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

Must consider changing and unchanging aspects of

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: 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

Lösel & Schmucker (2005)

Correctional Service of Canada Data

Nicholaichuk et al. (2000)		
N = 376; Follow Up = 6+ years		

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

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Treatment Effectiveness—Reasonable conclusions

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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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