BACKGROUND MATERIAL

AZSOMB ADULT GUIDELINES AND STANDARDS SUBCOMMITTEE

March 18, 2026

GUIDING PRINCIPLES

Guiding Principles

Purpose of the Guiding Principles is to establish the core foundation principles from which the *Standards and Guidelines* are created and to provide guidance in the absence of a specific standard or guideline.

1. The highest priority of these Standards and Guidelines is to maximize community safety[1] through the effective delivery of quality evaluation, treatment and management of sex offenders.[2]

2. Sexual offenses are traumatic and can have a devastating impact on the victim and victim's family.

   Sexual offenses violate victims and can lead to common and serious consequences across all areas of victims' lives, including chronic and severe mental and physical health symptoms,[3] as well as social, family, economic, and spiritual harm.[4] Research and clinical experience indicate that victims of sexual abuse often face long-term impact and continue to struggle for recovery over the course of their lifetime.[5] The impact of sexual offenses on victims varies based on numerous factors. By defining the offending behavior and holding offenders accountable, victims may potentially experience protection, support and recovery.[6] Professionals working with sexual

[1] Center for Sex Offender Management (2007). Enhancing the Management of Adult and Juvenile Sex Offenders: A Handbook for Policymakers and Practitioners. Center for Effective Public Policy, U.S. Department of Justice, Office of Justice Programs, 2005-WP-BX-K179 and 2006-WP-BX-K004; Colorado Revised Statutes16.11.7-101, "To protect the public and to work toward the elimination of sexual offenses, it is necessary to comprehensively evaluate, identify, treat, manage and monitor convicted adult sex offenders who are subject to the criminal justice system…"

[2] Mann, R. (2009). Sex offender treatment: The case for manualization. *Journal of Sexual Aggression, 15*(2): 121-131; Schmucker, M. & Losel, F. (2015). The effects of sexual offender treatment on recidivism: an international meta-analysis of sound quality evaluations. *Journal of Experimental Criminology, 11*(4):597-630.

[3] Chen et al. (2010). Sexual abuse and lifetime diagnosis of psychiatric disorders: Systematic review and meta-analysis. *Mayo Clinic Proceedings, 85*, 618–629; Dworking, E. R., Menon, S. V., Bystrynski, J., & Allen, N. E. (2017). Sexual assault victimization and psychopathology: A review and meta-analysis. *Clinical Psychology Review, 56,* 65-81; Mason, F. & Lodrick, Z. (2013). Psychological consequences of sexual assault. *Best Practice & Research Clinical Obstetrics and Gynaecology, 27,* 27-37; O'Leary, P., Easton, S. D., & Gould, N. (2017). The effect of child sexual abuse on men: Toward a male sensitive measure. *Journal of Interpersonal Violence, 32(2),* 423-445; Pérez-Fuentes, G., Olfson, M., Villegas, L., Morcillo, C., Wang, S., & Blanco, C. (2013). Prevalence and correlates of child sexual abuse: A national study. *Comprehensive Psychiatry, 54,* 16-17; Walsh et al. (2012). National prevalence of posttraumatic stress disorder among sexually re-victimized adolescent, college, and adult household-residing women. *Archives of General Psychiatry, 69(9)*, 935-942; Wilson, D. (2010). Health Consequences of Childhood Sexual Abuse. *Perspectives in Psychiatric Care. 46(1)*, 56-64.

[4] Dworking et al (2017); Mason et al (2017); O'Leary et al (2017); Pérez-Fuentes et al (2013).

[5] Campbell, R., Dworkin, E., & Cabral, G. (2009). An ecological model of the impact of sexual assault on women's mental health. *Trauma, Violence, & Abuse, 10*, 225-246; Cuevas, C. A., Finkelhor, D., Clifford, C., & Ormrod, R. K. (2010). Psychological distress as a risk factor for re-victimization in children. *Child Abuse & Neglect, 34,* 235-243; Dworking et al (2017); Finkelhor, D. (2009). The Prevention of Childhood Sexual Abuse. *Future of Children, 19(2)*, 169-194; Mason et al (2017); O'Leary et al (2017); Pérez-Fuentes et al (2013).

[6] Whittle et al. (2015). A Comparison of Victim and Offender Perspectives of Grooming and Sexual Abuse. *Deviant Behavior, 36(7)*, 539-564.

offenders should be alert to how offenders' behaviors may inflict further harm on persons they have previously victimized.[7]

3. Community safety and the rights and interests of victims and their families, as well as potential victims, require paramount attention when developing and implementing assessment, treatment and management of sex offenders.[8]

4. Offenders are capable of change.

   Responsibility for change ultimately rests with the offender. Individuals are responsible for their attitudes and behaviors and are capable of eliminating abusive behavior through personal ownership of a change process. While responsibility for change is the offender's, the therapeutic alliance between the offender and the therapist is a predictive and important facet of responsivity leading to behavioral change.[9] A warm, direct, and empathic therapeutic approach contributes to an offender's motivation to change, as does the supervising officer's positive working alliance with the offender. [10]

   The treatment and management of sex offenders requires a coordinated response by the Community Supervision Team (CST) and will be most effective if SOMB providers and the entirety of the criminal justice and social services systems apply the same principles and work together.[11]

   Community safety is enhanced when treatment providers and community supervision professionals' practice in their area of specialization and work together. This collaboration should include frequent and substantive communication about information that will assist in reducing an offender's risk to the community. When the CST members respect the individual roles and mutually agree upon their goals, the offender can be treated and managed more effectively.[12]

5. Community supervision is an opportunity, the success of which is dependent upon a sexual offender's willingness and ability to cooperate with treatment and supervision,

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[7] Hanson, R. K. & Yates, P. M. (2013). Psychological treatment of sex offenders. *Current Psychiatry Reports, 15(3),* 1-8; Littleton, H. (2010). The impact of social support and negative disclosure reactions on sexual assault victims: A cross-sectional and longitudinal investigation. *Journal of Trauma & Dissociation, 11,* 210-227; Patterson, D. (2011). The linkage between secondary victimization by law enforcement and rape case outcomes. *Journal of Interpersonal Violence, 26(2),* 328– 347; Watson, R., Daffern, M., & Thomas, S. (2017). The impact of interpersonal style and interpersonal complementarity on the therapeutic alliance between therapists and offenders in sex offender treatment. *Sexual Abuse: A Journal of Research and Treatment, 29(2),* 107-127; Watson, R., Thomas, S., & Daffern, M. (2015). The impact of interpersonal style on ruptures and repairs in the therapeutic alliance between offenders and therapists in sex offender treatment. *Sexual Abuse: A Journal of Research and Treatment,* 1-20.

[8] Campbell et al (2009); Cuevas et al (2010); Dworking et al (2017)

[9] Blasko, B., & Jeglic, E. (2014). Sexual offenders' perceptions of the client–therapist relationship: The role of risk. *Sexual Abuse: A Journal of Research and Treatment, 28*(4):1–20; Kozar, C. J. & Day, A. (2012). The therapeutic alliance in offending behavior programs: A necessary and sufficient condition for change? *Aggression and Violent Behavior, 17,* 482-487; Watson et al. (2017); Watson et al. (2015).

[10] Kozar et al (2012); Labrecque, R. M., Schweitzer, M., & Smith, P. (2014). Exploring the perceptions of the offender-officer relationship in a community supervision setting. *Journal of International Criminal Justice Research, 1,* 31-46; Watson et al. (2017); Watson et al. (2015).

[11] Alexander, R. (2010). Collaborative supervision strategies for sex offender community management. *Federal Probation, 74(2),* 16-19; Palmiotto, M. & MacNichol, S. (2010). Supervision of sex offenders: A multi-faceted and collaborative approach. *Federal Probation, 74(2),* 27-30.

[12] Alexander (2010); Palmiotto & MacNichol (2010).

and be accountable for their behaviors.[13] Accordingly, members of the Community Supervision Team should employ practices designed to maximize offender participation and accountability.[14]

6. Treatment and supervision are most effective when they are individualized, and incorporate evidence-based and research informed practices.[15]

7. Risk for future sexual offending varies and may increase or decrease. The intensity and duration of treatment and supervision should respond to these variations in risk.[16]

   Individual assessment and evaluation of risk should be an ongoing practice. Treatment approaches and supervision plans should be modified accordingly. Effective management of risk balances the use of external controls with the development of individual protective factors and self-regulation in order to reduce risk, enhancing the offender's ability to live safely in the community.

8. Victims have the right to safety, to be informed and to provide input to the Community Supervision Team (CST).

   Physical and psychological safety is a necessary condition for victims to begin recovery related to sexual abuse. Victims experience additional trauma when they are blamed or not believed, which may be more damaging than the abuse itself.[17] Victim impact is substantially reduced when victims are believed, protected and adequately supported.

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[13] Hönig, M., Vogelvang, B., & Bogaerts, S. (2017). "I am a different man now" – Circles of Support and Accountability: A prospective study. *International Journal of Offender Therapy and Comparative Criminology, 61(7),* 751-772.

[14] D'Orazio et al (2014); Woldgabreal, Y., Day, A., & Ward, T. (2016). Linking positive psychology to offender supervision outcomes: The mediating role of psychological flexibility, general self-efficacy, optimism, and hope. *Criminal Justice and Behavior, 43(6),* 697-721.

[15] Gallo et al. (2014); Hanson, R. K., Bourgon, G., & Hodgson, S. (2009). The principles of effective correctional treatment also apply to sexual offenders. *Criminal Justice and Behavior, 36(9),* 865-891; Levenson, J. (2014). Incorporating trauma-informed care into evidence-based sex offender treatment. *Journal of Sexual Aggression, 20(1),* 9-22; Seewald, K., Rossegger, A., Gerth, J., Urbaniok, F., Phillips, G. & Endrass, J. (2017). Effectiveness of a risk-need-responsivity-based treatment program for violent and sexual offenders: Results of a retrospective, quasi-experimental study. *Legal and Criminological Psychology, 23,* 85-99; Ward, T. & Gannon, T. (2014). Where has all the Psychology Gone: A Critical Review of Evidence-Based in Correctional Settings. *Aggression and Violent Behavior, 19*(4):435–446; Ward, T., Gannon, T., & Yates, P. (2008). The treatment of offenders: Current practice and new developments with an emphasis on sex offenders. *International Review of Victimology. 15(2),* 183–208.

[16] Bonta, J., & Wormith, J. S. (2013). Applying the risk-need-responsivity principles to offender assessment. In L.A. Craig, L. Gannon, L., & T. A. Dixon (Eds.), *What works in offender rehabilitation: An evidence-based approach to assessment and treatment* (pp. 71–93). Hoboken, NJ: Wiley-Blackwell; Gallo et al. (2014); Hanson et al. (2009); Parent, G., Guay, J., & Knight, R. (2011). An assessment of long-term risk of recidivism by adult sex offenders: One size doesn't fit all. *Criminal Justice and Behavior, 38(2),* 188-209; Seewald et al. (2017); van den Berg, J. W., Smid, W., Schepers, K., Wever, E., van Beek, D., Janssen, E., & Gijs, L. (2017). The predictive properties of dynamic sex offender risk assessment instruments: A meta-analysis. *Psychological Assessment,* 1-13.

[17] Beaver, W. R. (2017). Campus sexual assaults: What we know and what we don't. *The Independent Review, 22(2),* 257-268; Hayes, R. M., Abbott, R. L., & Cook, S. (2016). It's her fault: Student acceptance of rape myths on two college campuses. *Violence Against Women, 22(13),* 1540-1555; Littleton, H. (2010). The impact of social support and negative disclosure reactions on sexual assault victims: A cross-sectional and longitudinal investigation. *Journal of Trauma & Dissociation, 11(2),* 210-227; Najdowski, C., & Ullman, S. E. (2011). The effects of re-victimization on coping in women sexual assault victims. *Journal of Traumatic Stress, 24(2),* 218-221; Paige, J. & Thornton, J. (2015). Healing from intrafamilial child sexual abuse: The role of relational processes between survivor and offender. *Children Australia, 40(3),* 242-259; Patterson, D. (2011). The linkage between secondary victimization by law enforcement and rape case outcomes. *Journal of Interpersonal Violence, 26(2),* 328– 347; Rennison, C. M. & Addington, L. A. (2014). Violence against college women: A review to identify limitations in defining the problem and inform future research. *Trauma, Violence, and Abuse, 15(3),* 159-169; Ullman & Peter-Hagene (2016). Longitudinal relationships of social reactions, PTSD, and re-victimization in sexual assault survivors. *Journal of Interpersonal Violence, 31*6), 1074-1094; Yung, C. R. (2015). Concealing campus sexual assault: An empirical examination. *Psychology, Public Policy, and Law, 21(1),* 1-9.

The CST can assist the victim in this by providing information and affording the victim representation in the supervision and management of the offender. Victim input and knowledge of the offender are valuable information for the supervision team.[18] Victims are empowered to determine their level of participation.

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

10. The SOMB Standards and Guidelines are based on current and emerging research and best practices.[19]

    Treatment, management, and supervision decisions should be guided by empirical findings when research is available. Since there is limited and emerging empirical data specific to sexual offending, decisions should be made cautiously to minimize unintended consequences.

11. A continuum of treatment and management options for sex offenders should be available in each community in the state. Additionally, efforts should be made to maximize continuity of care whenever a transition from one treatment setting to another to maximize positive treatment progress.[20]

    It is in the best Interest of public safety for each community to have a continuum of management and treatment options so that treatment is appropriately matched to the client.

12. Successful treatment and management of sex offenders is enhanced when the Community Supervision Team (CST) models and encourages family, friends, employers and other members of the community in pro-social support of the offender.[21]

    Families, friends, employers and members of the community who have influence in the lives of offenders can meaningfully contribute to their successful functioning in society. Family and friends should be included in the supportive

[18] Center for Sex Offender Management (2007). The Role of the Victim and Victim Advocate in Managing Sex Offenders (training curriculum). Silver Spring, MD.

[19] Colorado Revised Statutes16-11.7-103(e)(I), "The board shall research, either through direct evaluation or through a review of relevant research articles and sex offender treatment empirical data, and analyze, through a comprehensive review of evidenced-based practices, the effectiveness of the evaluation, identification, and treatment policies and procedures for adult sex offenders developed pursuant to this article."

[20] Boer, D. (2013). Some essential environmental ingredients for sex offender reintegration. *International Journal of Behavioral Consultation and Therapy, 8(3-4), 8*-11; Scoones, C., Willis, G., & Randolph, G. (2012). Beyond static and dynamic risk factors: The incremental validity of release planning for predicting sex offender recidivism. *Journal of Interpersonal Violence, 27(2),* 222–238.

[21] Miller (2015). Protective strengths, risk, and recidivism in a sample of known sexual offenders. *Sexual Abuse: A Journal of Research and Treatment, 27(1),* 34-50; de Vries Robbé, M., Mann, R. E., Maruna, S., & Thornton, D. (2015). An exploration of protective factors supporting desistance from sexual offending. *Sexual Abuse: A Journal of Research and Treatment, 27(1),* 16–33; Tharp, A. T., DeGue, S., Valle, L. A., Brookmeyer, K. A., Massetti, G. M., & Matjasko, J. L. (2013). A systematic qualitative review of risk and protective factors for sexual violence perpetration. *Trauma, Violence & Abuse, 14(2),* 133-67.

network in a manner that is sensitive to the possible negative impact of the offense on them.[22]

13. Information sharing among CST members is vital to public safety and offender success.

    Sexual offense-specific treatment is not conducted with the same degree of confidentiality as non-mandated treatment.[23] Sex offenders waive confidentiality with regard to therapeutic and/or public safety goals. When sensitive and private information is shared, the dignity and humanity of all involved must be respected.

14. Sex offense-specific assessment, evaluation, treatment, behavioral monitoring and supervision should be humane, non-discriminatory and bound by the rules of ethics and law.[24]

15. The individualization of evaluations, assessment, treatment and supervision requires particular attention to social and cultural factors. Recognition of these factors are essential when interacting with clients from different social, cultural, and religious backgrounds. A basic premise is to recognize the client's culture, your own culture, and how both affect the client-provider relationship.

    This premise extends to all professional members of the CST and positive support persons and is essential in creating an equitable and inclusive environment regardless of differences in culture or lifestyle.[25]

[22] Wilson, R., & McWhinnie, A. (2013). Putting the 'Community' back in community risk management of persons who have sexually abused. *International Journal of Behavioral Consultation and Therapy, 83-4), 72-79.*

[23] Levinson J. & Prescott, D. (2010), Sex offender treatment is not punishment. *Journal of Sexual Aggression, 16(3); 275-285;* McGrath et al. (2010). *Current Practices and Emerging Trends in Sexual Abuser Management: The Safer Society 2009 North American Survey*. Brandon, VT: Safer Society Press; Sawyer, S. & Prescott, D. (2011). Boundaries and dual relationships. *Sexual Abuse: A Journal of Research and Treatment, 23(3)*, 365-380.

[24] Birgden, A. & Cucolo, H. (2011). The treatment of sex offenders: Evidence, ethics, and human rights. *Sexual Abuse: A Journal of Research and Treatment, 23(3)*, 295–313; Harrison, K. & Rainey, B. (2013). Legal and ethical aspects of sex offender treatment and management, Chichester, K, John Wiley & Sons, Ltd.

[25] Ratified by the SOMB 05/21/2021