Best Practices in Sex Offender Treatment

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During the last 30 years, there have been significant advances in our knowledge about the characteristics of sex offenders, methods for assessing their risk and treatment needs, and elements of effective programmes for this population. The purpose of this article is to identify current best practices in sex offender treatment and to highlight how these practices have been implemented in England and Wales.

In a perfect world, best practices would be empirically derived. Unfortunately, empirical evidence does not exist to guide all programme development decisions in the sex offender field. Consequently, in some areas of practice, theory and expert consensus must inform the delivery of services. In England and Wales, national Accreditation Criteria detail best practice standards against which programmes are judged; and, in the US, the Association for the Treatment of Sexual Abusers Practice Standards and Guidelines serves this function.

In areas of programme development where a sex offender literature does not exist or is in its infancy, programme developers and treatment professionals can turn to two other sources. These are the general correctional rehabilitation literature, typically referred to as the 'what works' literature, and the general psychotherapy literature. Based on these sources, we believe that several principles guide best practices in sex offender treatment. Programmes should:

(1) have a clear, evidenced-based model of change;
(2) adhere to the risk, need, and responsivity principles, such that:
    (a) intensity of services is matched to risk (the risk principles);
    (b) treatment targets are chosen that are clearly linked to reoffending (need principle);
    (c) use effective methods, primarily, cognitive behavioral and skills based, and ensure treatment is adjusted to the learning style of the individual and; methods are designed to engage and motivate (responsivity principle);
(3) ensure continuity of care;
(4) provide staff appropriate training and supervision;
(5) conduct ongoing programme monitoring and evaluation.

Model of Change

In the general offender rehabilitation literature, programmes that clearly specify an evidenced-based model of change are much more effective in reducing recidivism than those that do not[1]. Early sex offender treatment models were based on conditioning theories that focused primarily on offenders' deviant sexual interests. Over time though, models became more comprehensive and began targeting a wider range of problems, such as attitudes supportive of offending, intimacy deficits, and general self-management problems. These newer programmes were characterised as more broadly cognitive-behavioral in nature. Beginning in the late 1980s to early 1990s, models based on concepts from relapse prevention (RP), borrowed from the addiction field, became more prominent. The RP model focused not only on initiating change but also on maintaining change.

Beginning in the mid-1990s, increased criticism of the RP model focused both on its theoretical underpinnings and the lack of data to support its efficacy. Specific problems with applying the traditional RP model from the addiction field to sex offenders were that it assumed that offenders were attempting to avoid offending and that offending was triggered by negative affect or interpersonal conflict. In reality, there are actually multiple pathways to offending, and Hudson, Ward, and McCormack (1999)[2] described these in their Self-Regulation Model of relapse. Although a complex theory, a key focus is on providing differential treatment interventions for offenders who attempt to avoid offending, called avoidance pathway offenders, versus those that are not so motivated, called approach pathway offenders. Of note, for these latter types of offenders, offending is not triggered necessarily by negative affect or interpersonal conflict, but simply by a desire to continue offending. Webster

1. Andrews, D. A., & Bonta, J. (2006). *The psychology of criminal conduct (4th Edition)*. Cincinnati, OH: Anderson Publishing.
2. Hudson, S. M., Ward, T., & McCormack, J. C. (1999). 'Offense pathways in sexual offenders'. *Journal of Interpersonal Violence*, 14, 779-798.

(2002)[3] has provided further support for this model by investigating a small group of offenders who completed the English and Welsh prison treatment programme and reoffended. He found that the predominant pathway for this recidivist group was an approach pathway.

Although covered in the next section, the principles of the risk, need, and responsivity (RNR, Andrews and Bonta, 2006) have also guided general and sex offender rehabilitation efforts especially in England and Wales and Canada. These principles were integrated into the Association for the Treatment of Sexual Abusers last Practice Standards and Guidelines in 2005[4].

An emerging theory that has influenced models of change in the English and Welsh Probation Service and Prison Service programmes is the Good Lives' Model (GLM[5]). Ward and colleagues initially criticised the RP model and RNR model as being focused too heavily on risk management and avoidance goals, that is, what offenders need to avoid. In contrast, they argued that the GLM model is strength based, focusing on helping offenders obtain what is termed human goods — such as intimacy, autonomy, and knowledge — that all human beings seek. Initial concern in the field was that Ward and colleagues were rejecting the empirical supported RNR principles. However, they now stress the compatibility of the two models. Basically, they reframe criminogenic needs as internal and external obstacles to achieving human goods and if one focuses on achieving human goods one reduces criminogenic needs. Clearly, this is a more balanced view. While still maintaining the need for risk management, focusing on approach goals would seem to be more motivating to offenders than focusing simply on what one should not do. Programmes in England and Wales have integrated concepts of GLM, especially motivational components, into their treatment models while retaining the key concepts from the RNR and risk management models. Until more research support is available for the GLM model, this seems an appropriate path.

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Principles of Risk, Need and Responsivity

There is now an extensive body of empirical research that supports the importance of adhering to the RNR principles in reducing recidivism. The risk principle is concerned with the fact that treatment effectiveness is increased when intensity of treatment services are matched to the risk level of the offender. High-risk individuals should receive intensive services while low-risk individuals should receive less intensive services and/or no services. The need principle highlights that interventions are most effective if they focus on criminogenic needs or dynamic risk factors that are linked to offending behavior rather than targeting problems that are not, such as general psychological functioning. The responsivity principle suggests that services are most successful when effective methods are used and when treatment is matched to the learning style of the offender.

Risk Principle

To apply the risk principle, it is necessary to use valid risk instruments. In the last 10 to 15 years, researchers have developed several scales that have been validated in a number of countries across the world with surprisingly consistent findings. These include such scales as the STATIC-99 and an instrument used across the UK, the Risk Matrix 2000. Overall, these scales increase our ability to predict reoffending by 20 to 30 per cent over chance and reliably classify individuals into risk levels to guide treatment programming.

Data from the English and Welsh Prison Service provides some support for the importance of the risk principle in sex offender treatment[6]. Subjects who completed the CORE programme, a moderate intensity programme, were compared to those who did not enter this programme. Using the STATIC-99,

3. Webster, S. D. (2002). 'Pathways to sexual offense recidivism following treatment: An examination of the Ward and Hudson self-regulation model of relapse'. *Journal of Interpersonal Violence*, 20, 1175-1196.
4. Association for the Treatment of Sexual Abusers. (2005). Practice standards and guidelines for the evaluation, treatment, and management of adult male sexual abusers. Beaverton, OR: Author.
5. Ward, T., & Gannon, T. A. (2008). 'Goods and risks: Misconceptions about the Good Lives Model'. *The Correctional Psychologist,* 40, 2-7.
6. Friendship, C., Mann, R. E., & Beech, A. R. (2003). 'Evaluation of a national prison-based treatment programme for sexual offenders in England and Wales'. *Journal of Interpersonal Violence*, 18, 744-759.

offenders were divided into low, moderate-low, moderate-high and high risk groups. This study found no impact of treatment for the low and high risk group, but did find a significant decrease in serious (sexual and non-sexual violence) reoffending for both the moderate-low and moderate-high risk treatment groups. The risk principle would have predicted that low risk offenders were unlikely to benefit from the programme. It is also not surprising that treatment was ineffective with the high risk group as the CORE programme is probably not of sufficient intensity by itself for a high risk offender

Need Principle

Andrews and Bonta[7] have reviewed the extensive literature on general offenders, identified their empirically validated criminogenic needs, and found that the number of the needs targeted in programmes for these offenders was linearly related to reductions in reoffending rates. However, not until the publication of an influential meta-analysis[8] did we begin to have empirical evidence identifying important criminogenic targets for sex offenders. This has led to the development of a number of dynamic risk factor scales such as the Structured Assessment of Risk and Need (SARN) developed by David Thornton and his colleagues in England and Wales. Recent studies by Thornton and his colleagues indicate that dynamic risk factors themselves are predictive of recidivism and that combining dynamic and static risk factors slightly increased prediction. The major question for the field currently, however, is how changes in these dynamic risk factors are related to reductions in recidivism.

Dynamic risk factors for sex offenders include sexual self-regulation, intimacy deficits, attitudes supportive of offending and general self-management deficits such as impulsivity and poor problem solving. The meta-analytic literature has also identified a number of what have been 'favourite' treatment targets that appear to have no relationship to recidivism. Three of these factors are empathy, adverse childhood experiences, and denial at intake. There have, however, been recent investigations that suggest that the relationship between denial and recidivism may be more complex than we thought[9]. There are some indications that denial may be associated with slightly increased recidivism in low-risk child molesters and rapists while denial may be related to decreased recidivism in high-risk child molesters. However, further studies with larger sample sizes and more consistent definitions of denial will need to be conducted before determining how these findings should affect the delivery of services.

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Responsivity Principle

Responsivity is composed of two components. One is that programmes use an overall approach that is effective with offenders and, second, that they deliver treatment in a therapeutic manner that is matched to the ability and learning style of the individual offender. Broadly, general offenders appear to be most responsive, in terms of reducing their reoffense rates, to cognitive-behavioral programmes that are skill based and there is similar data for sex offenders. Aos, Miller, and Drake (2006)[10], in a meta-analysis of the sex offender literature, found that neither general psychotherapy nor behavioral therapy only approaches had any impact on sexual recidivism, while cognitive-behavioral therapy in prison led to an almost 15 per cent reduction in sexual recidivism and this approach in the community led to a 31 per cent reduction in recidivism.

The second component of the responsivity principle concerns well established findings in the general psychotherapy literature that positive treatment outcomes are associated with the strength of the therapeutic relationship, not just treatment techniques used. In fact, the impact of therapeutic relationship variables often is found to outweigh the effect of other factors.

7. See note 1.
8. 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, 1154-1165.
9. Nunes, K. L ., Hanson, R. K., Firestone, P., Moulden, H. M., Greenberg, D. M., & Bradford, J. M. (2007). Denial predicts recidivism for some sexual offenders. *Sex Abuse* , 19, 91-105.
10. Aos, S., Miller, M., & Drake, E. (2006). *Evidence-based adult corrections programmes: What works and what does not*. Olympia, Washington: Washington Institute for Public Policy.

Unfortunately, early sex offender treatment did not always attend to responsivity issues, but its importance has been demonstrated in several studies, the most noteworthy of which were conducted on UK samples. Beech and Fordham (1997)[11] found that increased cohesiveness in treatment groups was related to better outcomes, and Marshall (2005)[12] found that therapists who were warm and empathetic, rewarded progress and were more direct, showed greater reductions in measures of dynamic risk than therapists who did not show these characteristics.

A final point is the similarity of findings between the general offender rehabilitation literature and sex offender treatment literature on how adherence to the principles of RNR collectively relate to outcome. Andrews and Bonta[13] reported that programmes that follow none of the RNR principles show a slight increase in recidivism and programmes become increasingly more effective as they adhere to an increasing number of the principles. Although fewer studies exist in the sex offender field, Hanson (2006)[14] found the same pattern of results in his analyses of 23 sex offender treatment outcome studies. Again there was a linear relationship between number of principles adhered to and recidivism reductions.

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Continuity of Care

There is increasing support that programmes that have adequate discharge planning, provide appropriate community after-care services, and involve significant others reduce recidivism. On the other hand, the evidence is clear that surveillance and monitoring alone have little impact on recidivism For example, Aos *et al.*, (2006)[15] found, for a general correctional population, zero per cent change in recidivism for intensive surveillance but 22 per cent reduction in recidivism for intensive supervision that is treatment oriented.

In addition, in the general correctional literature, a meta-analysis of relapse prevention for offenders[16] indicated that training of significant others had the largest effect size in terms of a component of relapse prevention that was related to recidivism. This meta-analysis was of general correctional literature but included some sex offender studies.

A recent study of the Kia Marana Sex Offender Programme in New Zealand, retrospectively coded relapse prevention plans of 39 sexual recidivists and 49 non-recidivists[17]. They found that factors such as adequate accommodations, adequate employment and secondary goods from the Good Lives' Model separated recidivists from non-recidivists. This suggests the importance of transition to the community and addressing not just sex offender specific issues but more general resettlement issues such as employment and accommodation.

Trained Staff

Programmes can be well designed, have an adequate model of change, be designed to follow the RNR principles, and have adequate continuity of care, but unless they are implemented as designed, they will not be effective. The meta-analytic literature[18] has found that programmes that had printed programme and training manuals and used trained facilitators who were supervised regularly, were significantly more likely to reduce recidivism than programmes without these characteristics. An example of what happens when programme fidelity is not maintained is demonstrated in a recent evaluation of the state of Washington's Functional Family Therapy programme, a treatment designed for juveniles engaging in antisocial behavior[19]. This study found that

11. Beech, A., & Fordham, A. S. (1997). 'Therapeutic climate of sexual offender treatment programmes'. *Sexual Abuse: A Journal of Research and Treatment,* 9, 219-237.
12. Marshall, W. L. (2005). 'Therapist style in sexual offender treatment: Influence on indices of change'. *Sexual Abuse: A Journal of Research and Treatment*, 17, 109-116.
13. See note 1.
14. Hanson, R. K. (2006). *What works: The principles of effective interventions with offenders*. Paper presented at the 25th Annual Research and Treatment Conference of the Association for the Treatment of Sexual Abusers, Chicago, IL.
15. See note 10.
16. Dowden, C., Antonowicz, D., & Andrews, D. A. (2003). 'The effectiveness of relapse prevention with offenders: A meta-analysis'. *International Journal of Offender Therapy and Comparative Criminology*, 47, 516-528.
17. Willis, G. (2007). *Does poor reintegration planning contribute to sex offender recidivism?* Poster session presented at the 26th Annual Research and Treatment Conference of the Association for the Treatment of Sexual Abusers, San Diego, CA.
18. Andrews & Bonta (2005): See note 1.
19. Aos *et al.* (2006): See note 10.

when competent therapists delivered the therapy, the programme reduced recidivism by as much as 30 per cent. However, they also found that 47 per cent of therapists were rated as less than competent and for these therapists there was no treatment effect. Raynor (2004)[20] has raised similar issues regarding implementation problems with the Probation Service 'Pathfinders' programmes.

Although there is limited empirical data regarding these factors on sex offender treatment outcome, there is no reason to believe that they would not have the same relationship with recidivism as in the general correctional literature.

Ongoing Monitoring and Evaluation

Programmes are more effective when they monitor and evaluate themselves and improve what they do as a result. This involves focusing on process as well as outcome variables. Process variables include such things as monitoring staff training, supervision and retention, offender access to the programmes, service documentation, and participant attendance and completion rates. Outcome variables include intermediate targets such as assessing change on offender pre- and post-treatment measures and long-term targets such as recidivism studies.

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Treatment Effectiveness

Whether sex offender treatment is effective in reducing recidivism continues to be debated and reaching firm conclusions on this issue is complicated by the lack of high quality studies. The Collaborative Outcome Data Committee of the Association for the Treatment of Sexual Abusers headed by Karl Hanson[21], has developed guidelines for rating the strength of evidence in current research designs. In this model, randomised controlled trials are considered convincing evidence of treatment effectiveness; designs that involve incidental assignment of subjects or subject matching are considered to provide plausible evidence; and studies such as risk band studies provide possible evidence. Studies that provide no evidence of treatment effectiveness are those that compare treatment completers to treatment drop-outs or those where assignment is based on need. In the sex offender treatment area, most of our evidence is from studies rated as producing plausible or possible evidence.

Unfortunately, among adult sex offender treatment outcome studies, arguably the most well designed randomised controlled trial in the field[22] failed to find a treatment effect. However, two relatively large-scale meta-analyses, primarily including studies that would be rated as providing plausible evidence, did show treatment effectiveness. First, a meta-analysis of studies that used at least incidental assignment and used current treatments with a follow-up period of four to five years[23], found approximately a 41 per cent reduction in sexual recidivism for those receiving treatment (17 per cent recidivism in the comparison group versus 10 per cent in the treatment group). This meta-analysis also showed a 37 per cent reduction in general recidivism. A much larger meta-analysis[24] which involved studies published in North America and Europe (69 studies; N= 22,181 offenders) found sex offender treatment was associated with a 37 per cent reduction in sexual recidivism rates (17 per cent recidivism in the comparison group versus 11 per cent in the treatment group) and similar reduction in general recidivism. More recently a risk band study of the English and Welsh Probation Sex Offender Treatment Programmes[25] found that for all offenders (n = 791) the actual rate of reoffending was 11.5 per cent versus a predicted rate of 18.5 per cent, a statistically significant finding.

20. Raynor, P. (2004). The Probation Service 'Pathfinders': Finding the path and losing the way? *Criminal Justice*, 4, 309-325.
21. Collaborative Outcome Data Committee (Beech, A., Bourgon, G., Hanson, R. K., Harris, A. J. R., Langton, C., Marques, J., Miner, M., Murphy, W. D., Quinsey, V. L., Seto, M., Thornton, D. & Yates, P. M.). (2007). *Sexual offender treatment outcome research: CODC guidelines for evaluation. Part 1: Introduction and Overview*. Available: http://www.publicsafety.gc.ca/res/cor/rep/_fl/CODC_07_e.pdf.
22. Marques, J. K., Weideranders, M., Day, D. M., Nelson, C., & van Ommeren, A. (2005). 'Effects of a relapse prevention programme on sexual recidivism: Final results from California's Sex Offender Treatment and Evaluation Project (SOTEP)'. *Sexual Abuse: A Journal of Research and Treatment,* 17, 79-107.
23. Hanson, R. K., Gordon, A., Harris, A. J., Marques, J. K., Murphy, W. D., 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, 169-192.
24. Lösel, F., & Schmucker, M. (2005). 'The effectiveness of treatment for sexual offenders: A comprehensive meta-analysis'. *Journal of Experimental Criminology,* 1, 117-146.
25. Hollis, V. (2007). *Reconviction analysis of interim accredited programmes software (IAPS) data*. Ministry of Justice Research Development & Statistics.

Another recent publication by the Matrix Knowledge Group[26] addresses the important issue of the cost effectiveness of treatment. Based on their analysis of 14 studies, they concluded that sex offenders who received treatment in prison were 35 per cent less likely to reoffend after release than those who received only prison sentences. This led to a savings to tax payers of £35,213 over an offender's lifetime and, if one includes victim costs, savings of £130,576.

The meta-analytic findings suggest that the effectiveness of sex offender treatment is promising, as well as providing direction about how to design and implement programmes. We are also encouraged that the more closely sex offender programmes follow RNR principles, the better results they seem to achieve. Unfortunately, however, few studies exist in the published literature that adhere to all the principles. Despite the fact that Marshall and Marshall (2007)[27] have raised important issues about randomised controlled trials, this is the gold standard for treatment interventions throughout the medical and psychology fields. These types of studies are difficult and expensive to conduct, but sex offender treatment specialists should not hold themselves to lower standards than practitioners and researchers in other fields. More randomised controlled trials with adult offenders will need to be conducted before the question of treatment effectiveness can be more definitively answered.

A particular strength of programmes in England and Wales is the clear focus on several important responsivity issues.

Sex Offender Treatment in England and Wales

Our analyses of how sex offender treatment programmes have been implemented in England and Wales are influenced by our familiarity with these programmes, as well as those in other jurisdictions. We have conducted several yearly internal audits of Her Majesty's Prison Service sex offender programmes and therefore have had an opportunity to closely examine its operation. We can also compare the English and Welsh programmes against those in other countries, because, for example, we have both served on the accreditation panel of Correctional Service Canada and have reviewed a number of programmes in the United States and elsewhere. In addition, the first author has been a member of the Correctional Service Accreditation Panel and has regularly reviewed the Prison Service audits of accredited programmes.

It is important in looking at the implementation of probation and prison treatment programmes in England and Wales to compare them with the best practice criteria we have outlined. As a result of the accreditation process, treatment programmes both in the Prison Service and in the Probation Service are required to have a theoretical model underpinning their programmes. The models underpinning both the services' programmes are based on our current understanding of factors related to offending, and our current understanding of the most effective interventions. Over the years, both the Prison and Probation Services have updated their models of change as more literature becomes available.

In addition, sex offender treatment in England and Wales has followed the risk, need and responsivity model. For example, the Prison Service provides a suite of programmes including the Rolling Programme for low risk offenders, the CORE Programme for moderate risk offenders, and for those of higher risk, the CORE Programme plus the Extended Programme. In terms of responsivity, the Adapted Programme is designed for individuals with learning disabilities and the Healthy Sexual Functioning Programme for those with marked problems with deviant sexual interests. Programmes are clearly need-based. That is, they focus on those dynamic risk factors that are most closely linked to offending. The Prison Service has developed and uses one of the few researched dynamic instruments, the Structured Assessment of Risk and Need (SARN), that assesses the broad range of these types of criminogenic needs.

A particular strength of programmes in England and Wales is the clear focus on several important responsivity issues. Not only are the programmes cognitive-behavioural in nature and skill based, but they are also attentive to issues of offender engagement and motivation, as well as therapist style. Staff training and delivery approaches focus on treating offenders with dignity and respect and ensuring that all programmes have motivational components.

Although programmes have been driven by state-of-the-art theoretical models, they have also spent significant time in maintaining programme integrity. This

26. Matrix Knowledge Group. (2007). *The economic case for and against prison.* Available: http://www.matrixknowledge.co.uk/prison-economics/
27. Marshall, W. L., & Marshall, L. E. (2007). 'The utility of the random controlled trial for evaluating sexual offender treatment: The gold standard or an inappropriate strategy?' *Sex Abuse*, 19, 175-191.

begins with careful selection and extensive training of facilitators, and extensive training of those supervising facilitators. In addition, the nature of the accreditation process requires administrative support within the local prisons. The clinical audits, that is, auditing the actual delivery of the programme, also help guarantee that integrity is maintained. The authors, having reviewed the outcomes of the England and Wales programme audits for a number of years, have seen clear evidence that this information is used to not only give an institution a 'score' but also as a quality improvement tool to make changes in programmes where necessary and actually improves practice.

Continuity of care and transitioning from the prison to the community continues to be a programme development focus. Our observation is that there has been significant improvement since the first author served on the original Correctional Service Accreditation Panel. The Prison and Probation Services now have joint training and the programmes follow similar models. New programmes are being developed together so that programmes could run in either service. All of these factors should lead to a smoother transition from prison to community.

The programmes also are unique in that they have a built-in evaluation process. All offenders receive at least pre- and post-programme assessments so that change is measured. There have also been outcome evaluations of the programmes, both within the Prison Service and Probation Service, as outlined in the 'Treatment Effectiveness' section above.

Future Directions

The English and Welsh Prison Service and Probation Service sex offender programmes are clearly world leaders in the development and provision of high quality treatment services to adult sex offenders. Similar to programmes in other jurisdictions, however, several challenges remain. Even though treatment is associated with decreased rates of recidivism, convincing offenders to enroll in treatment programmes is often difficult. Engaging men who are resistant to treatment is an important endeavour. Men who present the highest risk to reoffend should be a high priority for intervention. Yet, this group may be the most difficult to treat and there is scant literature supporting evidence for positive outcomes. Further research needs to continue in this area. There is also a pressing need for identifying measures of treatment progress that directly relate to reductions in reoffense rates. Finally, the field needs adequate resources to conduct high quality outcome studies that are on par with those in other branches of psychology and medicine.