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Chapter 5

An introduction to sex offender treatment programmes and their risk reduction efficacy

Sarah Brown

Introduction

The use of sex offender treatment programmes has developed and expanded enormously in recent decades such that they are now used routinely in many countries and in some they have become an integral part of the countries' criminal justice systems' responses to sex offenders. For example, in England and Wales all offenders who are sentenced for a sexual offence and who have time to complete a treatment programme are assessed for their suitability to complete this form of intervention and to determine which programme or programmes they should complete.

In order to meet the principles outlined by the Carlton University Group (see Andrews 1989; Andrews *et al.* 1990a; Andrews and Bonta 2003) of risk (offenders should receive intervention according to their level of risk), need (offenders should receive interventions that address their criminogenic needs), and responsivity (offenders should receive treatment that meets their specific characteristics, such as intellectual functioning) that have been repeatedly shown to be associated with effective interventions (Andrews *et al.* 1990b; Lipsey 1989, 1995) and to allow for large-scale, cost-effective delivery to as large a group of appropriate offenders as possible, England and Wales have a suite of programmes that have the same underlying principles that fit together so that a package of programmes that is most appropriate for each offender can be delivered. These programmes are delivered in both community and custodial settings, and a system of accreditation ensures that all programmes (a) are

suitable for use, as by having a sound underlying theoretical base and model of change that is evidence-based; and (b) are delivered as intended; that is, have programme integrity – for example, by reviewing programme delivery and treatment providers' practice. The suite of programmes is designed so that some offenders, such as those with short sentences and/or lowest risk and/or need, complete a single programme, while others, such as those with long sentences or highest risk and/or need, complete two or more programmes. Some programmes are completed on a rolling format, where offenders join at the start of any module, a format which provides for offenders who have short sentences and limited periods of time in which to complete the intervention, although the majority of programmes have specific start and end points, with all offenders starting the programme at the same time. In addition, specific programmes are available for offenders with learning difficulties and for offenders whose sexual offences involved the Internet.

This is just one approach to the implementation of sex offender treatment: there is great variability from country to country and in some countries, such as the USA, from state to state and county to county, although many states now have a system of accreditation for treatment providers. While much of the large-scale provision (for example, in the UK and Canada) has been centred on criminal justice, in some parts of the world sex offender treatment is located within more therapeutic, public health and/or mental health settings. Despite this variation, the most common, though by no means only, treatment approach used for adult male offenders is the cognitive-behavioural approach, which has been shown by the so-called What Works evidence base, to be an effective approach for offender intervention (for a review, see Vennard *et al.* 1997). Interventions with juvenile/adolescent sex offenders, which are still being developed and are gradually being used more extensively, use a greater variety of approaches (e.g. Reitzel and Carbonell 2006 and Chapter 9 of this volume) with multi-systemic treatment to date showing good outcome data, though the evidence base for these programmes is still small (Reitzel and Carbonell 2006).

Before looking at the development of sex offender treatment and outlining the principles/content of cognitive-behavioural programmes, it is important to note that although the word 'treatment' is commonly used to refer to this form of offender intervention, it is not the most appropriate term if this conjures up ideas about medical treatment. Cognitive-behavioural programmes require offenders to engage in them actively, learn skills, and assimilate ideas/messages, etc., that

they are then expected to employ in order to live non-offending lives in the community. Although medical treatment usually requires some kind of engagement/participation (for example, to take the required amounts of medication at the correct times), it is more passive in nature; for example, it can be administered with great effect to a person who is unconscious. The same could never be said for cognitive-behavioural treatment, which requires the client to be alert, to be motivated to some extent to learn and absorb the messages, skills and ideas of the programme, and to actively implement these thoughts, skills and behaviours in their lives, and in many instances into all aspects of their lives for very long periods of time.

Some forms of treatment for sex offenders are medical, though they are used less commonly. For example, some jurisdictions still use surgical castration; however, ethical and human rights issues tend to mean that this method is used only on a small number of offenders/men, largely those who volunteer to have the procedure (for more information on surgical castration, see Chapter 6 of this volume). Hormonal treatments are used in some programmes or with some offenders (for a review of evaluation studies and treatment issues, see Chapter 6 of this volume). As discussed by Lösel and Schmucker (2005), hormone treatments are not normally used in isolation, and problems such as negative side effects and potential increased risk following termination mean that the use of this treatment is not likely to be widespread, though it may be particularly useful for some groups of offenders (for example, high-risk offenders, or when sexual arousal plays a significant causal role in offending). Because of these issues, the rest of this chapter will focus on describing cognitive-behavioural programmes, which is the most commonly used approach, in countries such as Canada, the USA, the UK, New Zealand and Australia.

Cognitive-behavioural programmes

The origins of cognitive-behavioural programmes (for a more detailed review of the development of these programmes, see Laws and Marshall 2003; Brown 2005) can be found in the 1970s delivery of traditional behavioural programmes, such as aversion therapy, which were designed to reduce deviant sexual arousal and in some instances, as with orgasmic or masturbatory reconditioning, to increase appropriate sexual arousal (for a more detailed discussion of the range of techniques applied to sex offenders, see Marshall *et*

al. 1999; Wood *et al.* 2000; Law and Marshall 2003). The effectiveness of these programmes was limited (Quinsey and Earls 1990; Laws and Marshall 2003), perhaps due to the simplistic idea that sexual arousal is the sole and single motivator for inappropriate sexual behaviours.

At a time when psychology more generally saw a shift from favouring behavioural to cognitive theories and explanations, and the complexity of the causes and motivations for sexual behaviour was increasingly recognised, sex offender treatment programmes also developed and expanded their content. For example, some therapists (Marshall and Williams 1975) reasoned that appropriate sexual relationships would not be formed if offenders were not able to develop relationships with adults, and this was likely to be a problem given that many of their clients had poor social skills; accordingly, they added social skills and sex education elements to their behavioural programme. Throughout the 1970s, the range of factors incorporated into behavioural treatments was expanded upon. By the late 1970s, Abel *et al.* (1978) had added components on assertiveness, sexual dysfunction and gender role behaviour, and by 1980 had also incorporated empathy enhancement (Murphy *et al.* 1980), forming what could arguably be described as one of the first cognitive-behavioural treatment programmes for sex offenders.

Over time, the cognitive element of these programmes expanded such that although still called cognitive-behavioural programmes, current programmes have a small behavioural element, which is largely centred on behavioural theories and explanations of behaviour; for example, that behaviours have causes and consequences and those that are perceived positively are likely to be repeated. Few current cognitive-behavioural programmes use the more traditional behavioural therapies, such as aversion therapy, although these approaches have seen a small revival in recent years, being employed on an individual basis with some offenders whose motivations for sexual offending and/or risk factors are amenable to these approaches. However, these techniques are more likely to be used as an add-on to cognitive-behavioural, group-based programmes on an individual basis, rather than being used and delivered more routinely. Most programmes do employ techniques that are derived from behavioural principles, such as modelling and role-play.

The shift from behavioural to cognitive-behavioural approaches in sex offender treatment developed in two ways. The first occurred rapidly in North America, with treatment practitioners adding more cognitive components to what had originally been behavioural programmes. Eventually, most programmes explored and attempted

to change attitudes towards sexual behaviour and sexually deviant behaviour; attitudes towards women and children and sexual entitlement; cognitive distortions (or thoughts and attitudes encouraging sexually deviant behaviour); offence cycles or offence chains, including thoughts and behaviours leading to sexually deviant behaviour; empathy; self-esteem; and social skills. The other way in which cognitive-behavioural programmes were developed can be illustrated by the introduction of sex offender programmes to the prison service of England and Wales, where, once a decision had been taken at a political level to introduce sex offender treatment programmes, a focus on evidence-based practice led to a review of the What Works literature, which determined that cognitive-behavioural programmes were the most effective programmes (generally and with sex offenders). Thus, the new initiative was introduced, with programmes being modelled on the most promising programmes from North America, incorporating the more general findings and principles from the What Works literature.

In the 1980s, as cognitive-behavioural programmes continued to develop, relapse prevention became an important component of treatment programmes; indeed, some programmes were designed to be centred on these principles (e.g. Marques *et al.* 2005). Although some treatment providers had attempted to develop relapse-prevention-type strategies, it was not until Pithers *et al.* (1983) extended the relapse-prevention model, originally developed in the area of addiction by Marlatt (1982; see also Marlatt and Gordon 1985) that relapse prevention became a key element, if not a central part, of most cognitive-behavioural programmes. The main aim of relapse prevention is to encourage and support the maintenance of treatment-induced abstinence; for example by encouraging offenders to think about how they will respond, and develop skills to respond to lapses/relapses in behaviour (such as having a cigarette or alcoholic drink in the original additions model, or thinking about a sexual offence when adapted for sex offender treatment programmes).

Although popular for a number of years, and argued by Marshall (1996) to be '[w]ithout doubt, the most important development in the 1980s' (180), the enthusiasm for relapse prevention has waned in recent years (for a more detailed discussion see Brown 2005; Mann and Marshall 2009), not helped by the poor outcome of a randomised, control evaluation of a programme centred on relapse prevention (Marques *et al.* 2005; see also Mann and Marshall 2009) and the fact that in their meta-analysis, Gallagher *et al.* (1999) showed no difference in the outcome of cognitive-behavioural with and without

relapse-prevention elements. Relapse prevention also encourages a focus on what cannot be done and what should be avoided – that is, avoidance goals; yet, as Mann (1998, cited in Marshall and Serran 2000) observed, research indicates that avoidance goals are more difficult to attain than approach goals. This approach also conflicts with positive models of offender engagement that have become popular in recent years.

Following the incorporation of relapse-prevention techniques, the core elements and principles of cognitive-behavioural treatment for sex offenders had been established and the most significant development in the 1990s and early 2000s was the rapid increase in the use of these programmes. This period also saw the approach being used (with adaptations as necessary) with a broader group of offenders, such as juvenile/adolescent offenders, female offenders and offenders with learning difficulties.

The principles of behavioural theories/approaches show that positive reinforcement for desired behaviour is a much more effective method of adapting behaviour than either negative reinforcement or punishment. It is interesting that, given this, criminal justice systems and frequently offender interventions have been traditionally focused on punishment and negative reinforcement. Recently, coinciding with an increased interest in psychology more generally with positive psychology, work in this area has focused on offender engagement and working with offenders' potentials to live good, healthy, non-offending lives in the community. The Good Lives Model (Ward 2002; Ward and Stewart 2003) has been particularly influential. This explains that we all, offenders included, want to live good lives; that is, we want excellence in work, play and agency, knowledge, community, happiness and spirituality, to name a few of the goods identified in this model. It is believed that offenders will be more likely to desist from offending in the future if they are able to achieve these goods and are encouraged to achieve them without offending. Accordingly, it is argued that interventions that focus on offenders' potentials and what they can do will be more encouraging/motivating and more likely to have a positive impact on offenders than programmes that focus solely on offenders' potential to cause harm and focus on what cannot and should not be done. These principles are currently being integrated into many cognitive-behavioural programmes and into work more generally with offenders, though it is too early to see what impact this will have on treatment efficacy.

Most current cognitive-behavioural programmes, then, have a large cognitive component, in that offenders are encouraged to consider

how their thoughts (including their attitudes to women, children, sex, etc.; thoughts about behaviours and their consequences; ideas about the impact of offending behaviours on others or empathy; problem-solving abilities/tendencies; ideas about themselves, and their self-efficacy and self-esteem; attachment styles and relationship patterns, etc.) encourage, justify and/or support their offending behaviour and how these thoughts can be changed so that offending is avoided in the future. Thus, the cognitive-behavioural approach assumes that offenders have control over their behaviour and are able to change their behaviour and avoid offending in the future. Many programmes still also have a relapse-prevention component, or at least encourage offenders to think about how they will live offending free lives in the community and to practise relevant and appropriate skills to aid with this endeavour. This approach means that programmes often have similar elements, although programmes differ in a variety of ways (for example, content, length, number and timing of treatment sessions, etc.).

There is not scope in this chapter to describe programmes in detail (for a more detailed review, see Brown 2005, or programme details/descriptions that can be found elsewhere in the literature) and so some of the common elements of cognitive-behavioural programmes will be briefly outlined. All cognitive-behavioural programmes review offenders' attitudes and thoughts that may support and/or encourage offending. Most programmes ask offenders to discuss their offending, its causes and its consequences, and thoughts/attitudes that are offence supportive are challenged by training providers and treatment group members. Despite a shift in views about the link between empathy and sexual offending (that is, that most offenders do not have general empathy deficits but do not show appropriate levels of empathy specifically to their own victims (e.g. Fernandez *et al.* 1999), which may be related to thoughts and justifications about the behaviour and what offenders' perceptions are about what the victims apparently wanted) and some concern about the inclusion of empathy work (for more detailed discussions, see Brown 2005; Mann and Marshall 2009), many programmes contain an element that discusses the impact of sexual offending on victims and others who are affected by these offences. Another element involves offenders reviewing their offence chains/offending cycles to identify how behaviour can be changed in the future to eliminate offending, and this may be combined with planning future offence-free lives and practising relevant skills and behaviours that are relevant to each offender. Many programmes also include social and life skills,

problem-solving, assertiveness, anger management, attachment and appropriate relationship formation/maintenance, and sex education elements, as many offenders have deficits in these areas. Some work, such as improving self-efficacy and self-esteem, will be less easy to identify in programme content, despite the fact that it will be a core element of work throughout the programme. Some programmes include more idiosyncratic elements such as drama and work with offenders' partners.

Efficacy of cognitive-behavioural programmes

As discussed, cognitive-behavioural treatment programmes have been delivered in some countries since the 1980s, with early forms of the programmes developed in the 1970s. There are many published evaluations of sex offender treatment programmes, and so it would not seem overly ambitious to expect that we would be able to confidently deduce whether these programmes have a positive effect on the offenders who complete them; that is, that they would be less likely to reoffend than offenders who did not receive such intervention. Unfortunately, there is still a great deal of debate regarding the efficacy of sex offender treatment programmes, which is centred on methodological issues. Although it seems relatively easy to assess whether treatment programmes are effective or not (i.e. compare the outcomes of a group of treated offenders with a group of offenders who receive no treatment), there are a number of methodological, practical and ethical difficulties that make it difficult to establish conclusive findings regarding programme efficacy.

Randomised, control trials are widely regarded as the most methodologically robust method of testing programme effectiveness. In theory, randomisation to treatment or non-treatment groups ensures that there are no differences between these groups, such that differences after treatment can be confidently ascribed to the intervention, provided that the treatment and no-treatment groups are treated identically in all respects apart from the application of the relevant intervention. This design is even stronger if recipients, treatment providers and researchers are all blind to the condition of each research participant/client; however, this requires a placebo intervention (one that looks the same as the real intervention such that those receiving the placebo and treatment are not sure what they are receiving), and that is either not possible or extremely difficult to formulate with interventions of this sort.

The use of randomised, control trials with sex offender treatment programmes is controversial and keenly debated when evaluations of such programmes are considered (see, for example, the paper by Marshall and Marshall (2007), who conclude that randomised studies are not necessary to determine sex offender treatment efficacy, compared to the paper by Seto *et al.* (2008), who take issue with this point of view and the arguments used by Marshall and Marshall (2007)). Some have argued (Marshall 1993; Marshall and Pithers 1994; Marshall and Marshall 2007) that it is not ethical to withhold sex offender treatment from offenders, making random allocation impossible, because of the consequences for the potential victim(s) of the untreated offenders (note that this view tends to assume that sex offender treatment has positive consequences; that is, something potentially positive is being withheld). Others, such as Quinsey *et al.* (1993), have argued that we have an ethical duty to ascertain whether these programmes are effective and that the only way to do this such that we have firm conclusions is to use random allocation. Under this perspective, it is highlighted that potential victims can be harmed if offenders deemed to be safe following treatment are in fact not safe because the treatment had no impact (note here that the tendency is to assume that programmes are not effective, or that this has yet to be determined).

Aside from these ethical standpoints, there are actually a number of methodological and practical problems that mean that randomised studies are extremely difficult to conduct. For example, unless the sample size is large, random allocation cannot ensure groups are equivalent, and a large pool of offenders assessed as being suitable and in need of treatment needs to be identified prior to random allocation, so that group equivalence can be ensured. In addition, actual practice means that this type of study is extremely difficult or unlikely; for example, in the UK, either offenders are court ordered to complete sex offender treatment, or addressing their offending behaviour through the completion of these programmes is a sort of prerequisite for movement to less strict prison regimes or release into the community. Consequently, it is not possible to randomly allocate offenders under these conditions to no-treatment control groups, or their willingness to be part of the study if it was tried would be unlikely. In effect, this means that very few randomised, control trials have been conducted on sex offender treatment programmes. For example, Lösel and Schmucker (2005) found six (although a seventh study used this design, it was compromised), and Robertson *et al.* (submitted) identified only four studies.

To assess the relative merits of different methodological designs, Sherman *et al.* (1997) developed a coding system, the Maryland Scale of Scientific Rigor, that has become widely used. According to this scale, five, the highest rating, is assigned to studies that employ an uncompromised randomised design. The next best, four, is awarded for designs that apply procedures, such as participant matching or statistical control, to ensure equivalence between the treatment and no-treatment groups. While in theory this is possible in studies that evaluate sex offender treatment programmes, in reality it is difficult (a) to find enough untreated offenders who are not different at pretreatment from treated sex offenders – for example, because they refused treatment, were assessed not to need it, or dropped out of treatment – and (b) if untreated offenders are available, to find that they can be matched with treated offenders on enough variables (such as risk level, number of previous convictions, age, type of offending history, etc.) to enable equivalence to be guaranteed. The result is that there are very few studies that employ these designs, or, when they do, that they are unable to employ the designs in a way such that equivalence is guaranteed. Lösel and Schmucker (2005) identified six studies using this design.

Level three of the Maryland Scale of Scientific Rigor can be applied to studies where offenders are incidentally assigned to treatment and no-treatment groups such that equivalence can be assumed, as where equivalence on relevant variables is demonstrated. The problem of limited numbers of untreated offenders being available for study, which has become increasingly difficult as the use of sex offender programmes has been routinely expanded, also applies to studies trying to use this design. Groups of offenders who are available and have been commonly used in treatment evaluations, such as treatment refusers and drop-outs, do not allow for the assumption of equivalence. Some studies (nearly a quarter (19) of the studies included in Lösel and Schmucker's (2005) study) have been able to adopt this design – for example, by comparing treated offenders with similar offenders who were released before the introduction of sex offender treatment.

A commonly used method (60 per cent, or 48, of the studies identified by Lösel and Schmucker (2005), and 43 per cent, or 23, of the studies identified by Robertson *et al.* (submitted)) is to compare treated offenders with a comparison group, such as treatment drop-outs, treatment refusers, or those assessed as not needing treatment, where equivalence cannot be assumed between the treated and comparison groups. This type of study is given a two

on the Maryland Scale and causes controversy, as any post-treatment differences between the groups could be due to their pretreatment differences rather than the result of the impact of treatment. Studies that do not employ a control or comparison group are coded one on the Maryland Scale and are widely agreed to be extremely poor in methodological design, so much so that they are frequently excluded from review or meta-analytic studies (see below).

There are many other difficulties that can only be summarised here (for more detailed discussions of these issues, see Brown 2005; Harkins and Beech 2007). For example, measures of recidivism (such as official conviction rates, arrest rates, and trawls of records/files for evidence of reoffending) vary in their reliability, and the different measures used affect comparability between studies. Sex offenders have persistent, long-term risk of reoffending (Cann *et al.* 2004), meaning that long follow-up periods are needed. The result of this can be that by the time the evaluation outcome is known, the treatment has been modified, discontinued, or become outdated in comparison with the evidence. Most deliveries of programmes are small in scale (for example, 8–10 offenders in each treatment group/delivery) and many offenders dropout of treatment. This makes quantitative analysis of each programme delivery problematic. This is exacerbated by the fact that recidivism rates are relatively low, meaning that large samples are needed to reliably identify statistical differences between treated and control/comparison groups. These issues have resulted in many deliveries of a programme being combined and evaluated as a single programme. While this allows for more reliable statistical analysis, it means that differences between each delivery of the programme, which could be crucial to treatment effectiveness, are overlooked.

In reality, criminal justice requirements/orders mean that unless mandated at a high level or designed into the development and implementation of a programme, evaluators often have little flexibility in the designs they can use, and this means that they often have to use designs and data that are not ideal. Therefore, conclusions about programme efficacy are still being keenly debated, such that there is still a lack of clarity about the efficacy of sex offender treatment programmes: an issue that this chapter will now address. Given the methodological issues outlined above and the amount of evaluation research, it is not possible in this chapter to give a thorough review of all the evaluation research that has tried to examine whether the completion of sex offender treatment programmes reduces the risk of further offending (for a more detailed review, see Brown 2005). However, to provide a summary of the research in this area, the

meta-analyses that have been conducted to date will be discussed below.

A meta-analysis pools together treatment effects from a number of studies and so provides a method of assessing the consistency of results across studies, which should allow us to draw some overall conclusions about the efficacy of sex offender treatment programmes. By combining the samples of a number of studies, the power of the statistical analysis is increased, so that even small effects which might not be identified in a single study can be identified. Thus, this method is considered by some to be state-of-the-art in reviewing quantitative evaluation research; however, as we will see in the discussion below, the reliability of any meta-analysis depends on the studies that are included within it. While this may, at first glance, seem relatively straight-forward (for example, by including all that have been published), there are a number of issues that make the selection of studies crucial and far from straightforward (for example, including unpublished studies, as there is a tendency for studies that find statistically significant and positive results to be published and/or submitted for publication; for excluding studies with overlapping samples so that the same treatment programme is not over-represented in the analysis; and for including only studies that are seen to be methodologically sound in the analysis, which, as we have seen above, can be extremely difficult to determine, or there may not be a sufficient number of methodologically sound studies to include). Consequently, different researchers include different studies in their analyses.

This means that the meta-analyses, which are supposed to be helpful in that they provide a summary of the research, actually produce conflicting results depending on the studies that have been selected and incorporated into the review. Nevertheless, as discussed above, it is so difficult to conduct the sort of research that would produce *conclusive* results that the outcome of meta-analyses is the best method we have (without reviewing each study) to summarise the research in this area and to attempt to assess whether sex offender treatment has a positive effect on the future offending behaviour of those who complete it.

In 1989, Furby *et al.* attempted a meta-analysis, but the poor quality of the research that had been published at that time meant that they were unable to do this and instead they published a review of the research studies. They concluded that there was no evidence of effectiveness, though it is important to note that many of the programmes included in the review had been discontinued because

their approach was deemed obsolete. In addition, Marshall and Pithers (1994) showed that at least one-third of the samples reviewed by Furby *et al.* (1989) overlapped, creating, in this instance, a bias against positive results. So while the no-evidence conclusion may have been justified at the time and Furby *et al.* (1989) claimed to have made only tentative conclusions regarding treatment effectiveness, this review tells us little about the efficacy of current programmes. Despite this, the study has been cited as evidence that treatment is ineffective.

In 1995, Hall conducted a meta-analysis of 12 studies (published after Furby *et al.*'s 1989 review) that he argued had employed relatively rigorous and robust methodology (that is, they compared, using samples of 10 or more, treated offenders with comparison groups, using arrest records for sexual recidivism as outcome data): these 12 studies were selected from 92 studies, with 80 being discarded, as they did not meet his specified methodological requirements. Three of the 12 studies employed randomisation to control and treatment groups, but only four studies evaluated cognitive-behavioural programmes (although Hall categorised five studies as cognitive-behavioural, one was a multi-systemic programme for adolescents that had a particularly large treatment effect). The mean follow-up period was 6.9 years, and the analysis revealed that treated sex offenders had fewer rearrests (9 per cent) compared to untreated controls (12 per cent), with an average effect size of 0.12.

Grossman *et al.* (1999) argued that Hall's conclusion that treatment had a positive impact on recidivism constituted a 'robust finding' (359), but others have criticised this study. As well as reporting problems with the categorisation of treatment as cognitive-behavioural (see above), Becker and Murphy (1998) criticised the small number of studies included, and it is important to remember that the study only included four programmes that used a cognitive-behavioural approach (though these all had a positive treatment effect with effect sizes of 0.14, 0.45, 0.47 and 0.56). In order to rectify this problem, however, Hall would have had to have included studies with less robust methodologies, and this would have generated different problems that would no doubt have incurred criticism.

Becker and Murphy (1998) pointed out that some comparison groups received some treatment, while other comparison groups received no treatment, a fact that was not taken into account in the analysis. Furthermore, Hanson *et al.* (2004) argued that a major limitation of the study was that many of the comparison groups were made up of non-completers (drop-outs), a fact that Hall did

acknowledge in his report. When Rice and Harris (1997) reanalysed the data from Hall's study, they concluded that the treatment effects were confined to studies using non-completers, and an analysis excluding drop-out studies failed to find a treatment effect.

In 1999, Alexander reported the findings of an analysis of the results of 79 evaluation studies published from 1943 to 1996. Alexander recognised that the majority of studies included in her analysis did not have the methodological rigour of those assessed by Hall (1995), although she, too, excluded studies with fewer than 10 participants. She hoped, however, that the larger data set would reveal patterns that were not so readily discernible in Hall's data set. Alexander omitted studies with overlapping data sets, unclear or no outcome data, biomedical treatment and surgical castration. In addition, data for drop-outs, because of a lack of consistency in data and analyses, were omitted, an omission that Alexander acknowledges could have skewed the results.

Alexander found that less than 11 per cent of the treated sex offenders reoffended, and when offenders were subdivided by type of offence, the efficacy for some groups of offenders became more apparent. Treated offenders had lower recidivism rates than untreated offenders in all categories (rapists, child molesters, exhibitionists, and type not specified), except for type not specified. Rates for treated child molesters averaged 13.9 per cent while those for untreated child molesters averaged 25.8 per cent. Similarly, treated incest offenders had lower recidivism rates (4.0 per cent) than untreated incest offenders (12.5 per cent). There was little difference, however, in comparisons for treated and untreated rapists (20.1 per cent and 23.7 per cent respectively). While Alexander's study seems to suggest that treatment was effective, Hanson *et al.* (2002) pointed out that there were some anomalies in Alexander's results and suggested that there was too much variance in the methods employed across the range of studies analysed to enable firm conclusions to be drawn. Lösel and Schmucker (2005) highlighted that the majority of the studies contained no control or comparison group, which is very weak in terms of methodological rigour. Including studies from as early as 1943 and evaluations of such a wide range of treatment programmes also means that it is difficult to draw conclusions from this analysis about the efficacy of current treatment methods.

Published in the same year as Alexander's study, Gallagher *et al.* (1999) included 22 studies, with 25 treatment comparisons in their meta-analysis. They argued that Hall's study was compromised because it included only published studies, and so they broadened

and updated Hall's study by including published and unpublished literature that had a measure of sexual reoffence as an outcome measure and a no-treatment comparison group, was reported in the English language after 1975, and delivered treatment after 1970. Gallagher *et al.* criticised Hall for including studies published after 1989, as they said this was an arbitrary date in terms of treatment development, although it was chosen by Hall to include all studies published after Furby *et al.*'s (1989) review. However, like Alexander, Gallagher *et al.* can also be criticized for choosing to have such an early cut-off date, as treatment delivered in the 1970s (and before) differed enormously from that delivered in the 1990s, with the latter programmes being more similar to current treatment methods than the earlier programmes. In addition, the type of programmes included in Gallagher *et al.*'s study varied enormously, including two they categorized as behavioural, two as augmented behavioural, 10 as cognitive-behavioural/relapse prevention, three as cognitive-behavioural, one as surgical castration, four as chemical castration, and three as other psychosocial treatments. Three studies investigated programmes for juvenile offenders, and Becker and Murphy's (1998) criticism of Hall's classification of the multi-systemic programme can also be applied to Gallagher *et al.*'s study.

Of the studies analysed by Gallagher *et al.*, 20 demonstrated a better outcome for treated offenders, four a better outcome in untreated comparisons, and one study revealed no difference between treated and untreated groups. The average effect size was 0.43, which the authors argued could be considered statistically significant and a medium effect size. The behavioural, cognitive-behavioural (both relapse prevention and other), and augmented, chemical-medical programmes showed substantial reductions in post-treatment sexual recidivism. Gallagher *et al.* concluded that cognitive-behavioural programmes were effective, with programmes including relapse prevention being as effective as programmes without it. However, Hanson *et al.* (2004) pointed out that many of the studies reviewed contained threats to validity: many used drop-out comparison groups, and some contained preliminary reports which were contradicted by later studies. In addition, some offenders were double or triple counted, as they formed the treatment sample in more than one study.

In 2002, Hanson *et al.* attempted to bring some order to the methodological concerns and criticisms levelled at previously conducted meta-analyses. They included all credible studies of psychological treatment of sex offenders identified by May 2000 in

which treated sex offenders were compared to sex offenders who received no treatment or a form of treatment judged to be inadequate or inappropriate. Forty-three studies with combined sample sizes of 5,078 treated sex offenders and 4,376 untreated sex offenders were reviewed. When more than one study evaluated the same sample of treated offenders, the study with the largest sample size or longest follow-up period was included in the analysis. If a different method was used in more than one study using the same sample, then only the study that was determined to have the best methodology was included. Two studies were omitted due to unresolved anomalies in the data. Twenty-three published studies and 20 unpublished studies were included in the analysis. Most studies were North American (21 US, 16 Canadian) in origin, with five from the UK and one from New Zealand. The median publication year was 1996, with 10 (23 per cent) evaluations published in 1999 or later. The authors argued that the studies were mostly recent, although the earliest publication year was 1977, and treatment was delivered between 1965 and 1999 (80 per cent of the offenders received treatment after 1980). Most studies examined adult male sex offenders, but four investigated adolescent sex offenders, and one studied female offenders. More than half of the programmes evaluated (23 out of 43) were based exclusively in institutions, with 17 based in the community and three in both settings.

Averaged across all the studies, with a mean follow-up period of 46 months, the sexual recidivism rate of 12.3 per cent for treated offenders was lower than the sexual recidivism of 16.8 per cent for untreated offenders. This pattern was similar for general recidivism, with a rate of 27.9 per cent for treated offenders and 39.2 per cent for untreated comparisons. The better outcome displayed by treated offenders was statistically significant, but there was a great deal of variability across studies. The treatment effect was stronger in unpublished studies, a finding which perhaps counters arguments of a publication bias towards positive outcomes. Offenders who dropped out of treatment had higher rates of sexual recidivism, an effect that was consistent across the 18 studies that included drop-out data. However, surprisingly, offenders who refused treatment did not have higher recidivism rates than those who had attended at least some treatment. Offenders referred to treatment based on need had higher recidivism rates than offenders not considered to need treatment. These results suggest that the findings of studies which include comparison groups of drop-outs or offenders assessed as not needing treatment are unreliable, as many have argued. On average,

the 20 studies with the best methodological designs revealed an overall treatment effect, although there was a great deal of variability in the effects revealed by these studies. The recidivism rates averaged across the 15 studies evaluating current treatments that were deemed to be the most robust in terms of methodology were 9.9 per cent for treated groups and 17.4 per cent for untreated comparison groups. Institutional and community-based programmes seemed to be equally effective, as were programmes targeting adults or juvenile offenders. Hanson *et al.* concluded that the study undisputedly showed that recidivism rates were lower in treated sex offenders. However, what can be disputed, they argued, is the reason for this: either treatment is effective or other differences between the treated and untreated offenders account for the differences in recidivism. Hanson *et al.* (2002) believe that current treatments are effective at reducing recidivism, but argued that 'firm conclusions await more and better research' (186).

In 2005, Lösel and Schmucker attempted a 'comprehensive, independent, and international review' (Lösel and Schmucker 2005: 119) of treatment effectiveness, following their conclusions from a 2003 review that research analyses 'vary in effect size, type of treatment included, prevailing design quality, categorization of programs, treatment settings and meta-analytic techniques' (119). They also noted that most analyses were restricted to studies reported in English. In their meta-analysis, they included all studies reported in English, German, French, Dutch or Swedish up to 2003 that could be located (attempts were made to identify relevant unpublished studies) that used recidivism (though a broad definition of recidivism was used) as an outcome measure, included a comparison group not receiving the same treatment (could be a no-treatment control group but studies only reporting a drop-out control group were excluded, or some other comparison group that may have received some other form of treatment), and had sample sizes of at least 10.

This produced 80 comparisons from 69 studies, which were discussed in 66 reports. Most of the studies came from North America, one-third contained unpublished data, nearly three-quarters were published after 1990 and nearly one-third since 2000, and half the programmes were assessed as being cognitive-behavioural in approach (and two multi-systemic programmes were included in this category, they argued, due to basic similarities with the cognitive-behavioural programmes). Seven comparisons related to juvenile sexual offenders. Most of the studies (60 per cent) used comparison groups that could not be assumed to be equivalent; for example, in nearly one-quarter

of the comparisons the comparison groups consisted of treatment refusers (see discussion above). However, when group differences were tested and reported, the treatment group was more often at higher risk than the comparison group, though no information on group differences was available for 29 comparisons (including all the randomised, control trials). Only six comparisons, which used randomisation, could be given the highest methodological rating.

The mean rate of sexual recidivism was 11.1 per cent for treated offenders, compared to 17.5 per cent in offenders in comparison groups. Lösel and Schmucker (2005) argued that low base rates mean that this represents a reduction in sexual recidivism of nearly 37 per cent, with similar rates also identified for violent and general recidivism. After controlling for methodological and other study characteristics, only programmes with a cognitive-behavioural orientation showed an independent treatment effect, and this is encouraging as it is based on a 'solid number of 35 independent comparisons' (136). Although treatment programmes had an impact on violent and general recidivism as well as sexual recidivism, only programmes designed specifically for sex offenders had an impact. More modern programmes or findings published most recently were not necessarily the most successful. Lösel and Schmucker (2005) concluded: 'Bearing the methodological problems in mind, one should draw very cautious conclusions from our meta-analysis. The most important message is an overall positive and significant effect of sex offender treatment' (135).

To update the two previously discussed reviews, Robertson *et al.* (submitted) included studies published and located up to March 2008 using similar inclusion criteria as the previous studies (recidivism as outcome measure, comparison group of untreated or differently treated offenders, sample sizes of at least 10). In addition, they included only studies reported in English and those that contained recidivism criteria and follow-up periods that allowed for equal comparisons between the treated and control/comparison groups. Fifty-four studies were identified (53 of which reported sexual recidivism and 40 general recidivism), which dated from 1976 to 2005 (34 were published and 20 unpublished). As with other reviews, the majority of the studies were North America (24 US and 18 Canadian), with nine UK studies and one each from New Zealand, The Netherlands and Australia. Four studies evaluated interventions for adolescents, while the remainder focused on adult male sex offenders. The majority of the studies (40) used a cognitive-behavioural approach.

A significant treatment effect for sexual recidivism was demonstrated with a recidivism rate of 9.4 per cent for treated offenders compared to 15.6 per cent for untreated offenders (figures that are reasonably comparable to the two analyses previously discussed). The 31 studies with the strongest designs also demonstrated a treatment effect for sexual recidivism. It is important to note, however, that when all of the strongest 31 studies are considered, a significant variability between studies was demonstrated. Significant treatment effects on general recidivism were also found for all the studies and the 22 most methodologically robust studies, but again there was significant variability between studies in both these analyses. Programmes using a cognitive-behavioural (40) or systemic (2) approach were the only approaches to demonstrate a significant treatment effect on sexual recidivism (supporting the findings of most of the previously discussed reviews). Robertson *et al.* concluded that the results lent support for the efficacy of sex offender treatment programmes but that it was also important to take study design into account during evaluation.

All of the previously discussed reviews have combined adult and juvenile male (and in some cases the extremely limited number of adult female offender studies) sex offenders. Reitzel and Carbonell (2006) conducted a review that focused on juvenile (ages 7–20) sex offenders. Studies had to have a measure of sexual recidivism and a control or comparison group, and nine were identified (four published and five unpublished) and included in the analysis. Published papers dated from 1990 to 2001 with unpublished data from as late as 2003. The low numbers of studies and the usual methodological issues (a concern for a variety of reasons with many of the studies included in this analysis) mean that the conclusions of this analysis must be tentative; however, a significant treatment effect on sexual recidivism was found, with unweighted average recidivism rates of 7.4 per cent for treated and 18.9 per cent for untreated juvenile sex offenders and a weighted average effect size of 0.43 reported.

Conclusion

Despite the methodological problems and slight differences in the findings of these meta-analyses, each has found that treated sex offenders have lower sexual (and often violent and general) recidivism rates than untreated or comparison group sex offenders. These studies show increased support for the efficacy of treatment,

although there is great variability across evaluations studies, which perhaps reflects a large variation in the impact of different programmes. The methodological issues, as Hanson *et al.* (2002) highlighted, may also mean that the differences in recidivism rates are a consequence of differences in the control/comparison groups rather than the treatment programmes themselves. It is rather frustrating that it is still difficult to draw firm conclusions about the efficacy of these programmes given the efforts of many researchers to address this issue, the amount of time spent trying to answer the question, and the fact that it is unlikely that firm conclusions can be easily drawn in the future given the wide range of methodological issues that make evaluating the programmes problematic. The key issue still centres on the conclusiveness of the evidence base, with those seeking more conclusive results firstly bemoaning the small number of randomised studies that so many argue are the reference standard of evaluation design and then, secondly, stressing that those that have been conducted have shown no positive treatment effect. However, as Robertson *et al.* (submitted) point out in a recent attempt to provide clear guidance on research designs, the Association for the Treatment of Sexual Abusers' Collaborative Data Committee (CODC) published guidelines on this topic (CODC Guidelines 2007), arguing that it is highly unlikely that a definitive study would provide a clear conclusion to the debate on programme effectiveness. The guidelines suggested that a more definitive conclusion could be drawn from the accumulation of research studies that employed diverse methodologies. According to these principles, the reviews discussed above would seem to suggest that sex offender treatment, and particularly programmes that employ a cognitive-behavioural approach, are effective in reducing risk, at least in adult male sex offenders. If one takes the view that the variable results indicate that programmes have variable impacts on offenders (rather than being solely the artefact of methodological issues), a further problem is that it is difficult to reliably determine (particularly in a time frame that is useful to treatment providers) which programmes are effective, or the most effective and with which type of offenders they have efficacy, or even what exactly it is about the programmes that produces any reduction in risk. Perhaps a switch in focus to trying to assess what it is about programmes that does or does not have an impact on offenders would enable development in our understanding of treatment efficacy, as, currently, we seem to be at an impasse, with those in favour of the approach supported by the CODC arguing that treatment is effective, while many others await more firm and

conclusive evidence, which is extremely elusive and unlikely to be produced in the near future (if ever) such that this debate surrounding efficacy can be resolved to everyone's satisfaction.

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