5-2023

Sex Offender Treatment and Recidivism Reduction Strategies

Kathleen M. Newhouse

Sex Offender Treatment and Recidivism Reduction Strategies

By

Katie Newhouse

A Starred Paper

Submitted to the Graduate Faculty of

Saint Cloud State University

in Partial Fulfillment of the Requirements

for the Degree of Master of Science

in Criminal Justice

May 2023

Starred Paper Committee:
Mario Hesse, Chairperson
Lindsey Vigesaa
Jessica Davison

Table of Contents

Chapter I: Introduction

As of February 2023, there were a total of 786,838 people listed on the state sex offender registries, which is about a three percent increase from 2022 (Gabriele, 2023). The article suggested there are several reasons for this increase, including people completing probation, pending cases from the prior year, and population changes. Each year, Safe Home compiles a list of recent sex offender data from all 50 states and reports the key findings, which recently found that Texas accounts for nearly 13% of all registered sex offenders nationally, with 101,000 sex offenders registered (Gabriele, 2023). According to the American Psychological Association (n.d.), a sex offender or person who has committed a sexual offense is someone who tries to force or coerce a victim into unwanted sexual activity, often by making threats or taking advantage of victims who do not consent.

The criminal justice system's response to sex offenders has become progressively penal, relying on incarceration, but some states have invested in treatment and reentry programs as alternatives (Wilson, 2017). The field of adult sex offender treatment has advanced with the addition of the correctional component, and as research has evolved, this field has developed some of the most collaborative and effective systems for dealing with sex offenders. The assessment, treatment, and risk management of persons who have sexually offended are of considerable interest to a wide variety of stakeholder groups, including legislators and policymakers, court and law enforcement personnel, corrections and community supervision staff, mental health clinicians, victim advocates, and the community-at-large. Many of these stakeholders have expressed concerns regarding the potential for sexual recidivism and other harms posed by offenders released into the community. Consequently, most jurisdictions have enacted legislative structures to manage those risks (Wilson, 2017). Most incarcerated offenders

eventually return to the community, and effective treatment is vital for an offender's successful reintegration into society. Treatment does not eliminate the risk of re-offense, nor does it guarantee that any individual will or will not commit another offense. However, sex-specific treatment, along with other offender management strategies, balances community safety with addressing a client's needs (Thompson, 2016).

Due to a lack of studies and limited research, this paper will only assess adult male sexual offenders and will not include data on women who have committed sexual offenses. It is important to note that there is significantly less data on female sex offenders and effective treatment interventions than there are for males. This theory is based on the idea that sexual victimization is generally underreported. Because of this, it is hard to get reliable information about the types of sex crimes committed by women, which makes it hard to measure. Stigma is another big factor in how people feel about sexual offenses, which have long been seen as mostly "male-only" crimes. A possible contributing factor to this belief is the pervasive gender role stereotypes about women being nurturing and caring individuals who are, by nature, unlikely to engage in aggressive or destructive behaviors toward others (Allen, 1991). Another possible contributing factor is the theoretically operating sexist beliefs that depict men as controlling all sexual encounters and females as passive and submissive recipients. One final contributing factor to this belief is that the cases of adult females who were teachers and their younger male students have been viewed somewhat in the public as not as big of a deal, and some adult males and juvenile males have reported this crime as a sexual fantasy or something cool, and therefore the female can't be a predator (Allen, 1991; Becker et al., 2001; Schwartz & Cellini, 1995).

Utilizing best practices and continually staying up-to-date on the research is imperative to providing quality treatment and/or interventions that may reduce the likelihood of recidivism for individuals who have committed sexual offenses. The goal of treatment for sexual offenses as part of an overall intervention is to hold clients accountable, help them improve their lives, and achieve the ultimate outcome of no more victims (Hanson & Morton-Bourgon, 2005). Some people hold the misconception that 'sexual offender' treatment, as part of an overall offender management strategy, is a futile effort with sexual offenders who cannot be rehabilitated. Fortunately, research tells us differently and indicates that treatment is continually beneficial in reducing sexual reoffending (Thompson, 2016).

The purpose of this paper is to evaluate sex offender treatment and recidivism reduction strategies for adult male sexual offenders and how recidivism is best reduced through: individual and group psychotherapy, targeting dynamic and static risk factors, cognitive behavioral therapy, and restorative justice. Additionally, evaluating the effectiveness of community-based treatment settings versus institutional settings such as incarceration on the reduction of recidivism. Research continues to demonstrate that treatment of individuals who have committed a sexual offense is beneficial in reducing continued sexual reoffending (Thompson, 2016).

Chapter II: Review of Relevant Research/Problem

In the context of this paper, recidivism will be defined as a new arrest for a sexual offense, a new conviction for a sexual offense, or a new prison sentence for a sexual offense. Recidivism for all criminal offenders is an issue that affects every community member, and it is important that when it comes to sexual offenders' recidivism, professionals treating these offenders know the best practices to keep the community safe and treat the offender successfully. As of now, sexual offenders have more requirements for re-entry after prison than any other crime. This is because they must be assessed for risk levels which affects their housing and where they can live, availability of where they can work, and public stigma due to community notification policies (Hanson et al., 2002). Also, there are sex offender specific probation teams for some counties in the United States, and some states even have civil commitment programs for continuing offenders. This is a large problem, as it is costly for taxpayers to pay for continued out of community placements. We need to be focused on the effectiveness of implementing and providing treatment that is evidence based in reducing recidivism (Hanson et al., 2002).

In recent years, there have been a record number of sexual offenders returning to society and living in our communities and although recidivism has been a concern of both policymakers and practitioners in the field, it has received renewed attention due to growing rates of recidivism. Although past research has shown that adult male sex offenders are more likely to recidivate, it is often with a nonsexual offense or probation violation rather than a new sexual offense. For example, the individual could be charged with small-time theft, not following community registration conditions such as updating contact information, relapsing on drugs or

alcohol, and more. Prospective risk studies with sexual offenders are difficult because the expected base rate of recidivism is low. Between 10-15 percent would be expected to be detected committing a new sexual offense after five years (Hanson & Bussière, 1998; Hanson & Morton-Bourgon, 2005).

According to Duwe and Goldman (2009), they asked how effective treatment is and found that treatment for adult male sexual offenders reduced both the risk and pace of sexual reoffending. Studying a sample of Minnesota offenders, they found a 13.4 percent sexual reoffense rate for treatment completers versus a 19.5 percent re-offense rate for offenders who did not participate in treatment. Luong and Wormith (2006) found that treated sexual offenders reoffended at a substantially lower frequency than offenders who did not receive treatment. In a strong summary, Prentky et. al (2006) noted that "the most reasonable estimate at this point is that treatment can reduce sexual recidivism over a 5-year period by 5-8%." Hanson et al. (2014) found that treatment alleviated recidivism and that even 'high risk' offenders are not high-risk for extended periods of time because the risk of reoffending goes down with time, not up. This is statistically significant, as it proves that in more current research, the recidivism rate for sex offenders not only goes down with treatment, but the likelihood of reoffending also stays down in the long term. Two different recidivism studies were conducted in the United States in Arizona, New York, and Vermont that studied the data behind the recidivism of individuals in community-based settings while individuals were on probation and/or involved in cognitive behavioral therapy treatment and the results of their success when involved in treatment.

SOTIPS Recidivism Studies

A SOTIPS (sex offender treatment intervention and progress scale) study was conducted beginning in spring 2013 with an overall sample of 731 adult men assigned to probation for sexual crimes in New York City, NY (the 5 boroughs), and in Phoenix, AZ. New York had 192 participants as a sample size, and Arizona had 539 participants as a sample size. They assessed each individual three times: once at intake into probation, six months later, and six months after that, so approximately one year on probation utilizing SOTIPS. The mean age of each offender was 42.5 years old across all ethnic groups represented, such as Native American, Asian, African American, White, Hispanic, and Other/Unknown. This study also measured their employment status, including if they were retired and disabled, and the relationship status of each offender. Probation officers supervising these sexual offenders were trained on SOTIPS by one of the developers, Dr. Robert McGrath, in both New York and Arizona. Dr. McGrath also consulted nine different sex offender treatment programs and included the treatment providers to assist in case coordination with probation officers to identify any changes in the process of monitoring and decision making in the offenders' treatment completion (Newstrom et al., 2019). All participants in this study were adult men who were Static-99R eligible (an adult male convicted of a contact or non-contact sex offense with an identifiable victim), had no indications of cognitive disability from available records, were at least 18 years old, and were released to community supervision in New York City during or after April 2013 and in Maricopa County during or after January 2013. The results found that out of the 731 individuals in the sample size, 558 were able to be measured all three times, while the others had to be removed for numerous reasons, including reoffending, violation of probation, deportation, or moving out of the jurisdiction. Although the sample size was small, only 24% of the sexual offenders on probation

had a recidivism rate. The study does not specifically identify how many individuals completed a new crime out of that 24%, which suggests a much smaller statistic of recidivism as defined by this paper, where individuals currently on probation for sexual offenses are re-offending at a lower rate than prior research (Miner et al., 2022).

In Vermont, between 2001 and 2007, another SOTIPS study was conducted on 759 adult male sex offenders who were both under correctional supervision and enrolled in cognitive-behavioral therapy treatment. This study identified recidivism as all new charges for sexual, violent (sexual or nonsexual violence), and any criminal offenses resulting in a return to prison. The authors utilized a similar method to the previous study in Arizona and New York and utilized the Static 99R initially to determine eligible offenders and measured the offender at three different times: first during the first three months of treatment, second between four and nine months, and lastly between 10 and 15 months. However, they conducted a three year follow up period to more accurately assess recidivism among study participants (McGrath et al., 2012). The results concluded that after three years, 4.6% of offenders had a new sexual offense; an additional 2.6% of offenders had a new violent offense; any criminal recidivism, including probation violations, was 23.1%; and lastly, the number of offenders who returned to prison for another of those was 40.6%. This is statistically significant, as the recidivism rates for new sexual offenses are significantly lower than re-arrests for different crimes and/or probation violations, especially for individuals who rated moderately high or high on the SOTIPS risk scale. This study shows lower recidivism when individuals are enrolled in cognitive-behavioral therapy treatment than the prior study when individuals were on probation with differing requirements (McGrath et al., 2012).

The results of these studies show that even for high-risk sex offenders, community-based treatment programs and cognitive behavioral therapy can help reduce the number of times they commit new crimes. It emphasizes the need for evidence-based treatment programs to be made available to individuals who have committed sexual offenses, as these treatment programs have the potential to significantly reduce the number of new crimes committed.

Chapter III: Risk Assessment Tools

Risk assessment is a critical task in the effective management of sex offenders. Risk assessments inform decisions on sentencing, community registration and notification, treatment, supervision, release from detention, and discharge from services. Assessments can have a profound impact on community safety, offenders' liberty, and the smart allocation of public resources. The effectiveness of risk-assessment methods has improved over the past two decades, although room for improvement still exists (Yates & Kingston, 2005).

In the 1990's, Andrews and Bonta created the RNR model (risk, need, responsivity), which is an evidence-based framework measuring rates of recidivism and reoffending severity. Over the years, there have been many tools utilized to measure the rate of recidivism or "success" of sexual offenders through tools such as the Level of Service Case Management Inventory (LS/CMI), Static-99R (risk), and Minnesota Sex Offender Screening Tool-Revised (MnSOST-R), all of which contribute to determining each offender's level of risk category as determined by the Minnesota Department of Corrections. Tools that will be reviewed are utilized to determine recidivism and assign risk to the offender, which controls the treatment measures they will receive and the recommendations by professionals (Klima and Lieb 2008).

Bonta and Wormith (2008) say that progress in risk assessment can be broken down into four main phases. First-generation risk assessment approaches rest on unstructured professional judgment. In the sex offender treatment field, second-generation risk-assessment instruments began emerging in the late 1990s. These actuarial measures are composed of static risk factors, which are considered unchangeable traits of an individual's past, such as criminal history, including age of first offense, number of previous convictions, and victim characteristics. Static

actuarial instruments include the *Rapid Risk Assessment for Sex Offense Recidivism,* which is designed to assess different levels of sexual recidivism risk for convicted sexual offenders with at least one crime (RRASOR; Hanson, 1997), and the *Risk Matrix 2000 Sexual* is a statistically derived risk classification process intended for males aged at least 18 who have been convicted of a sexual offense. At least one of these sexual offenses should have been committed when the perpetrator was aged 17 or older (RM2000/S; Thornton et al., 2003). *Static-99R* is designed to estimate the probability of sexual and violent reconviction for adult males who have already been charged with or convicted of at least one sexual offense against a child or a non-consenting adult. This instrument may be used with first-time sexual offenders (Hanson & Thornton, 2000). The *Static-2002R* is an update of the *Static-99R,* which improved predictive accuracy for more violent recidivism with less variability (Helmus & Hanson, 2011).

Some second-generation actuarial risk instruments can include a small number of dynamic risk factors or called "criminogenic needs". These elements are changeable risk factors such as pro-offending attitudes, employment status, cooperation with supervision and offense-related sexual interests. Examples of instruments that include mostly static but some dynamic risk factors are the *Minnesota Sex Offender Screening Tool–Revised* which is a 16 item tool developed by the Minnesota Department of Corrections to provide empirically based estimates of risk for sexual recidivism for incarcerated male sex offenders (MnSOST-R; Epperson et al., 1997), *Sexual Violence Risk–20* is a set of structured professional judgement guidelines for conducting sexual violence risk assessments in criminal and civil forensic contexts (SVR-20; Hart & Boer, 1997) and the *Vermont Assessment of Sex Offender Risk* measures risk for adult male offenders aged 18 and older to assist probation officers in making placement and supervision decisions (VASOR; McGrath & Hoke, 2001). They are arguably second-generation

instruments because they do not include enough dynamic risk factors for rehabilitative professionals to make decisions comprehensively.

Contemporary research has focused primarily on developing third-generation instruments that combine both static and collections of dynamic risk predictors into a single risk-needs instrument or "set" of instruments. Adding multiple dynamic factors to the risk assessment equation leads to more comprehensive evaluations and has the capability to increase the long-term predictive accuracy of static instruments. Examples of these third-generation instruments include the *LS-CMI* (Level of Service/Case Management Inventory), which provides a general assessment of risk and needs for offenders paired with overall risk (Andrews et al., 2004). The *Sex Offender Treatment Invention and Progress Scale* is a 16-item rating scale to identify dynamic risk among adult male sex offenders and a degree of change at six-month intervals during treatment (SOTIPS; McGrath et al., 2012). *The Violence Risk Scale: Sexual Offender Version* (VRS:SO) is a recently developed instrument specifically designed to assess risks and needs among sexual offenders. Which contains seven static factors and 17 dynamic factors based on the Stages of Change or Transtheoretical Model (Beggs & Grace, 2010). The *Stable-2007* measures 'stable dynamic' risk factors, which are potentially changeable but may persist for months or years. The instrument incorporates a guided interview schedule that covers 13 major risk areas: significant social influences, capacity for relationship stability, emotional identification with children, hostility toward women, general social rejection, lack of concern for others, impulsivity, poor problem-solving skills, negative emotionality, sex drive and preoccupation, sex as coping, deviant sexual preferences, and cooperation with supervision (McGrath et al., 2012). *Acute-2007* measures 'acute dynamic' risk factors, characterized as transient conditions that can change over a period of weeks, days, or hours. The instrument

assesses seven areas of risk: victim access, hostility, sexual preoccupation, rejection of supervision, collapse of social support, emotional collapse, and substance abuse (Hanson et al., 2007).

Lastly, risk-needs instruments that fully integrate assessments with ongoing case planning are considered fourth-generation risk assessment tools, which are just beginning to make their way into practice. This phase emphasizes the structured monitoring of individuals over time to maximize treatment and supervision benefits. Fourth generation instruments focus on responsivity considerations that may affect how practitioners relate to their clients and select appropriate interventions for them at appropriate times (Bonta & Wormith, 2008). Hanson et al. (2009) found that treatment that focuses on the principles of an offender's risk, needs, and responsivity to intervention showed the largest reductions in sexual and general recidivism. Therefore, it is crucial for practitioners to use fourth-generation instruments to monitor the progress of their clients over time and ensure that they receive the appropriate interventions at the right time. By doing so, they can maximize the benefits of treatment and supervision, leading to a reduction in recidivism rates.

Chapter IV: Treatment Modalities or Interventions

Although measuring treatment efficacy can be difficult, there have been many contributions to how effective treatment is for adult male sexual offenders. But it's important to recognize that sexual offenders are an often-diverse group with many variations of offenses or crimes. Treatment efficacy should be measured by both the benefits of effective treatment and sexual recidivism, not solely based on recidivism. Sexual offender treatment falls under the umbrella of psychotherapy, more often in the modality of group therapy with individual therapy added as necessary. The goal of psychotherapy in this context is to teach clients how their sexual offenses occur, including contributing factors to look at such as compulsiveness, criminality, psychopathology, and sexual deviancy. Additionally, it aids the individual in exploring their unhealthy habits, life circumstances, or individual characteristics that can contribute or continue to contribute to their risk factors and how to mitigate that risk through group therapy.

From a human rights perspective, adult male sex offender treatment should aim to help individuals achieve as normal a level of functioning as possible and should only place restrictions on those activities that are highly related to problematic behavior. "Thus, a man who raped an adult woman might be encouraged to avoid certain situations in his future life but should not be expected to give up any hopes of developing an intimate relationship by being told to avoid all situations where single women might be present" (Ward, 2007, p. 196). The Good Lives Model (GLM) is based around two core therapeutic goals: to promote human goods and to reduce risk. Their model shares that by promoting specific goods or goals in the treatment of offenders, it is likely to eliminate commonly targeted dynamic risk factors (or criminogenic needs). By contrast, they argue that focusing solely on the reduction of risk factors is unlikely to

promote the full range of specific goods and goals necessary for longer-term abstinence from offending. Strength-based approaches such as the GLM of offender rehabilitation focus on the utilization of offenders' primary goods or values in the design of intervention programs and aim to equip them with the capabilities necessary to implement a better life plan founded on these values. (Ward & Brown, 2004).

Marshall and Laws (2003) provide a good overview of the development of sexual offender treatment over the past century or more, highlighting that often treatment for persons who have sexually offended has mirrored the approaches popular during a certain period. For instance, when psychodynamic approaches were in favor, clinicians treating sexual offenders were also likely to use psychodynamic methods. Similarly, the same was true for cognitive, behavioral, and cognitive-behavioral methods—the latter of which is currently most popular, and evidence suggests that they may be most likely to achieve positive outcomes. Cognitive Behavioral Therapy (CBT) is a version of talk therapy that is primarily focused on thinking and behavior change by utilizing coping strategies or learned skill sets to change how your thoughts, beliefs, and attitudes contribute to your actions and feelings (see McGrath et al., 1998, 2010). Within the last 10 years, empirical research suggests that cognitive-behavioral treatment remains the most widely accepted and empirically supported model of adult male sexual offender treatment with respect to reducing recidivism (e.g., Hanson et al., 2002). There are many different forms of CBT that are utilized, but one specific approach is focused on compassion-based therapy or victim therapy, which works by encouraging offenders to look at the cognitive and emotional understanding of the experience their victim(s) had in regard to their offense. Many clients can be too high risk to contemplate immediate community placement; however, many of these clients may be managed safely in the community provided they have access to

effective treatment options and evidence-based case management (via enhanced parole or probation supervision; see Wilson et al., 2009; Wilson & Prescott, 2014).

The use of different polygraphs to guide a sexual offender's treatment and measure his or her honesty and sense of responsibility is a treatment method that has been the subject of a lot of debate. The courts continue to argue against its admissibility, but it is still widely used in both outpatient programs and institutional treatment settings. Polygraphs are utilized both in institutional settings and outpatient treatment settings to assess a multitude of factors. The term 'polygraph' refers to an instrument that simultaneously measures several physiological indicators. Typically, in the detection of deception context, the physiological measures monitored by the polygraph are peripheral measures governed by the autonomic nervous system (ANS), such as changes in skin conductance, heart rate, and blood pressure (National Research Council, 2003). US research examining the polygraph as a "truth facilitator" suggests that its use lies in its ability to elicit more reliable information from offenders, including more accurate descriptions of their sexual histories, sexual fantasies, offense behaviors, and victim information such as number and type. It has been argued that using the polygraph in this way can be helpful for treatment in terms of gaining further information for relapse prevention and developing effective supervision. Although these findings are encouraging, it is not clear whether polygraph testing leads to offenders disclosing more risk-relevant information than they would under normal supervision. This is because no studies have incorporated adequate comparison groups and no evaluations of offenders' and offender managers' views have been conducted (Ahlmeyer et al., 2000).

The Penile Plethysmograph (PPG), which is a penile sexual arousal test that is often used to help determine whether a male participant is likely or unlikely to respond sexually to a child or adolescent, and the results may be used in arriving at an opinion as to whether a person is a likely sex offender or is likely to reoffend, is considered the most invasive method, and treatment professions have tried to pivot to the Abel Screening (Chammah, 2015). Abel Screening was founded in 1995 to aid in evaluating individuals who are a sexual risk to children by asking them a series of yes or no questions. People accused of sex offenses have taken the Abel assessment and used favorable scores to obtain therapy instead of a criminal conviction. Adult male sex offenders who have been convicted have found the conditions of their probation or parole affected by whether the test found them to have a "sexual interest" in children. For example, their conditions of probation could determine how often they must check in with a probation officer or what treatment is suggested (Chammah, 2015).

Restorative Justice

Historically, the primary mode of dealing with adult male sex offenders or individuals who commit sexual offenses was incarceration, regardless of the severity of the offense; prison sentences were usually 20-30 years and offered little restorative rehabilitation (Burdon & Gallagher, 2002). According to the Center for Sex Offender Management (CSOM; 2007), many federal and state agencies have tried to reduce overcrowded prison systems by transitioning sex offenders back into the community using a restorative justice philosophy. CSOM shared that by reducing prison populations and implementing restorative guidelines, such as increased support for sex offender "reentry" or inclusion into the community, improved confidence in public safety, and a significant increase in sex offenders' contributions to the workforce, success has been

achieved. An area not well studied within the restorative justice literature is addressing both victim and community needs for safety, amends, and healing, which is important to the process of restorative justice (Eisnaugle, 2003).

Studies have inferred that a victim's participation in restorative justice (RJ) practices can be beneficial for their psychological wellbeing by aiding in the reduction of symptoms of Post-Traumatic Stress Disorder (PTSD) and overall stressors experienced. RESTORE, a pilot program that ran from 2003 to 2007 in Arizona, is one of the best-known RJ programs focused on assisting victims of sexual violence through restorative justice. Taking a victim-centered approach to RJ, RESTORE offered victims the opportunity to participate in a dialogue with the offenders who attacked them as an alternative to criminal prosecution. This was not a one-off intervention: cases were carefully screened, and victims were supported prior to, during, and after the dialogues to ensure their safety and well-being. An evaluation of the RESTORE program found that victims showed a decrease in PTSD from intake (82%) to post-conference (66%). Victims who participated in the program not only experienced a reduction in stress but also felt empowered. All of the victims who participated in the RESTORE program strongly agreed with the statement that “taking back their power” was a major reason to select RESTORE over other justice options (Koss, 2014). Based on a study of 58 publications on sexual violence and Restorative justice, which included 10 victims’ accounts, Wager (2013) found that victims often thought of the conferencing experience as empowering rather than traumatizing. Conferencing is a tool that involves an open dialogue between a victim and an offender in the presence of support persons. Therefore, conferencing can be a powerful tool for victims of sexual violence to regain their sense of control and power in the aftermath of trauma, while also holding offenders accountable for their actions. It is important to continue exploring and implementing

restorative justice practices in cases of sexual violence to provide victims with a sense of agency and promote healing (Wager, 2013).

Different Settings Treatment Modalities Can Take Place

A 2016 meta-analysis conducted by Kim, Benekos, and Merlo (2016), studied past data that found "that sex offender treatment can be considered proven or at least promising," suggesting that incorporating treatment for individuals who have committed sexual offenses is more effective than the alternative of no treatment. This study evaluated and recorded that treatment in the community can be more effective than institutional treatment or out of society placements such as civil commitment programs, prisons, or jails. Research has demonstrated that factors that contribute to treatment efficacy include the development of empathy, also known as addressing distorted thinking patterns, while targeting an individual's criminogenic lifestyle (Kim et al., 2016).

In community-based settings, treatment is grounded in evidence-based practices, especially cognitive-behavioral therapy. Typically, treatment is more readily accessible in the community in an outpatient setting versus institutional settings, although that appears to be changing in the Department of Corrections. The common method of funding community-based treatment is by charging participants fees, which may restrict who has access to necessary resources due to financial constraints. Standardized risk assessment tools are widely used nationally in both institutional and community-based treatment; however, needs assessment tools are becoming more widespread in community supervision of sexual offenders. It is imperative that correctional institutions share documentation with community supervision agencies to

provide a continuity of care as it has been shown to contribute to less re-offending or recidivism (Hanson et al., 2002).

Offenders may not always have the option to complete sex offender treatment while incarcerated due to their short-term status or even how they are acclimating to the prison population. However, in cases where offenders have completed treatment while incarcerated, it is still a condition of release that they re-complete programming once they return to the community. Additionally, it is important to differentiate the correctional rehabilitation model from other forms of psychological or medical treatment received in community settings. In the correctional rehabilitation model, sexual offenses are regarded as both social transgressions and personal problems. Criminal justice sanctions can and ought to be used to persuade individuals who have committed sexual offenses to engage in treatment. Offenders have the right to refuse to cooperate with any intervention; however, that refusal would influence the sanctions they received, such as extensions of time served and/or increases in conditions of supervision. The clear objective of treatment is to prevent reoffending by addressing clients' criminogenic needs (Prescott & Levenson, 2010).

In contrast, the conventional treatment models for psychological or outpatient services suggest that everyone has full authority over the treatments that they receive or do not receive. Although the primary responsibility of traditional mental health care is to a patient's welfare, providers can not and do not have the primary responsibility to prevent reoffending by an individual in their care (Evrard, 2009). As an illustration, a 2007 trial conducted in France highlighted a prison physician who prescribed a Viagra medication to a high-risk pedophile just before being released per the pedophiles request. Within one month of release, this individual

rapidly reoffended, and the prescribing physician offered an interesting perspective as to why that may be. This physician justified his decision by saying that prison doctors do not have access to an individual's criminal records due to HIPPA and therefore could not discriminate and decline to give a medication to an individual because he didn't know what they were incarcerated for. This point of view is not an irregularity within the medical community in France and emphasizes the important distinction between the medical model of treatment and the correctional rehabilitation model (Evrard, 2009). The case highlights the ethical dilemma that medical professionals face when treating incarcerated individuals, especially those with a history of sexual offenses. While medical professionals are bound by the Hippocratic Oath to provide care to all patients, they also have a responsibility to protect society from potential harm.

Chapter V: Critique of Research and Limitations

Recidivism is still a challenging concept to quantify, especially when it comes to adult male sex offenders and their risks. The problem is due to the nature of sex crimes, and the low reporting of sexual offenses to the police, and the various methods used by researchers to determine recidivism rates. Several studies have reported that the likelihood of a person reporting sexual assault declines as people get older and more time has passed. Additionally, since recidivism is measured in various ways by researchers, it is crucial to critically analyze all of the data. The evaluation of the best practices for treating individuals who have committed a sexual offense, is subject to various criticisms that I have, including inaccurate or unreliable reported crime rates, inadequate follow-up periods for calculating recidivism (less than five years), a lack of consistency among researchers' methods, and smaller sample sizes of sexual offenders.

The main treatment strategy for sexual offenders has been the relapse prevention (RP) model approach, but there is little data to support its efficacy with sexual offenders because it was designed more for alcoholic patients who had trouble maintaining abstinence. The RP model incorrectly views sexual offending behavior as an addictive process, which presents conceptual challenges such as defining what constitutes a lapse and represents a "one size fits all" approach that fails to adequately address the varied treatment needs that offenders present with or the pathways to offending they follow (Laws & Ward, 2006; Yates & Kingston, 2005).

It is important to note the rates of crimes relating to sexual offending and how that correlates with the relapse prevention model that treatment was based on. Thus, across the disparate populations studied, researchers consistently have found that approximately one-half of all sexual assaults are committed by men who have been drinking alcohol (Laws & Ward, 2006). According to Crowell and Burgess (1996), depending on the size of the sample studied and the

procedures utilized, the amount of alcohol use among offenders has ranged from 34 to 74 percent.

Thanks to technology, there have been vast improvements in how we can access old and new data to aid in completing effective and efficient recidivism studies. Some jurisdictions with more access to centralized assessments and criminal history records make it more possible to revise and update recidivism estimates with a relatively minimal price point. On the other hand, excellent quality treatment outcome studies necessitate much larger investments of time and effort. Making comparisons between treated and untreated offenders from the same setting is usually subjective because those who get treatment are methodically different from those that do not, due to factors such as lack of cooperation and/or major mental illness. Strong experimental designs require that experimenters' control who gets treatment, which is unpopular with treatment providers but also drives researchers to use prospective designs. Taking into account that the outcome of interest or "sexual recidivism" has a low base rate (typically less than 2% per year), long follow-up periods (≥5 years) are required to detect even large effects. The combination of high costs and long follow-up periods eliminates a lot of qualified researchers from being able to conduct appropriate studies to provide effective study results (Collaborative Outcome Data Committee, 2007a, 2007b).

Sex offender treatment is integral to holding those who have committed sexual offenses responsible and accountable for their crimes through a multi-faceted plan that can include assessment, rehabilitation, supervision or probation, and restorative justice when applicable. The literature makes it clear that the quality of community reintegration planning can have marked effects on recidivism and client reintegration potential. The overall goal for treatment

intervention is to assist the client with a better understanding of their past behaviors and generate no more victims (Willis & Grace, 2008). According to current research findings, when treatment best practices are put in place, there is a positive correlation which reduced sexual offenses. In spite of the limitations and disagreements above, the research suggests that the extent of sex offender recidivism can help both policymakers and criminal justice practitioners in several purposeful ways: 1) they can provide a verifiable basis to understand more effectively the differential public safety risks by different types of convicted sex offenders; 2) they can help recognize the risk factors that are linked to recidivism; 3) they can help policymakers and criminal justice practitioners implement and construct more tailored and effective recidivism reduction strategies (Willis & Grace, 2008).

References

Ahlmeyer, S., Heil, P., McKee, B., & English, K. (2000). The impact of polygraphy on admissions of victims and offenses in adult sexual offenders. Sexual Abuse: *A Journal of Research and Treatment, 12, 123–138*. doi:10.1177/ 107906320001200204.

American Psychological Association (n.d.). *Sexual Assault and Harassment.* Retrieved from: https://www.apa.org/topics/sexual-assault-harassment.

Andrews, D.A., Bonta, J. & Wormith, J.S. (2004). *The Level of Service/Case Management Inventory (LS/CMI)*. Toronto, ON: Multi-Health Systems.

Allen, C. (1991). *Women and men who sexually abuse children: A comparative analysis*. Brandon, VT: The Safer Society Press.

Becker, J., Hall, S., & Stinson, J. (2001). Female sexual offenders: Clinical, legal and policy issues. *Journal of Forensic Psychology Practice, 1*, 29-50.

Beggs, S.M. & Grace, R.C. (2010). Assessment of dynamic risk factors: An independent validation of the Violence Risk Scale: Sex offender Version. *Sexual Abuse: A Journal of Research and Treatment, 22,* 234–251.

Bonta, J., & Wormith, S. J. (2008). Risk and need assessment. In G. McIvor & P. Raynor (Eds.), *Developments in social work with offenders* (pp. 131-152). London, UK: Jessica Kingsley.

Burdon, W. M., & Gallagher, C. A. (2002). Coercion and sex offenders: Controlling sex-offending behavior through incapacitation and treatment. *Criminal Justice and Behavior, 29*, 87-109

Center for Sex Offender Management (U.S.), United States Office of Justice Programs, & Center for Effective Public Policy. (2007). *Female sex offenders*. Center for Effective Public Policy.

Chammah, M. (2015, July 9). The Sex-Offender Test: How a computerized assessment can help determine the fate of men who've been accused of sexually abusing children. *The Atlantic*. Retrieved from https://www.theatlantic.com/politics/archive/2015/07/the-sex-offender-test/397850/.

Collaborative Outcome Data Committee. (2007a). *Sexual offender treatment outcome research: CODC Guidelines for evaluation Part 1: Introduction and overview* (Corrections Research User Report No. 2007-02). Ottawa, Ontario: Public Safety Canada.

Collaborative Outcome Data Committee. (2007b). *The Collaborative Outcome Data Committee's guidelines for the evaluation of sexual offender treatment outcome research Part 2: CODC guidelines* (Corrections Research User Report No. 2007-03). Ottawa, Ontario: Public Safety Canada.

Crowell, N.A., & Burgess, A.W. (1996). *Understanding Violence Against Women.* Washington, D.C.: National Academy Press.

Duwe, G., & Goldman, R. (2009). The impact of prison-based treatment on sex offender recidivism: Evidence from Minnesota. *Sexual Abuse: A Journal of Research and Treatment, 21*, 279–307.

Eisnaugle, C. N. (2003). An international truth commission: Utilizing restorative justice as an alternative to retribution. *Vanderbilt Journal of Transnational Law, 6*, 209-241

Epperson, D.L., Kaul, J.D., Huot, S.J., Hesselton, D., & Alexander, W. (1997, October). *Climbing the slippery slope of risk prediction: Updated developments on the Minnesota*

Sex Offender Screening Tool (MnSOST). Paper presented at the 16th annual conference of the Association for the Treatment of Sexual Abusers, Arlington, VA.

Evrard: les surprenantes explications du médecin qui a prescrit le Viagra [Evrard: The surprising explanations of the doctor who prescribed Viagra]. (2009, October 28). *La Parisien*. Retrieved from http://www.leparisien.fr/faits-divers/ evrard-les-surprenantes-explications-du-medecin-qui-a-prescrit-le-viagra-28-10-2009-691597.php

Gabriele, R. (2023, March 29). *Sex Offender Registry Rates: 2023 Report*. SafeHome.org. Retrieved March 30, 2023, from https://www.safehome.org/data/registered-sex-offender-stats/

Hart, S. D., & Boer, D. P. (2010). Structured professional judgment guidelines for sexual violence risk assessment: The Sexual Violence Risk-20 (SVR-20) and Risk for Sexual Violence Protocol (RSVP). In R. K. Otto & K. S. Douglas (Eds.), *Handbook of violence risk assessment* (pp. 269–294). Routledge/Taylor & Francis Group.

Hanson, R. K. (1997). *The development of a brief actuarial risk scale for sexual offense recidivism*. Retrieved January, 2023.

Hanson, R. K., & Bussière, M. T. (1998). Predicting relapse: A meta-analysis of sexual offender recidivism studies. *Journal of Consulting and Clinical Psychology, 66*(2), 348–362. https://doi.org/10.1037/0022-006X.66.2.348

Hanson, R. K., Gordon, A., Harris, A. J. R., Marques, J. K., Murphy, W., Quinsey, V. L., & Seto, M. C. (2002). First report of the collaborative outcome data project on the effectiveness of psychological treatment for sex offenders. *Sexual Abuse: A Journal of Research and Treatment, 14,* 169-194.

Hanson, R. K., Harris, A. J. R., Scott, T.-L., & Helmus, L. (2007). *Assessing the risk of sexual offenders on community supervision: The Dynamic Supervision Project* (User report, Corrections research). Ottawa, ON, Canada: Public Safety Canada. Retrieved from http://www.publicsafety.gc.ca/cnt/rsrcs/pblctns/ssssng-rsk-sxl-ffndrs/index-eng.aspx.

Hanson, R.K., Harris, A.J.R., Helmus, L., & Thornton, D. (2014). High-Risk Sex Offenders May Not Be High Risk Forever, Journal of Interpersonal Violence, *29*(15), 2792-2813.

Hanson, R. K., & Morton-Bourgon, K. E. (2005). The Characteristics of Persistent Sexual Offenders: A Meta-Analysis of Recidivism Studies. *Journal of Consulting and Clinical Psychology, 73*(6), 1154–1163. https://doi.org/10.1037/0022-006X.73.6.1154

Hanson, R.K., Bourgon, G., Helmus, L. & Hodgson, S. (2009). The principles of effective correctional treatment also apply to sexual offenders: A meta-analysis. *Criminal Justice and Behavior, 36*, 865-891.

Hanson, R. K., & Thornton, D. (2000). Improving risk assessments for sex offenders: A comparison of three actuarial scales. *Law and Human Behavior, 24*(1), 119–136. https://doi.org/10.1023/A:1005482921333

Helmus, L., & Hanson, R. K. (2011). More fun with statistics! How to use logistic regression to predict criminal recidivism risk. *Crime Scene*, *18*(2), 8-12. Retrieved from http://www.cpa.ca/docs/file/Sections/Criminal%20Justice%20Psychology/Crime%20Scene%202011-10.pdf

Kim, B., Benekos, P., Merlo, A. (2016). Sex offender recidivism revisited: Review of recent meta-analyses on the effects of sex offender treatment. *Trauma, Violence, & Abuse, 17*, 105-117.

Klima, T. & Lieb, R. (2008). *Risk assessment instruments to predict recidivism of sex offenders: Practices in Washington State*. Olympia: Washington State Institute for Public Policy, Document No. 08-06-1101.

Koss, M.P. (2014). The RESTORE Program of Restorative Justice for Sex Crimes: Vision, Process and Outcomes. *Journal of Interpersonal Violence, 29*(9) 1623-1660.

Laws, D.R., & Marshall, W.L. (2003). A brief history of behavioral and cognitive behavioral approaches to sexual offenders: Part 1. Early developments. Sexual Abuse: *A Journal of Research and Treatment, 15*(2), 75-92.

Laws, D. R., & Ward, T. (2006). When one size doesn't fit all: The reformulation of relapse prevention. In W. L. Marshall, Y. M. Fernandez, L. E. Marshall, & G. A. Serran (Eds.), *Sexual offender treatment: Controversial issues* (pp. 241–254). John Wiley & Sons Ltd. arch and Treatment, 15, 75-92.

Luong, D., & Wormith, S.J. (2006). *The Effectiveness of Psychological Sex Offender Treatment: A MetaAnalysis*. Department of Psychology, University of Saskatchewan, Saskatoon, Canada. Available from the authors at Duyen.Luong@usask.ca.

Marshall, W.L., & Laws, D.R. (2003). A brief history of behavioral and cognitive behavioral approaches to sexual offender treatment: Part 2. The modern era. *Sexual Abuse: A Journal of Research and Treatment, 15*, 93-120.

McGrath, R. J. & Hoke, S. E. (2001). *Vermont Assessment of Sex Offender Risk*. Waterbury, VT: Author. (Original work published 1994)

McGrath, R.J., Cumming, G.F., Burchard, B.L., Zeoli, S., & Ellerby, L. (2010). *Current practices and emerging trends in sexual abuser management: The Safer Society 2009 North American survey*. Brandon, VT: Safer Society Press.

McGrath, R. J., Lasher, M. P., & Cumming, G. F. (2012). The Sex Offender Treatment Intervention and Progress Scale (SOTIPS): Psychometric Properties and Incremental Predictive Validity With Static-99R. *Sexual Abuse: A Journal of Research and Treatment*, *24*(5), 431–458. https://doi.org/10.1177/1079063211432475

McGrath, R.J., Hoke, S.E., & Vojtisek, J.E. (1998). Cognitive-behavioral treatment of sex offenders: A treatment comparison and long-term follow-up study. *Criminal Justice and Behavior*, *25*, 203-225.

Miner, M.H., Broillette-Alarie, S., Davies, S.T., Newstrom, N., Robinson, B.E., Thornton, D., & Hanson, R. K. (2022, April). Reliability and Factor Structure of the Sex Offender Treatment Intervention and Progress Scale. *ATSA*, *35*(1). https://doi-org.scsuproxy.mnpals.net/10.1177/107906322210826

Newstrom, N. P., Miner, M., Hoefer, C., Hanson, R. K., Robinson, B. B. E. (2019). Sex offender supervision: Communication, training, and mutual respect are necessary for effective collaboration between probation officers and therapists. *Sexual Abuse*, *31*(5), 607–631. https://doi-org.scsuproxy.mnpals.net/10.1177/1079063218775970

Prentky, R., Schwartz, B., & Burns-Smith, G. (2006). *Treatment of Adult Sex Offenders*. Harrisburg, PA: VAWnet, National Online Resource Center on Violence Against Women/Pennsylvania Coalition Against Domestic Violence

Schwartz, B., & Cellini, H. (1995). Female sex offenders. In B. Schwartz & H. Cellini (Eds.), *The sex offender: Corrections, treatment and legal practice* (pp. 5-1 – 5-22). Kingston, NJ: Civic Research Institute.

Thompson, M. D. (2016, October 6). *Is 'Sex Offender' Treatment Effective?* Retrieved February 28, 2023, from https://mnatsa.org/wp-content/uploads/2020/02/MnATSA-Treatment-Efficacy-Thompson-Oct-2016R.pdf.

Thornton, D., Mann, R., Webster, S., Blud. L. Travers, R., Friendship, C., & Erickson, M. (2003). Distinguishing and combining risks for sexual and violent recidivism. In R. Prentky, E. Janus, & M. Seto (Eds.) *Understanding and managing sexually coercive behavior*. Annals of the Academy of Sciences.

Wager, N. (2013). The experience and insight of survivors who have engaged in a justice meeting with their assailant. *Temida, 16*(1), 11-32.

Ward, T. (2007). On a clear day you can see forever: Integrating values and skills in sex offender treatment. *Journal of Sexual Aggression, 13*(3), 187–201. https://doi.org/10.1080/13552600701794036

Ward, T. & Brown, M. (2004). The Good Lives Model and conceptual issues in offender rehabilitation. *Psychology, Crime & Law, 10*, 243257

Willis, G. M. & Grace, R. C. (2008). The quality of community reintegration planning for child molesters: Effects on sexual recidivism. *Sexual Abuse: A Journal of Research and Treatment, 20*, 218–2

Wilson, R. J. (2017, June 22). *Best Practices in the Assessment, Treatment, and Risk Management of Persons Who Have Sexually Offended*. National Institute of Corrections. U.S. Department of Justice. Retrieved October 29, 2022, from https://s3.amazonaws.com/static.nicic.gov/Library/033135.pdf.

Wilson, R.J. & Prescott, D.S. (2014). Community-based risk management of sexual offender risk: Options and opportunities. In K. McCartan (Ed.), *Sexual offending: Perceptions, risks and responses*. Basingstoke, UK: Palgrave-MacMillan.

Wilson, R.J., Cortoni, F., Picheca, J.E., Stirpe, T.S., & Nunes, K. (2009). *Community-based sexual offender maintenance treatment programming: An evaluation*. [Research Report R-188] Ottawa, ON: Correctional Service of Canada.

Yates, P. M., & Kingston, D. A. (2005). Pathways to sexual offending. In B. K. Schwartz & H. R. Cellini (Eds.), *The Sex Offender* (Volume V, pp.1-15), Kingston, NJ: Civic Research Institute.