Myth: Risk assessment of sex offenders is not reliable or empirically sound

- Must consider changing and unchanging aspects of individual.
  - Changing factors include treatment completion, advanced age or other characteristics specific to an individual that have been shown to affect risk.

- Risk assessment allows us to do the most important things
  - Identify the most dangerous sex offenders
  - Apply the most intensive interventions to those who need the greatest level of supervision, treatment, and monitoring.

Principles for Assessment

- Risk assessment must be comprehensive in best practice model
- It must include multiple sources of information and multiple risk factors including static and dynamic; short-term and long-term risk; or stable and acute factors
- Actuarial measures give estimates of long-term risk for groups of individuals with same score
- Other information can be presented in arguing for increased risk or its mitigation, so long exercised prudently and with caution

Principles for Assessment

- Caveats to use of any actuarial risk assessment instrument:
  - Over-interpretation
  - Proxy variables (e.g., prior arrests for sexual offense)
  - Coding rules can use the same words in different ways (e.g., charges in Static-99 vs. MN-SOST)
  - Error rates
  - Knowledge of other limitations

Treatment of sex offenders

- **Facts:**
  - Offenders who attend and cooperate with treatment are less likely to re-offend
  - Treatment effectiveness is related to multiple factors, including
    - Type of sexual offender
    - Treatment methods
    - Related interventions involved in probation and parole or community supervision.

Treatment Effectiveness

- Different measures can be used to measure effect of treatment
- Most studies use criminal behavior as the outcome measure
  - Reconviction for sexual offense
  - Re-arrest or new charges for sexual offense
  - Reconviction for nonsexual (violent offense)
  - Re-arrest or new charges for nonsexual (violent offense)
  - Any reoffending, e.g., as reported by complainants in any context

Treatment Effectiveness: Notable Study

- Hanson, et al. (2002)
  - Metaanalysis of 43 studies of sex offender treatment (N=9,454)
  - Both community and institutional programs
  - Average follow-up=4-5 years
  - Current treatments (i.e., e.g., CBT programs since 1980) significantly reduced both sexual and general recidivism

Hanson et al. (2002)

K = 16		
N = 3461		
Follow Up = 4 years		
	Sexual recidivism	General recidivism
Treated	9.9%	32.3%
Untreated	17.3%	51.3%

Treatment Effectiveness

- Hanson, et al. (2002): Discussion
  - Treatment of sex offenders is effective in reducing recidivism or increase public safety regardless of setting of delivery
  - Not all types of treatment equally effective
  - Cognitive-Behavioral Treatment (CBT) has the highest degree of promise
  - CBT aims at teaching offenders how to identify patterns (habits, values, social influences) that contribute to offending and self management skills to cope effectively or adaptively to high risk situations
  - Completing treatment lowers risk than not completing whether it occurs in community or in institutions
  - Training and supervision must focus on methods associated with evidence for effectiveness

Lösel & Schmucker (2005)

K = 69			
N = 22,181			
Follow Up = 5+ years			
	Sexual recidivism	Violent recidivism	Any reoffense
Treated	11.1%	6.6%	22.4%
Untreated	17.5%	11.8%	32.5%

Correctional Service of Canada Data

Nicholaichuk et al. (2000)		
N = 376; Follow Up = 6+ years		
	Sexual Offences	All Non-sex offenses
Treated	14.5%	32.1%
Untreated	33.2%	35.0%
Looman et al. (2000)		
N = 178; Follow Up = 10 years		
	Sexual Offences	All Non-sex offenses
Treated	23.6%	61.8%
Untreated	51.7%	74.2%

Rockwood Positive/Motivational Program Outcome (Marshall, 2008)

N = 534		
Follow Up 7.4 years		
	Sexual Offenses	General Offenses
Treated	3.2%	13.6%
Expected	16.8%	40.0%
OR = 6.14; d = 1.00		

Treatment Effectiveness: Other Recent Studies

- Marques, et al (2002; Cited by Marshall, 2008)
  - High risk offenders
  - Sexual recidivism:
    - Received treatment= <10%
    - Did not receive TX= >50%
- de Vogel, et al (cited by Marshall, 2008)
  - Treatment completers 42% sexual recidivism
  - Non completers= 62% sexual recidivism

Treatment Effectiveness: Other Recent Studies

- Craig, et al. (2003)
  - 18 of 19 studies reviewed 1995-1999 showed positive treatment efficacy
  - One-third of the 18 studies used sound empirical methods

- Other reviews—earlier studies up to 1999
  - Sexual recidivism
    - 18% to 27% in untreated group
    - Treated group= 5% to 10% lower on average than untreated

Treatment Effectiveness

- Effect Size: Interpreted as percentage of reduction in the undesirable effect
- Typical effect sizes for sex offender treatment
  - 0.11 to 0.47
  - Average= 0.25 (5 studies between 1995 to 2003)
- Typical effect size for some medical/psychological interventions
  - Aspirin for myocardial infarction = 0.03
  - Coronary bypass surgery and heart disease= 0.15
  - Chemotherapy for breast cancer= 0.08
  - Neuroleptics for dementia= 0.32
  - Treatment of adult and juvenile nonsexual offenders=0.10 to 0.29 (three studies)

– Source: Marshal (2006)

Treatment Effectiveness—Reasonable Conclusions

- A "cautiously optimistic" view
  - TX appears to help reduce risk for recidivism, in light of better empirical procedures used to assess effect
  - More research is needed
  - TX as one aspect of comprehensive risk management strategy
  - Even when treatment effect is lacking, more funding for research and intervention is needed to distinguish between effective and less effective measures through actual trials and outcome studies
  - TX effectiveness may vary for particular groups.
    - Higher initial risk level may show a greater reduction in recidivism
    - Psychopathy
    - Degree of client responsivity
  - Expansion of treatment outcome measures or targets

Treatment Effectiveness—Reasonable conclusions

- As the ATSA position paper regarding this issue illustrates,

  - Sexual offender policies are based partly on the myth that sex offenders cannot be treated. Early studies, conducted in the 70's and 80's, were unable to detect differences in recidivism rates between sex offenders who had undergone treatment and those who had not. This finding was widely publicized, leading to skepticism about the benefits of treatment, and opening the door to punitive public policies. […] Recent, statistically sophisticated studies with extremely large combined samples have found that contemporary cognitive-behavioral treatment does help to reduce rates of sexual reoffending by as much as 40%. However, treatment does not work equally well for all offenders (like any psychological or mental health treatment or medical interventions, for that matter). Treatment failure is associated with higher recidivism rates, and research indicates that sex offenders who *successfully* complete a treatment program reoffend less often than those who do not demonstrate that they "got it."

Treatment Components

- Criminogenic needs
  - Also referred to as dynamic risk factors
  - Factors that tend to maintain sexual aggression or associated with time of offending
  - Include stable and acute factors
  - Recent research has identified two major pathways to sexual offending
    - Sexual deviance (e.g., enduring sexual interest in children; sexual preoccupation)
    - Antisocial orientation

Sources: Hanson & Morton-Bourgon (2004; 2005); Hanson & Harris (2000)

Crucial components in Community-Based supervision of adult SO

- Community Supervision (special role of supervision agents)
  - Incarceration sanctions often not sufficient to lower risk to community and unique challenges upon release
  - Intensive monitoring
  - Special conditions and restrictions
    - Disclosure
    - Treatment
    - No contact with victim
    - No contact with children
    - No sexual contact or unsupervised contact with minors
    - No pornography
    - Employment
    - No position of supervision with minors or women
    - No Alcohol/drugs
    - Electronic/Internet and technology restrictions

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