COLORADO
Division of Criminal Justice
Department of Public Safety

Office of Domestic Violence and Sex Offender Management
700 Kipling Street, Suite 3000
Lakewood, CO 80215

Colorado Sex Offender Management Board
Provider Data Collection System
Denial Policy Brief #3
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Colorado Sex Offender Management Board

In 1992, the Colorado General Assembly passed legislation that created a Sex Offender Treatment Board to develop standards and guidelines for the assessment, evaluation, treatment, and behavioral monitoring of sex offenders. The General Assembly changed the name to the Sex Offender Management Board (SOMB) in 1998 to more accurately reflect the duties assigned to the SOMB.

The Legislative Declaration for the Sex Offender Management Board (SOMB) states:

"(1) The general assembly finds that, to protect the public and to work toward the elimination of sexual offenses, it is necessary to comprehensively evaluate, identify, treat, manage, and monitor adult sex offenders who are subject to the supervision of the criminal justice system and juveniles who have committed sexual offenses who are subject to the supervision of the juvenile justice system. (2) Therefore, the general assembly declares that it is necessary to create a program that establishes evidence-based standards for the evaluation, identification, treatment, management, and monitoring of adult sex offenders and juveniles who have committed sexual offenses at each stage of the criminal or juvenile justice system to prevent offenders from reoffending and enhance the protection of victims and potential victims. The general assembly does not intend to imply that all offenders can or will positively respond to treatment." (§16-11.7-101, C.R.S.)

Provider Data Collection System

Colorado House Bill 16-1345 requires the SOMB to collect data from the evaluators, treatment providers, and polygraph examiners who provide services to adults convicted and juveniles adjudicated for a sex offense. Each provider is required to submit service information about the treatment to the SOMB Provider Data Management System at the time of service completion, regardless of the outcome of each service. Formal data collection began in 2019 and has continued since that time. Annual reports on the data can be found in the SOMB Annual Legislative Reports (add link) beginning in 2020.

Policy Issue

In addition to the annual report on the SOMB Data Collection outcomes, the SOMB will periodically complete policy briefs related to special topics from the data collection by approved providers. This is the third in a series of briefs related to specialized topics and will cover data related to addressing denial with clients convicted of a sexual offense. Issues related to denial of the sexual offense and how to successfully address this in treatment have been a point of discussion at SOMB meetings, with stakeholders, and at the Colorado State Legislature. Concerns have been raised about the impact of denial on the client's risk for recidivism, victim healing and recovery, and for those who have been wrongfully convicted of a sex crime.[1]

[1] Please note that it is outside the purview of the SOMB to resolve wrongful convictions.

The focus of this brief is to review strategies employed by treatment providers to assist clients in moving beyond denial towards successful participation in sex offense-specific treatment.

Sample

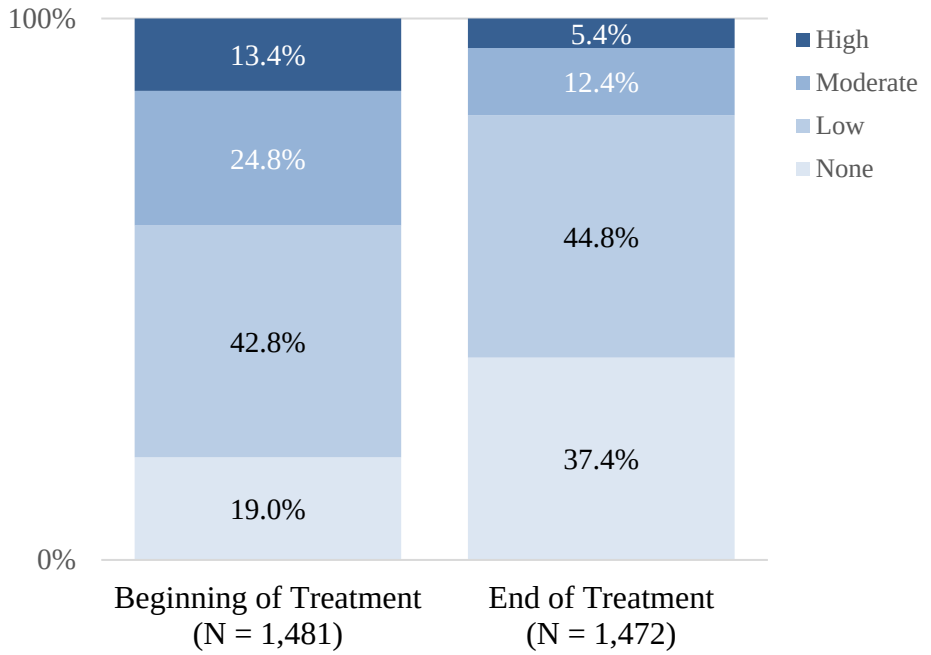
Approved treatment providers in the state of Colorado submitted data on 1,786 adult treatment discharge records between October 18, 2019, and November 1, 2022. Each record contains information regarding the client's level of denial (None, Low, Moderate, or High) at the beginning and end of treatment.[2] Additionally, a total of 365 records (20%) contained information regarding how treatment providers addressed denial with the client during treatment. These records were included in a qualitative analysis characterizing the methods providers utilized to address denial within treatment.

Results

Client denial levels recorded at the beginning and end of treatment are displayed in **Figure 1** below. At the beginning of treatment, the majority of clients (62%) had either no denial or low levels of denial. The overall proportion of clients with no denial or low levels of denial increased to 82% at the end of treatment. At the beginning of treatment, 13% of clients had high levels of denial; this proportion decreased to 5% by the end of treatment.

[2] The levels of denial are defined in the Adult Standards and Guidelines (add link):
Low Denial: This level consists of clients who accept most of the responsibility for the unlawful sexual behavior involved in the offense, but may place some blame elsewhere. They may either justify their intent behind its occurrence and/or minimize its importance or harmful impact on the victim. These clients demonstrate some motivation to change.
Moderate Denial: This level consists of clients who accept some of the responsibility for the unlawful sexual behavior in the offense. However, they place most of the blame elsewhere. They may deny the intent behind their unlawful sexual behavior and/or may not recognize the harmful impact their behavior has had on the victim. They may admit engaging in other harmful sexual behavior. They exhibit some motivation to change, although it may only be externally motivated.
High Denial: This level consists of clients who do not accept any responsibility for any unlawful sexual behavior. They deny committing the current unlawful sexual behavior or even remotely similar behavior. They may not recognize the harmful impact sexual offending behavior has on victims (even if it is not their own behavior) and appear to have no motivation to change. Clients presenting with this level of denial may blame the victim or the system, and/or present as excessively hostile or defensive.

Figure 1. Beginning and End of Treatment Denial Levels of Clients Treated by Approved Treatment Providers in Colorado, October 18, 2019 - November 1, 2022



The change in number and proportion of clients at each level of denial from the beginning to the end of treatment are shown in **Table 1** below. Of the clients that started treatment with high denial, 65% (129 clients) made progress in decreasing denial and taking some or full responsibility for their sexual offenses. The remaining 35% (69) continued to have high denial at the end of treatment. Of the clients ending treatment with high denial, 86% also had high denial at the beginning of treatment. The remaining 14% (11 clients) had partial denial (low or moderate denial) at the beginning of treatment. Overall, this represented less than 1% of the sample. An additional 8 clients (0.5%) increased their level of denial from the beginning to the end of treatment from either none to low or low to moderate.

Table 1. Beginning of Treatment Denial Level by End of Treatment Denial Level (N=1472)					
		End of Treatment Denial Level			
		None (N = 550)	**Low** (N = 659)	**Moderate** (N = 183)	**High** (N = 80)
Beginning of Treatment Denial Level	**None** (N = 277)	275 (99%)	2 (0.7%)	0	0
	Low (N = 623)	185 (29%)	438 (69%)	6 (1%)	3 (0.5%)
	Moderate (N = 265)	68 (19%)	163 (45%)	126 (35%)	8 (2%)
	High (N = 198)	22 (11%)	56 (28%)	51 (26%)	69 (35%)

Table Legend	
	Denial Level Increase
	No Change
	Denial Level Decrease

Several factors predicted greater likelihood of having high denial at the beginning of treatment. These factors were female gender, being African American, having gone no further in school than a high school diploma, having a higher risk level at the beginning of treatment, and having a contact offense.

Several factors also predicted having a less likelihood of being in the high denial group at the beginning of treatment. These factors were having a victim under 18 years of age, having had prior sex offense-specific treatment, and having concurrent substance abuse treatment.

In addition, several factors predicted a greater likelihood of being in high denial at the end of treatment. These factors included older age, female gender, having a contact offense, having a higher risk level at the end of treatment, and being African American, Native American, or Asian/Pacific Islander.

Several factors also predicted less likelihood of being in high denial at the end of treatment. These were having previous offense-specific treatment, as well as three responsivity factors: having an individualized treatment plan, receiving increased resources, and having a higher total number of responsivity factors.

Finally, reductions in denial were predicted by a greater lowering of risk level, being Hispanic/Latino, modifications to treatment assignments, and increased support, while lack of engagement with the community was negatively correlated with denial reduction.

As part of the data collection process, treatment providers are also able to enter qualitative data related to factors contributing to discharge. Treatment providers entered 365 specific comments related to denial which were organized thematically.

The two overarching themes were Client Progress and Therapeutic Approach. Within Client Progress, the sub-themes indicated the comments centered on no intervention being needed, progress being made, lack of progress being made, or that denial could not be treated for a range of reasons. Within the Therapeutic Approach, 9 sub-themes were identified indicating that a range of interventions, models, and therapeutic strategies were used to address high denial in accordance with the Standards and Guidelines. The included

use of deniers intervention, accountability group, polygraph or plethysmograph (PPG), additional treatment, general therapeutic strategies, group therapeutic strategies, group therapeutic processes, individual treatment, a range of therapeutic models, and a wide range of specific therapeutic strategies. The range of themes is suggestive of providers drawing upon a wide range of approaches when working with client denial within the umbrella of the Standards and Guidelines, the Risk, Need, Responsivity (RNR) model, and contemporary cognitive-behavioral practices.

Table 2 lists the sub-themes and lower-level categories that reflected client progress, while **Table 3** lists the sub-themes and lower-level categories that reflected therapeutic approaches. The numbers in the parentheses provide an indication of the density of that idea being mentioned optionally by an approved provider and thus, provide an indication of the salience for approved providers. Because the comments field was optional for approved providers to complete, those numbers should not be generalized as the general frequency or significance of occurrence across all clients in the SOMB database.

Table 2. Superordinate Theme 1 Client Progress
NO INTERVENTION NEEDED (21) • Took responsibility (11) • No intervention needed (10)
PROGRESS MADE (11) • Progressed & took full responsibility (4) • Decreased to partial denial & some responsibility (3) • Decreased denial to taking responsibility but unstable (2) • Progressed into regular group treatment (2) • Previous offense-specific treatment addressed denial (2)
LACK OF PROGRESS (6) • Denial persisted (3) • Denial worsened (3)
DENIAL COULD NOT BE ADDRESSED (37) • Unable to address denial (14) • Contact ended - client discharged (13) • Contact ended - client discontinued (6) • Engaged in legal process (3) • Contact ended - imprisonment (1)

Table 3. Superordinate Theme 2 Therapeutic Approach
DENIER INTERVENTION (54) • Denier's protocol/intervention (30) • Deniers' group (15) • Individual deniers' treatment (5) • Deniers' intervention level 1 or 2 (4)

ACCOUNTABILITY GROUP (16)
- Accountability group (14)
- Victim impact group (2)

POLYGRAPH OR PPG (84)
- Polygraph (76)
- Sequence and detail (7)
- PPG (1)

ADDITIONAL TREATMENT (6)
- Additional/adjunct treatment (6)

GENERAL THERAPEUTIC STRATEGIES (58)
- Develop therapeutic relationship (24)
- Discussed/processed in treatment (22)
- Therapeutic approach (not further specified) (14)
- Ongoing assessment (1)

GROUP THERAPEUTIC PROCESSES (68)
- Group treatment process (36)
- Group peer feedback & accountability (32)

INDIVIDUAL TREATMENT (66)

THERAPEUTIC MODELS (44)
- Cognitive Behavioral Treatment (CBT) (12)
- Motivational interviewing (10)
- Dialectical Behavior Therapy (DBT) (9)
- Support system involvement/meetings (3)
- Trauma focused (2)
- Trauma-informed CBT (1)
- Eye movement desensitization and reprocessing (EMDR) (1)
- Psychoeducational group (1)
- Boot camp group (including deniers' protocol) (1)
- Probation (1)
- Team sessions (1)
- Young adult protocol (1)

SPECIFIC STRATEGIES TO ADDRESS DENIAL (195)
- Work on cognitive distortions (29)
- Disclosure work (23)
- Develop victim empathy (not further defined) (23)
- Review collateral information (21)
- Psychoeducation (21)
- Develop accountability (not further defined) (19)
- Targeted/additional assignments (13)
- Assignments (9)
- Sex history packet (8)

- Accountability assignments/statement (6)
- Cycles assignments (5)
- Victim empathy work (5)
- Decrease stigma and shame (5)
- Collaborative treatment goals/planning (3)
- Boundaries packet (1)
- Covert sensitization (1)
- Decision-making models (1)
- Skills building (2)

A small number of comments did not fit into these themes as they related to: Domestic violence treatment being more appropriate and referred (1); Legitimate cognitive issues affected memory of offense (1); Individual treatment initially and not denial treatment (special needs/treatment responsivity issues) (1); and Transfer client (1).

Summary

Overall, 62% of clients in the study were in low or no denial, while 13% were in high (categorical) denial, at the beginning of treatment. Following treatment completion, 82% of clients were in low or no denial, while 5% were in categorical high denial. Approximately two-thirds (65%) of the client successfully reduced their categorical denial to a level where they were deemed appropriate to begin sex-offense specific treatment, while about one-third of clients (35%) were unable to reduce their categorical denial. Of the clients who ended treatment in categorical denial, 14% had regressed from a low or moderate level of high denial, while 86% remained in categorical denial throughout treatment.

Factors predicting high levels of denial at the beginning of treatment included female gender, being African American, having gone no further in school than a high school diploma, having a higher risk level at the beginning of treatment, and having a contact offense. Conversely, factors predicting lower levels of denial at the beginning of treatment included having a victim under 18 years of age, having had prior sex offense-specific treatment, and having concurrent substance abuse treatment.

Factors predicting high levels of denial at the end of treatment included older age, female gender, having a contact offense, having a higher risk level at the end of treatment, and being African American, Native American, or Asian/Pacific Islander. Conversely, factors predicting lower levels of denial at the end of treatment included having previous offense-specific treatment, as well as three responsivity factors: having an individualized treatment plan, receiving increased resources, and having a high total number of responsivity factors.

Finally, reductions in denial was predicted by a greater reduction in risk level, being Hispanic/Latino, modifications to treatment assignments, and increased support, while lack of engagement with the community was negatively correlated with denial reduction.

In terms of treatment strategies that appear to mitigate categorical denial, as identified by Approved Provider comments, the following, among others, were identified:

- Use of a denier's intervention as prescribed by the SOMB Standards and Guidelines
- Use of the group process
- Use of a polygraph exam
- Addressing victim impact
- Developing a therapeutic relationship
- Decreasing stigma and shame
- Focusing on distorted thought patterns related to the offense
- Supporting client motivation
- Use of client support systems
- Addressing client trauma history
- Providing psychoeducational

Regarding the application of denial interventions related to issues of equity, diversity, and inclusivity, this preliminary and exploratory data does seem to suggest that certain sexual offending populations are less successful in reducing denial. It is recommended that providers identify individualized treatment approaches, in particular, which are relevant and responsive to clients who are female, African American, Native American, or Asian/Pacific Islander. While there is no specific data related to LGBTQ clients, this may be another client group in need of an individualized and responsive treatment approach to denial.

In summary, treatment records entered by approved providers demonstrates success in addressing client denial. Approved providers identified a number of strategies to effectively address client denial, including use of interventions prescribed by the SOMB Standards and Guidelines. The SOMB continues to support the need to effectively address and overcome categorical denial prior to entering sex offense-specific treatment. It appears as if this expectation is working for most clients and approved providers have identified a number of effective treatment strategies to address denial. It is recommended that approved providers consider focusing on the above-noted treatment strategies and populations to assist and support clients in overcoming all levels of denial, but particularly categorical denial. As always, treatment should be individualized for each client based on the unique presenting client RNR factors, and the above strategies may serve that purpose depending upon the client.