (Count 582)
None	10%	3%
Some	30%	16%
Most	32%	35%
Full	28%	47%

B.4b. Acceptance of Responsibility for Juvenile Treatment Clients, 2025 (Count 40)

Responsibility Level	% of Juvenile Clients at Each Beginning Level (Count 40)	% of Juvenile Clients at Each Ending Level (Count 40)
None	12%	5%
Some	35%	5%
Most	35%	42%
Full	18%	48%

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B.5a. Change in Acceptance of Responsibility During Adult Treatment, 2025 (Count 582)

Beginning Responsibility Level	% of Adult Clients with a Decrease in Responsibility Level	% of Adult Clients with No Change in Responsibility Level	% of Adult Clients with an Increase in Responsibility Level
None (Count 60)	NA	25%	75%
Some (Count 174)	0%	43%	57%
Most (Count 187)	2%	57%	42%
Full (Count 161)	1%	99%	NA

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B.5b. Change in Acceptance of Responsibility During Juvenile Treatment, 2025 (Count 40)

Beginning Responsibility Level	% of Juvenile Clients with a Decrease in Responsibility Level	% of Juvenile Clients with No Change in Responsibility Level	% of Juvenile Clients with an Increase in Responsibility Level
None (Count 5)	NA	20%	80%
Some (Count 14)	7%	14%	79%
Most (Count 14)	0%	36%	64%
Full (Count 7)	0%	100%	NA

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B.6. Beginning Risk Level for Treatment Clients by Court, 2025 (Count 623)

Risk Level	Percent of Adult Clients (Count 583)	Percent of Juvenile Clients (Count 40)
High	13%	8%
Moderate-high	12%	20%
Moderate	27%	25%
Moderate-low	18%	18%
Low	30%	30%

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B.7. End Risk Level for Treatment Clients by Court, 2025 (Count 622)

Risk Level	Percent of Adult Clients (Count 582)	Percent of Juvenile Clients (Count 40)
High	18%	0%
Moderate-high	9%	8%
Moderate	14%	18%
Moderate-low	12%	18%
Low	47%	57%

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B.8. Change in Risk Level During Treatment, 2025 (Count 622)

Beginning Risk Level	% of Clients Decreased Risk	% of Clients No Risk Change	% of Clients Increased Risk
High (Count 78)	33%	67%	NA
Moderate-high (Count 77)	47%	36%	17%
Moderate (Count 168)	49%	32%	19%
Moderate-low (Count 114)	53%	27%	20%
Low (Count 185)	NA	81%	19%

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B.9. Treatment Discharge Outcomes by Court Type, 2025 (Count 624)

Treatment Outcome	Adult Clients (Count 584)	% Adult Clients (Count 584)	Juvenile Clients (Count 40)	% Juvenile Clients (Count 40)
Successful, Tx. Completed	229	39%	21	52%
Successful, Continued Tx. Needed	62	11%	5	12%
Administrative	83	14%	5	12%
Unsuccessful	210	36%	9	22%

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B10. Successful Discharges by Beginning Risk, 2025 (Count 623)

Beginning Risk Level	% of Clients Successful Discharges	Overall % of Clients Successful Discharge (All Clients)
Low (Count 186)	66%	51%
Moderate-low (Count 114)	61%	51%
Moderate (Count 168)	49%	51%
Moderate-high (Count 77)	31%	51%
High (Count 78)	24%	51%

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B.11. Treatment Length by Discharge, Beginning Risk, and Court, 2025 (Count 623)

Discharge Type	Median Treatment Length (Months)	Overall Median Treatment Length for All Clients (Months)
Administrative (Count 88)	7.8	20.7
Successful Continued Tx. Needed (Count 67)	17.7	20.7
Successful Tx Completed (Count 250)	40.8	20.7
Unsuccessful (Count 218)	9.2	20.7

Beginning Risk Level	Median Treatment Length (Months)	Overall Median Treatment Length for All Clients (Months)
High (Count 78)	8.2	20.7
Moderate-high (Count 77)	15.6	20.7
Moderate (Count 167)	23.2	20.7
Moderate-low (Count 114)	22.8	20.7
Low (Count 186)	22.0	20.7

Court Type	Median Treatment Length (Months)	Overall Median Treatment Length for All Clients (Months)
Juvenile Court (Count 40)	10.9	20.7
Adult Criminal Court (Count 583)	22.3	20.7

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B.12. Types of Disclosures Made During Adult and Juvenile Polygraph Exams, 2025 (Count 2,078)

Adult Criminal Court (Count 2,057) Disclosure Type	Count of Clients	Percent (%)
No Admissions	1,044	51%
Sexual Behavior	288	14%
Change of Circumstance/Risky Behavior	251	12%
Historical Information	235	11%
Sexually Abusive Thoughts, Feelings, & Attitudes	158	8%
Other	414	20%

Juvenile Court (Count 21) Disclosure Type	Count of Clients	Percent (%)
No Admissions	7	33%
Sexual Behavior	7	33%
Change of Circumstance/Risky Behavior	3	14%
Historical Information	2	10%
Sexually Abusive Thoughts, Feelings, & Attitudes	1	5%
Other	10	48%

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B.13. Outcomes of Polygraph Exams by Court, 2025 (Count 2,092)

Exam Outcome	Count of Adult Clients (Count 2,071)	% of Adult Clients (Count 2,071)	Count of Juvenile Clients (Count 21)	% of Juvenile Clients (Count 21)
Deception Indicated / Significant Response	477	23%	9	43%
No Deception Indicated/ No Significant Response	1,246	60%	7	33%
No Deception Indicated/ No Opinion	231	11%	2	10%
Inconclusive / No Opinion	117	6%	3	14%

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B.14. Outcome of Polygraph Exams by Exam Type, 2025 (Count 2,092)

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 1,483)	64%	11%	5%	20%
Sex History Exam (Count 471)	54%	13%	7%	26%
Specific Issue (Count 53)	47%	2%	11%	40%
Instant/Index Offense Exams (Count 36)	8%	6%	8%	78%
Child Contact Screening Exam (Count 4)	0%	0%	25%	75%
Other (Count 1)	0%	100%	0%	0%

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B.15. Successful and Unsuccessful Discharge, Years 1-6

Data Collection Year	% Successful	% Unsuccessful
Year 1	36%	40%
Year 2	40%	43%
Year 3	48%	39%
Year 4	51%	30%
Year 5	50%	32%
Year 6	51%	35%

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Appendix C: Full List of Individualized Strategies

Evaluation Results[16]

Recommendations most frequently made to match treatment to client risk level were:

- Adjunct non-sex offense-specific treatment (62%)
- Adjustments to community access (e.g., level of restrictions) (39%)
- Adjustments in frequency of treatment services (23%)
- Type of placement, length of stay, or step-down (19% vs. 24% last year)
- Adjustments to types of groups (24% vs. 20% last year)
- Recommended changes to supervision (17%)
- Other adjustments (4.3%)
- Implementing changes to supervision (2.3%)

Recommendations most frequently made to address client criminogenic and non-criminogenic needs were:

- An individualized treatment plan (79%)
- Increased support (51% vs. 46% last year)
- Increased resources (49% vs. 44% last year)
- Implement modification to treatment modality (group, individual, telemental health, and adjunct treatment) (16%)
- Modify supervision conditions (14%)
- Modified assignments (11%)
- Modified programming (7%)
- Modifications to treatment expectations (7%)
- Used the young adult modification protocol (7%)
- Flexible scheduling options (4%)
- Implement modification to supervision conditions (3%)
- Used the sex offense history evaluation matrix (2%)
- Modified the *Standards and Guidelines* by the MDT/CST (4 cases, 1%)
- Other treatment needs included no treatment recommended (3 cases), family therapy, Domestic Violence (DV) treatment, denier's intervention, suicide caution, victim therapy, Dialectical Behavior Therapy (DBT), drug and alcohol therapy, or adjunct mental health treatment (4%).[17]

Recommendations most frequently made to address treatment responsivity barriers were:

- Use of mental health related adjunct therapy (62% vs. 65% last year)
- Use of external supports (47% vs. 49% last year)
- Feedback from the client (42% vs. 37% last year)
- Adjustments in frequency or modality of treatment services (23%)

[16] Multiple selections were possible so percentages do not add to 100%.
[17] Results are based on the qualitative texts entered by evaluators.

- Use of specialized resources (22%)
- Assessment of intellectual/cognitive functioning with additional testing (22%)
- Interventions to increase motivation for treatment (22%)
- Modifications to increase progress (18%)
- Assessment of cultural/language/sexual orientation/gender identification and family needs (14%)
- Recommendation to modify supervision conditions (9%)
- Housing/transportation/treatment/polygraph/financial voucher provided by supervising officer (9% vs. 7% last year)
- Implemented modification to supervision conditions (7%)
- Other treatment adjustments include DV treatment, trauma-informed care (3 cases), life skills training, curfew requirements, electronics monitoring and random substance abuse screening and suicide risk monitorning (3%).

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Treatment Results[18]

Strategies and resources used to individualize treatment and address client needs were:

- An individualized treatment plan (95%)
- Increased support (51% vs. 42% last year)
- Modified assignments (48% vs. 44% last year)
- Flexible scheduling (42% vs. 34% last year)
- Increased resources (42%)
- Modification to treatment modality (group, individual, telemental health, and adjunct treatment) (24%)
- Modified treatment expectations (15%)
- Modified programming (10%)
- Young adult protocol (8%)
- Recommendation to modify supervision conditions (6%)
- Modifications to the *Standards and Guidelines* by the MDT/CST (2%)
- Implemented modification to supervision conditions (2%)
- Sex offense history evaluation matrix (1 case, 0.2%)
- Modifications to the *Standards and Guidelines* through a variance (1 case; 0.2%)
- Other scenarios (7.4%) were referrals for mental health and substance abuse treatments, and occasional issues such as client absconding or transferring care.

Most frequent barriers to treatment progress reported were:

- Client-related factors (62%)
- Lack of motivation for treatment (37%, a slight increase from 34% last year)
- Lack of support systems (36%, an increase from 29% last year).

[18] Multiple selections were possible so percentages do not add to 100%.

- Client's mental health/trauma needs (29%)
- Finances (26%)
- Employment (25%)
- Substance use (23%)
- Lack of community engagement (22%)
- Housing (21%)
- Need for adjunct treatment (18%)
- Transportation (12%)
- Cultural needs (5.3%)
- Community limitations (4.6%)
- Specific resources (3.2%)
- Terms of supervision (2.6%)
- A very small percentage of records (1.9%, a drop from 4% in the previous year) listed the SOMB *Standards and Guidelines* as a barrier. Other unique factors (6%) cited were medical needs, immigration status, porn addiction, or learning disabilities. Approximately 10% of the treatment records did not list any barriers or indicated "N/A."

To adjust treatment to address client responsivity factors, providers reported:

- Utilizing client feedback (76%)
- Adjusting frequency or modality of treatment services (56%)
- Using interventions to increase motivation for treatment (36% vs. 32% from last year)
- Using external supports (36% vs. 26% last year)
- Using mental health related adjunct therapy (31% vs. 28% last year)
- Housing/transportation/treatment/polygraph/financial voucher provided by supervising officer (20%)
- Modifications to increase progress (18%)
- Assessment of cultural/language/sexual orientation/gender identification and family needs (13%)
- Use of specialized resources (11%)
- Assessment of intellectual/cognitive functioning (e.g., additional screening/testing) (10%)
- Implementing modifications to supervision conditions (8%)
- Recommending modification to supervision conditions (4%)
- Other efforts (5%) included using homework groups to help the client, changing therapists, etc. (5%)

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Appendix D: SOMB Reauthorization Bill SB 23-164

This is a concise summary of the major changes in the **SOMB Reauthorization Bill, SB 23-164**. For more detail and the exact wording of the statutory mandates, see the full Senate Bill (**SB 23-164**).

The reauthorization bill adopted recommendations from the **2022 DORA Sunset Report** and established several new mandates to enhance oversight, access to treatment, and accountability.

I. Sunset Report Recommendations Adopted

The bill formalized the continuation of the SOMB and clarified several administrative and provider practices:

1. **SOMB Continuation:** The Board is continued for **5 years** until September 1, 2028.
2. **Supervising Officer Accountability (§ 16-11.7-106(8)):** Supervising officers must follow the *Adult and Juvenile Standards and Guidelines*. Agencies employing these officers must collaborate with the SOMB to develop **accountability procedures** for officers who fail to comply.
3. **Provider Selection Flexibility (§ 16-11.7-105(2)(3)):** The bill **repealed the prior limitation on the number of treatment providers** a client could be offered. Key requirements for supervising agencies and officers include:
    a. Providing a **complete list** of providers with expertise specific to the client's risks and needs.
    b. Making specific recommendations that consider **provider capacity, geographic proximity, program offerings,** and community safety.
    c. Requiring recommendations for SOMB Approved Providers with the **requisite Developmental/Intellectual Disability listing** for clients with these disabilities.
    d. Allowing the **Division of Youth Services (DYS) to assign juveniles** to providers, but requiring procedures for the juvenile/family to seek a change based on responsivity factors.
4. **Compliance Reviews (§ 6-11.7-103(4)(h.5)):** Beginning September 1, 2024, the Board must conduct compliance reviews on a minimum of **10% of Approved Providers** every two years (biennial review requirement).
5. **Administrative Updates (§ 16-11.7-106(2)):** Language concerning fingerprint collection for provider applications was updated, and the DORA's responsibility to publish the Approved Provider list was repealed.

II. Additional Mandates (New Statutory Requirements)

The bill added several significant requirements focused on treatment access, data, and policy revision:

- **Treatment Responsivity (§ 16-11.7-103(4)(b)(I)):** Programs must ensure treatment is responsive to the client's **developmental status** and characteristics including **linguistic, cultural, religious, and racial background**, as well as **sexual orientation, gender identity, and gender expression**.
- **Policy & Guideline Revision (Determinate Sentences) (§ 16-11.7-103(4)(m)):** The SOMB, in collaboration with the State Parole Board, must revise the **sex offender release guideline instrument** for determinate sentences by December 1, 2023. The revised guideline must:
    - Incorporate **Risk-Needs-Responsivity (RNR)** principles
    - Be flexible to ensure **timely access to necessary programming**
    - **Prohibit denying parole** based on an offender's **inability to access treatment while incarcerated** (if eligible)
- **Data Reporting (DOC Treatment Gaps) (§ 16-11.7-105(1.5)):** The **Department of Corrections (DOC)** must identify all classified inmates eligible for sex offense-specific treatment who **have not been provided the opportunity** to receive it. DOC must report data (including risk scores, capacity, frequency of group cancellations, and efforts to increase capacity) to the SOMB by July 31, 2023.
- **Treatment Solutions Workgroup (§ 16-11.7-105(1.5)(c)(d)):** The SOMB was required to form a subcommittee with the Department of Corrections and other stakeholders to study and develop solutions to address treatment resource barriers for incarcerated sex offenders. The subcommittee's report and proposal were due to the judiciary committees by February 1, 2024, with directives to analyze DOC data, identify barriers, and recommend policy revisions across DOC/Parole guidelines to prevent unnecessary treatment backlog.
- **DOC Provider Flexibility (§ 16-11.7-106(1.5)):** The bill allows the DOC to employ or contract with individuals for evaluation, treatment, or polygraph services, provided the program director is an Approved Provider, the program conforms to SOMB *Standards and Guidelines*, and the staff meet specific educational and training requirements (e.g., licensed mental health professional with a baccalaureate degree or above for treatment).
- **Definition Updates (§ 16-11.7-102):** The definitions for "adult sex offender," "juvenile who committed a sexual offense" (clarifying inclusion of certain district court sentences), and the application of "sex offender" status for persons with prior offenses were updated.

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Appendix E: SOMB Committee and Workgroup Updates

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

   Purpose: The SOMB Executive Committee is responsible for upholding and advancing the mission of the Board. Its functions include developing and organizing the monthly Board agenda—encompassing presentations, action items, and decision items—and providing oversight and coordination for the Board's committees and workgroups. The Executive Committee typically meets once per month.

   Major Accomplishments: The Executive Committee met consistently throughout 2025 and effectively managed the monthly SOMB agenda. The Committee provided oversight of committee and workgroup activities, facilitated coordination on policy issues, and played a central role in planning and executing the Board's strategic planning retreat. It also monitored progress toward fulfilling the statutory requirements of the SOMB Reauthorization Bill (SB 23-164) and ensured alignment between Board activities and legislative directives.

   Future goals: In the coming year, the Executive Committee will continue to uphold the mission of the SOMB, monitor implementation of the remaining reauthorization bill directives, and guide the development of the Board's strategic planning document based on the retreat and subsequent processes. The Committee will also continue to ensure that Board agendas, committee oversight, and system coordination support efficient operations and strategic alignment.

2. **Application Review Committee (ARC)**
   Active
   Committee Chair: Lauren Rivas
   Committee Vice-Chair: Theresa Weiss

   Purpose: The Application Review Committee (ARC) is responsible for reviewing all new and renewal applications for treatment providers, evaluators, and polygraph examiners seeking placement on the SOMB Approved Provider List. The Committee also reviews complaints against listed providers and conducts randomized, voluntary, and for-cause Standards Compliance Reviews (SCRs). The ARC typically meets twice per month.

   Major Accomplishments: The ARC convened 20 times during 2025 and carried out its statutory and regulatory oversight functions with diligence and consistency. The Committee reviewed a high volume of provider applications, addressed complaints, and monitored variances to ensure compliance with the *Adult and Juvenile Standards and Guidelines*. Key accomplishments included:

   - **Application Review:** Managed **335 applications** for initial placement, continued listing, status upgrades, and renewals on the Approved Provider List (November 1, 2024–October 31, 2025).

- **Complaint Oversight:** Reviewed **22 complaints** involving **17 providers**; as of October 31, 2025, **7 were founded**, **8 unfounded**, **6 remained pending**, and **2 cases** carried over from 2024 were resolved. The Committee also reviewed and processed **one appeal** related to a complaint determination.

- **Standards Compliance Reviews:** Implemented the first full year of the revised SCR process pursuant to **SB 23-164**. Conducted **16 SCRs**—including random, voluntary, and for-cause reviews—to assess compliance with standards and require corrective action when necessary.

Future Goals: The ARC will continue to review applications, complaints, variances, and appeals to ensure rigorous oversight of listed providers. The Committee will also continue implementing the SCR process to meet the **biennial requirement to review at least 10% of all Approved Providers by August 31, 2026**, and will refine processes as necessary to support consistency, transparency, and high standards of practice.

3. **Best Practices Committee**
Active
Committee Chairs: Hannah Pilla and Sonya Hickson

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 *Juvenile 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 2025. The committee did not convene when it fell during the ODVSOM annual conference. The Committee reviewed and actioned various proposed revisions to the *Adult Standards and Guidelines* and *Juvenile Standards and Guidelines,* and discussed issues arising in the field. Actions included advising the Adult and Juvenile Standards Revisions Committee of issues to consider, forwarding proposed revisions to the Board for consideration, reviewing and addressing public comment, and returning proposed revisions to the Board for ratification. Highlights include:

- Review of proposed revisions to the *Adult Standards and Guidelines Section 3.000* concerning the Risk Assessment process, Core Treatment Concepts, and Language, Culture, and Ethnic Considerations and Use of Interpreters.

- Revisions to the *Adult Standards and Guidelines Appendices* included updates to Appendix I and M. Appendix I was revised to change the language from “Under Seal” to “As Suppressed” to allow clients access to Discharge Reports filed with the Court while maintaining the confidentiality of those documents. Following discussion in 2024 regarding the use of electronic devices and monitoring (People v. Silvanic), the committee recommended removal of the Computer Use Agreement document from Appendix M and replacing it with a Guidance Document for Teams on Internet Use and Electronic Monitoring. This appendix provides guidance to teams on how to apply an individualized approach to internet use and electronic monitoring rather than using blanket restrictions.

- Review of revisions made to the *Juvenile Standards and Guidelines* included updates to the language in *Section 5.000, Establishment of a Multidisciplinary Team for the Management and Supervision of Juveniles Who Have Committed Sexual Offenses and Section 10.000 and Appendix K, which* removed outdated language regarding *Additional Conditions of Supervision*.

- Review of revisions made to the *Adult Standards and Guidelines* and the *Juvenile Standards and Guidelines* in Appendix B: Considerations for MDTs/CSTs: Working with Victims When Facilitating Contact, Clarification, and/or Reunification. This appendix was revised to provide additional guidance to teams regarding the clarification process for both familial and non-familial victims.

- Revisions to Appendix S of the *Adult Standards and Guidelines* were approved in November 2025. These updates were at the request of treatment providers needing direction following the Colorado Court of Appeals decisions concerning a client's Fifth Amendment rights during offense-specific treatment (People v. Vigil). The additions are intended for informational purposes to help providers determine how to proceed if a client is under appeal, has filed a post-conviction motion, or has been granted Use Immunity while pursuing either of those options.

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 Guidelines*. 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.

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

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 6 of the 12 months in 2025. 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) and has been on hiatus since September, while smaller workgroups proceed with revisions to specific sections. Highlights of the work of the Committee include:

- Revisions from 2025 that were finalized included the Section 3 standards on *Language, Culture, and Ethical Considerations and the Use of Interpreters*, as well as revisions related to treatment within DOC's SOTMP Program. This and all subsequent revision work involved conducting and reviewing public comments, making necessary amendments, and presenting proposed revisions to the Best Practices Committee and the Board.

- Additional revisions to *Section 3.000 Standard of Practice for Treatment Providers* included updates to the standards regarding risk assessment and the core treatment concepts to emphasize an individualized approach with increased focus on the RNR principles. Specifically, these revisions promoted attention to individual's proactive and stability factors. Revisions to *Section 5.000 Standards of Practice for Community Supervision Teams Working with Adult Sex Offenders* were also finalized, incorporating new statutory language regarding treatment recommendations and referrals.

- In August 2025, the Committee tasked workgroups with initiating revisions to *Section 5.000 Standards of Practice for Community Supervision Teams Working with Adult Sex Offenders*. Two workgroups were established—one for Treatment Providers and one for Supervising Agencies—to review and propose revisions to the sections outlining their respective responsibilities. The Victim Advocacy Committee and Polygraph Workgroup will also review and propose revisions to their sections. Staff are working collaboratively with family members and client advocates on their section as well.

- The Treatment Modifications Workgroup concluded its work in 2025. Consensus was reached that additional information was needed before revising any standards related to clients who present significantly lower than average risk. The group recommended a data collection process that allows providers to request modifications to standards with approval from the Application Review Committee. This process was presented to the Board in October 2025 and approved for implementation beginning in January 2026. Providers will submit a form to collect additional data on the need for modifications and the specific standards-related barriers. This data will be analyzed after one year of implementation, and recommendations regarding potential revisions or next steps will be made to the Board.

Future Goals: The Committee will continue reviewing and revising *Section 5.000 Standards of Practice for Community Supervision Teams Working with Adult Sex Offenders* as part of its systematic approach to updating sections of the *Adult Standards and Guidelines*. The Committee 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 7 times in 2025. The committee did not convene when there were conflicts with holidays. Highlights include:

- Revisions to Sections 2.000, 3.000, 5.000, and 9.000 and the removal of Appendix G to provide guidance to evaluators, providers, and multidisciplinary teams around juveniles who have their own children or minor sibling contact.

- Reviewed Public Comment for 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 (ATSA) practice guidelines, reflect legislative changes, and improve the clarity of the standards. The revisions were ratified by the Board.

- Reviewed Public Comment for 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 and officers, incorporate legislative changes, update the language about individualized treatment plans, and improve the clarity of the standards. The revisions were ratified by the Board.

- Reviewed Public Comment for 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 revisions were ratified by the Board.

- The Committee identified a need for the DD/ID standards to be reviewed. This need was then addressed by the Best Practices committee who convened a DD/ID workgroup to review DD/ID standards for both juvenile and adult populations.

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 11 times in 2025. 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 and Guidelines*.

   - The Committee reviewed public comment for Appendix B: Considerations for MDTs/CSTs: Working with Victims When Facilitating Contact, Clarification, and/or Reunification and sent the revisions to the best practice committee for their review of the public comment prior to ratification at the Board.

- The Committee worked to make revisions to Section 5.000 of the *Adult Standards and Guidelines* pertaining to the role of the victim representative.
- The Committee provided feedback to the Board's strategic planning initiative to ensure continued support of victim-centered approaches by the Board.

Future Goals: The Committee will collaborate with SOMB staff to create a plan to support the implementation of the revised document once it is finalized. 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 is composed of Approved Providers, Supervising Officers, Victim Representatives and Treatment Victim Advocates, and other key stakeholders. Its primary responsibilities include identifying priority training topics and objectives, planning and coordinating both small and large-scale training events—including the ODVSOM Annual Conference—and assessing system-wide training needs related to sex offending and domestic violence. The Committee also works to develop and support trainers in partnership with other agencies, provide guidance on training resources, and recommend training priorities and best practices to program staff.

Main Accomplishments: The Committee met monthly for two hours throughout 2025 and made significant progress in advancing the training and professional development objectives of the SOMB and DVOMB. Key accomplishments included:

- **Annual Conference:** Planned and delivered the 2025 ODVSOM Annual Conference, which was well-received and successfully implemented under the code of conduct established to guide expectations for participant behavior at all ODVSOM training events.
- **Training Initiatives:** Continued to develop a diverse range of training offerings that provide both content-specific expertise and opportunities for professional skill-building and practice collaboration across disciplines.
- **Individually Responsive Care:** Sustained a strong focus on integrating principles of individually responsive care across training content, with emphasis on cultural responsiveness, trauma-informed practice, and specialized approaches for diverse client populations.

Future Goals: The Committee will continue to plan and implement training events and expand opportunities for joint DVOMB–SOMB educational activities. Future priorities include sustaining a balanced roster of local, national, and occasional international speakers to ensure that providers across Colorado receive high-quality training and exposure to emerging best practices. The Committee will also focus on strengthening the pool of qualified trainers, particularly for the SOMB supported training related to risk assessment.

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 2025, the Committee presented its recommended allocations for fiscal year 2026-2027 to the SOMB, which were approved as follows:

- $405,387 to the Division of Criminal Justice for the administration and implementation of the *Standards and Guidelines* with $100,000 for a one-time expense for victim training. This includes $245,387 for personnel, contract, and operation expenses, plus $60,000 for funded FTE appropriated positions.
- $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 (personnel, operating, and POTS dollars for FTE appropriated positions).
- $38,250 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 $946,681. 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 2027-2028.

9. SOMB Workgroups

Purpose: Article 8 of the SOMB Bylaws outlines the purpose and structure of Committees and Workgroups. Workgroups are defined as “A staff-driven process in which a DCJ staff member asks other professionals and community members to work with him/her on a specific work product, which may eventually be taken to the Board for decision-making. For such work groups, votes shall be by consensus, meetings shall be open to the public, and meeting minutes shall be available to the public within a reasonable timeframe.” Workgroups are typically formed by staff or by a specific committee recommendation. During 2025, the following workgroups met and completed work on behalf of the Board:

A. Treatment Modifications Workgroup: Specific Task

Originating Committee: Adult Standards Revisions

Purpose: To review and examine issues arising from clarification that the SOMB purview includes low-risk or unique cases that were previously referred for alternative interventions. The workgroup was 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*.

Accomplishments: The group met 7 times between June 2024 and May 2025. Consensus was reached that more information was needed before revising the standards related to clients who present significantly lower than average risk. The group recommended a data collection process that allows providers to request modification to standards with approval of the Application Review Committee. This process was presented to the Board in October 2025 and approved for implementation beginning in January 2026. Providers will submit a form to gather more data on the need for modifications and the specific standards-related barriers. This data will be analyzed after one year of implementation, and recommendations regarding potential revisions or next steps will be made to the Board.

B. Polygraph Workgroup: Ongoing

Originating Committee: Best Practices

Purpose: To enhance collaboration with Polygraph Examiners on SOMB matters such as revisions to standards, the PDMS, and all policies and procedures that involve polygraph examiners or exams. To enhance the sharing of information with examiners to help with the function of CSTs/MDTs.

Accomplishments: The group began meeting quarterly in 2024 and shifted to bimonthly meetings in 2025, meeting four times. The group contributed to language updates required for the Adult Standards Committee revisions to *Section 3.500 Accountability and Responsibility*. They provided essential feedback to clarify the use of instant-offense polygraph for clients exhibiting different levels of accountability. The group also reviewed the duties of Polygraph Examiners outlined in *Section 5.000 Standards of Practice for Community Supervision Teams Working with Adult Sex Offenders*. In November 2025, the group attended a training with an examiner who specializes in outcome data for maintenance and monitoring exams. The group will review the information from this presentation and determine whether any changes to current polygraph practices are needed.

C. DD/ID Workgroup: Task Specific, may move to ongoing

Originating Committee: Best Practices

Purpose: To review the current standards for clients who are Developmentally and/or Intellectually Disabled to ensure they are still relevant and sufficient.

Accomplishments: The group has met 4 times since its inception in June 2025. Following a thorough review, no revisions were recommended to either the *Adult or Juvenile Standards and Guidelines*. The group discussed the definition and application of DD/ID within the Standards and reached consensus that additional education and training are needed; an implementation and project plan is currently underway to support SOMB providers and CSTs/MDTs members in this area.

D. Section 5 Revisions Workgroups: Treatment Providers, Supervising Agencies

Originating Committee: Adult Standards Revisions

Purpose: Workgroups representing treatment providers and supervising agencies on the CST shall review *Section 5.000 Standards of Practice for Community Supervision Teams Working with Adult Sex Offenders*, which includes role-specific sections outlining the duties of each member.

Accomplishments: Each professional group has met 3 times and is developing proposed revisions to their roles and responsibilities. The groups are considering supervision agency policies and procedures, along with research and evidence-based practices. Recommended revisions aim to allow each member to individualize their approach based on client risk and need while maintaining consistent expectations for teams.

E. School Resource Document Workgroup: Specific Task

Originating Committee: Juvenile Standards Revisions

Purpose: To update the *Reference Guide for School Personnel Concerning Juveniles Who Have Committed Sexually Abusive and Offending Behaviors,* which was originally published in 2015.

Accomplishments: The group has met 8 times this year and has made significant progress in revising and updating the Reference Guide. The group is taking into consideration school district and SOMB policies and procedures, along with research and evidence-based practices. Recommended revisions are intended to provide more focused guidance and support for school personnel working with this population and within Multi-Disciplinary Teams.

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Appendix F: Section Three Screen-Reader Accessibility Tables

F.1. Number of Adult and Juvenile SOMB Providers by County

County	Count of Adult Evaluation Providers	Count of Juvenile Evaluation Providers	Count of Adult Treatment Providers	Count of Juvenile Treatment Providers	Count of Adult Polygraphers	Count of Juvenile Polygraphers
Adams	44	27	75	56	14	8
Alamosa	4	2	7	4	8	6
Arapahoe	41	28	64	52	14	8
Archuleta	4	3	5	3	3	1
Baca	2	2	3	2	2	1
Bent	2	2	3	2	3	2
Boulder	22	14	37	30	12	7
Broomfield	16	10	25	18	6	4
Chaffee	4	3	8	3	4	3
Cheyenne	3	2	5	6	2	1
Clear Creek	8	6	11	9	2	1
Conejos	2	1	4	2	1	0
Costilla	2	1	4	2	1	0
Crowley	3	2	5	3	2	1
Custer	2	1	4	2	1	0
Delta	5	3	10	7	4	3
Denver	56	36	92	74	14	6
Dolores	2	2	3	2	5	3
Douglas	28	21	48	39	10	5
Eagle	8	6	12	8	5	3
El Paso	23	15	52	40	9	5
Elbert	3	1	5	3	2	1
Fremont	11	4	37	5	6	4
Garfield	10	5	14	5	4	3
Gilpin	4	4	6	7	2	1
Grand	4	3	6	4	2	1
Gunnison	2	1	6	2	3	2
Hinsdale	2	1	3	1	2	1
Huerfano	3	2	4	2	1	0
Jackson	1	1	2	1	1	0

County	Count of Adult Evaluation Providers	Count of Juvenile Evaluation Providers	Count of Adult Treatment Providers	Count of Juvenile Treatment Providers	Count of Adult Polygraphers	Count of Juvenile Polygraphers
Jefferson	35	23	65	54	16	8
Kiowa	1	1	3	2	1	0
Kit Carson	1	1	3	3	2	1
La Plata	3	2	5	2	4	2
Lake	3	2	5	2	1	0
Larimer	20	12	30	27	8	6
Las Animas	2	1	3	2	1	0
Lincoln	1	1	3	2	2	1
Logan	5	6	7	7	2	1
Mesa	9	4	17	10	4	3
Mineral	1	1	3	2	1	0
Moffat	3	3	5	3	4	3
Montezuma	4	2	6	2	5	3
Montrose	6	3	11	7	4	3
Morgan	6	4	7	5	3	2
Otero	3	2	4	2	2	1
Ouray	1	1	2	1	4	3
Park	4	2	8	3	2	0
Phillips	2	2	3	2	1	0
Pitkin	3	2	4	3	3	2
Prowers	2	2	3	2	1	0
Pueblo	17	6	29	16	6	3
Rio Blanco	3	3	4	3	2	1
Rio Grande	2	1	4	2	1	0
Routt	6	4	8	4	3	2
Saguache	2	1	4	2	1	0
San Juan	3	2	4	2	4	2
San Miguel	1	1	2	2	3	2
Sedgwick	3	3	4	3	2	1
Summit	7	3	9	4	5	3
Teller	4	2	5	3	2	0
Washington	3	3	4	3	2	1
Weld	27	18	38	40	8	5
Yuma	4	4	6	5	2	1

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F.2. ODVSOM Shared Services Model and Organizational Chart, 2025

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	Maija Mustapick
ODVSOM Documentation Specialist	Ellen Creecy
ODVSOM Staff Researcher	Dr. Rachael Collie
ODVSOM Staff Researcher	Dr. Yuanting Zhang
ODVSOM Staff Researcher (0.5)	Jessica Manrique
ODVSOM Program Assistant	Vacant
DVOMB Program Coordinator	Caroleena Frane
DVOMB Implementation Specialist	Reggin Palmitesso-Martinez
DVOMB Application and Compliance Review Coordinator	Brittinie 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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