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Mitigating Sexual Recidivism: 'Treatment' or 'Intervention'?

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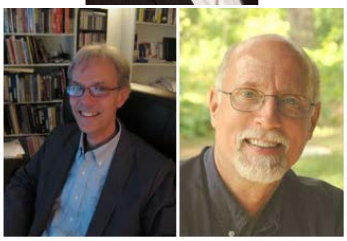
Trending research demonstrates low rates of sexual recidivism for nearly all juveniles and most adult sexual offenders. Many studies have been aimed at trying to determine whether 'sex offender' treatment is effective at reducing recidivism. But there is growing evidence that most sexual offenders will not reoffend, regardless of treatment, and moreover, that treatment has only a small or moderate effect on recidivism. If treatment isn't as effective as we want it to be, what do we do with such 'inconvenient' data? We can consider elements of an effective *intervention*, and uniquely tailor individual pathways for clients to recover. When indicated, it should include sex-specific treatment.

A recent, large meta-analysis by Schmucker and Lösel (2015) reports sexual recidivism of 13.7% for untreated offenders, and 10.1% for clients who completed treatment - an absolute reduction in recidivism of 3.6%, and a relative reduction of 26.3%. Previous studies by Lösel and Schmucker (2005), (2008) showed a slightly stronger, but still low-moderate treatment effect. Duwe and Goldman (2009) found a 13.4% sexual reoffense rate for treated clients versus 19.5% sexual recidivism for offenders who did not participate in treatment. Many other studies have found similar results.

Karl Hanson and colleagues (2014) confirmed a low rate of reoffending (1%-5%) for low risk sexual offenders, and a 22% rate of reoffending for high-risk offenders after five years, but then discovered that after ten years offense-free in the community, high-risk offenders effectively became low recidivism offenders. Michael Caldwell (2016) completed the largest meta-analysis to date, which revealed current sexual recidivism rates for juveniles is likely to be less than 3%. In both studies, if clients reoffended, it was likely to occur within the first few years after intervention. Authors in both studies were unable to determine WHY recidivism was low and desistance was stronger over time; yet it seems that effective



SAJRT Bloggers' Profile
Chief Blogger Kieran McCartan, Ph.D. and Associate Bloggers David S. Prescott, LICSW and Jon Brandt, MSW, LICSW are longtime members of ATSA. We are dedicated to furthering the causes of evidenced-based practice, understanding, and prevention in the field of sexual abuse.

The Association for the Treatment of Sexual Abusers is an international, multi-disciplinary organization dedicated to preventing sexual abuse. Through research, education, and shared learning ATSA promotes evidence based practice, public policy and community strategies that lead to the effective assessment, treatment and management of individuals who have sexually abused or are risk to abuse.

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treatment might enhance outcomes.

Risk for reoffending, as part of a psychosexual assessment, seems to have become overly simplified into essentially three categories: low, medium, and high risk, which then often determines outcomes: everything from plea agreements, to incarceration, treatment, and perhaps conditions of supervision or imposition of civil regulations. So how can we analyze the cost-benefit of interventions to clients, and to public interests?

Gregory DeClue has suggested an empirical process from the world of medical treatment might be helpful to determine the cost-benefit of treatment. Dr. DeClue points to statistical concepts known as "Number Needed to Treat" (NNT), and "Number Needed to Harm" (NNH). Together, NNT and NNH provide an empirical way to consider, in an aggregate manner, the cost-benefit to "treat" or "not to treat." According to DeClue, using data from Schmucker and Lösel (2015), NNT reveals that only about one person in 28 is likely to not reoffend as the direct result of treatment. That seems like a weak return on the investment, but more troubling is the counterbalance: to what extent is treatment actually unwarranted, counterproductive, or indeed harmful to individuals and their families – known as iatrogenic consequences?

A meta-analysis by Kim, Benekos, & Merlo (2016) found "that sex offender treatments can be considered proven or at least promising." They also determined that ages of clients and types of interventions influence the success of treatment. This study also suggests that outpatient treatment may be more effective than treatment in prison, "If community treatment is more effective than institutional treatment, then a review of existing sentencing statutes and policies might be appropriate." So if *treatment* is not the primary change agent, what is? It might be, broadly, the *intervention*.

Most individuals arrested for sexual offending do not sexually reoffend, and treatment effect alone doesn't account for low recidivism rates; so what else might broadly mitigate reoffending? Research indicates that civil regulations (the registry, residency restrictions, etc.) are not only ineffective, they might be counterproductive. More and more, civil regulations are being challenged by the judiciary in state and federal courts as not only being ineffective, but unconstitutional. Caldwell wrote, "The bulk of available evidence indicates that the decline in adult and juvenile sexual recidivism rates has occurred, unrelated to, and perhaps despite, these recent policy trends." The sex offender registry is especially harmful to juveniles. Birgden and Cucolo (2011) argue that treatment as management, rather than treatment as rehabilitation, panders to public policy and puts unwarranted concerns about public safety ahead of effective treatment. CSOM promotes a systems approach to interventions, including effective supervision, and that recovery is not all about 'treatment.'

We should be mindful that reducing risk is not the only aim of treatment, and only tells part of the story about an effective *intervention*. And how do we determine what kind of treatment experiences we should offer? For example, Levenson and Prescott (2013), discuss many benefits that may be derived from treatment, resulting in improved outcomes for clients, victims, and their families - better lives AND safer communities. Indeed, the same authors have published three studies indicating that people who have sexually abused typically believe their treatment experiences to be worthwhile (e.g., Levenson & Prescott, 2009). Perhaps one avenue for professionals to consider is moving beyond treatment interventions that focus on reducing risk and help people remain at low risk. Another treatment target might be helping clients adjust to the social consequences of being publically labeled a "sex offender." Still

another focus of treatment might be “cognitive transformation” – promoting desistance by helping clients view themselves as having become a different (better) person.

When recidivism rates are low, and treatment effect is weak, it raises questions about when sex offender ‘treatment’ is indicated – effectively begging the question: “to treat” or “not to treat.” The answers are only partially informed by risk/recidivism studies. Many questions abound, including the influence of treatment on the nature, severity, imminence, and frequency of re-offense, if it does occur. Further, while it makes sense to ask whether treatment works, we are still in need of research into the effective components of both treatment and treatment providers. In addition to psychological factors, we should consider situational factors that might contribute to re-offending after treatment completion.

How should new data on the weak effectiveness of ‘treatment’ guide interventions with individual clients? How should public policies be reviewed in light of new research? Collectively, new data, and anecdotal evidence, provides strong evidence that the “sex offender system” might be mired not just in ‘old research’ about what works in the treatment and management of sexual offenders, but that public policies are straining valid concerns for public safety. As a result, systems are overreaching and over-treating individuals, in large numbers, from juveniles to the civilly committed. The consequences to individuals and families, and the costs to public interests, are incalculable.

Why are so many people ending up in the “sex offender system”? Perhaps one reason is a tendency to conflate “seriousness” of a sexual offense with “dangerousness.” This results in catching too many individuals in the “sex offender net,” regardless of “dangerousness” and, out of fear of *any* risk of reoffending, the system is reluctant to let them go. In order to avoid any true positives (predicted to reoffend and does), or false negatives (predicted to NOT reoffend but does), the system is willing to tolerate a high percentage of false positives (predicted to reoffend but doesn’t). Or simply stated, “Better to lock up ten sex offenders than one might reoffend.” The fallacy is that about nine out of ten offenders are not likely to sexually reoffend, yet we commit vast, unwarranted public resources to nine out of ten sexual offenders, as an unwarranted hedge against possible recidivism.

In the UK, with the introduction of the transforming rehabilitation agenda, distinguishing between low and high risk offenders is becoming more salient in community management. It distinguishes between sex offenders and non sex offenders, by risk categories and management. All sex offenders are now managed by a streamlined probation services, while low/medium risk non sex offenders are managed by private Community Rehabilitation Companies (on a payment-by-results scheme). All high/very high risk offenders are managed by traditional probation. This suggests that the UK government perceives low risk sex offenders as generally more dangerous than low-risk non sex offenders.

Interestingly, in the UK (and elsewhere outside the USA) not all sex offenders receive treatment – it is based on their level of risk and whether or not clients deny their offence. In the UK, it is usually medium, high and very high risk sex offenders that receive Sex Offender Treatment Programmes (SOTP); with low risk offenders receiving a form of cognitive skills program. Putting low-risk sex offender in SOTP could actually make clients worse and increase their likelihood of offending. Practitioners and policymakers suggest that we look at alternatives to traditional SOTP, and Ruth Mann points to a wide-range of psycho-social treatment interventions. With skepticism about whether sex offender treatment works, in the UK, treatment must be evidence-based.

So what are the takeaways here? One is to avoid the tendency to measure the success of 'treatment' in a dichotomous manner - whether or not clients reoffend. There is much more to consider in decisions about treatment, e.g. when is treatment indicated? Should treatment be compulsory? If so, where should treatment take place (institution or in the community)? What are the specific treatment targets to measure progress and determine completion? What kind of treatment is effective for a particular client? How much treatment is enough? Principles of Risk-Need-Responsivity and Good Lives are able to empirically guide the application of aggregate data and other research to individual clients. Sometimes, when empirical evidence suggests treatment is not indicated, we still need to *intervene*, but find the courage to not put clients through unwarranted or lengthy 'treatment.'

By all indications, a wide-range of interventions seems to effectively mitigate recidivism, so perhaps rather than focusing on "does treatment work," what might be needed is to fine-tune characteristics of interventions that are demonstrated to be effective with specific types of clients, e.g. juveniles, low risk, non-contact, females, repeat offenders, etc. Not all sexual offending is rooted in sexual deviancy, sexual compulsion, or sexual violence. Sometimes people simply lose their sexual boundaries, and it's not likely to happen again. While it may be useful to trace pathways to sexual offending, not every sexual offender has a sexual offense "cycle." With half of all sexual assaults occurring under the influence of alcohol, treatment for chemical abuse or addiction might be primary. Not everyone who sexually offends needs sex-specific treatment. A large percentage of adolescent offenders, and their families, might be well-served by participation in a time-limited psycho-sexual education program.

Because sexual offending is often more about relationship violations than sexual violence, interventions might focus much more on managing social damage, repairing relationships, and restoring families. When there is so much that can be accomplished by creating a recovery plan that is unique to individuals and their families, it's unfortunate that there is so much emphasis placed on "relapse prevention," strict compliance with supervision, or criminal enforcement of civil regulations. Effective interventions can build on the optimism of protective factors, use positive psychology to build social skills, competency, and resiliency, and embrace strength-based principles of Good Lives.

When sexual misconduct occurs, *intervention* is almost always warranted – 'treatment' might not be. Interventions can be empirically guided by a client's Risk-Need-Responsivity and principles of Good Lives, and perhaps by uniquely tailoring interventions to individual clients, with consideration of the five "W's": who, what, when, where, and why.

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