Attorney General's Sexual Assault Task Force

SEX OFFENSE-SPECIFIC TREATMENT DISCHARGE OUTCOMES FOR ADULTS†

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Abstract

When it comes to making decisions that involve sex offenders, responsible stakeholders (i.e., supervising agencies, social service agencies) look at treatment outcomes to assist them in the decision-making process. Without uniformity of treatment or a clear understanding of treatment objectives and desired outcomes, these stakeholders may experience confusion regarding how progress or lack of progress should factor into their decisions. This paper will provide some guidance addressing these issues in the hopes that a better understanding of treatment outcomes will lead to better decisions involving sex offenders, their families, and the public at large.

Adults convicted of sex crimes or those accused of sexual offense behavior are routinely required to participate in sex offense-specific treatment as a condition of supervision or family reunification. In the state of Oregon, sex offense-specific treatment for adults is largely provided in outpatient settings by practitioners utilizing an array of treatment approaches. Some practitioners run structured programs with a clear beginning, middle and end of treatment, graduating clients who "complete" treatment. Other providers run open-ended groups, some structured while others may be less structured. Those that lead open-ended groups generally do not conceptualize treatment as having an endpoint, but rather, like substance abuse treatment, a client's participation in treatment is considered to be on-going, with the "maintenance" phase of treatment seen as a life-long process. It may be said that the latter approach has gained wide acceptance in the field in recent years, replacing the concept that sex offenders ever "complete" treatment.

Sex offense-specific treatment is specialized and complex. It takes a great deal of specialized knowledge to deliver services to this population and it takes the same specialized knowledge to assess treatment progress. It is beyond the scope of this paper to provide substantive information related to the components of treatment and treatment outcomes. However, the following information offers some guidance pertaining to the most common questions we think stakeholders may pose. For further information about sex offense-specific treatment, we provide a list of resources (Appendix A).

Despite differences in treatment delivery, the general consensus among leaders in the field is that cognitive-behavioral approaches that target criminogenic[1] risks and needs continue to represent the gold standard. Consistent with current standards of practice, most sex offense-specific treatment is delivered via group psychotherapy along with intermittent individual sessions. Most treatment programs currently emphasize skill building, specifically in areas identified as being associated with offense behavior. Best practice standards include targeting the following domains in sex offense-specific treatment: accountability; thinking errors; problematic attitudes; general self-regulation; sexual self-management; social skills; relationship skills; and relapse prevention. Some criminogenic factors, such as deviant arousal, may require specific treatment interventions and maintenance (e.g., arousal reconditioning along with periodic phallometric assessment). Additionally, individuals with co-occurring disorders, such as substance abuse and mental illness, may be referred to groups that target chemical dependency and/or the need for psychotropic medications.

Treatment success means something different for each offender. Simply put, treatment success means the offender has been addressing his/her risk factors in treatment and the treatment provider has assessed that he or she has made substantial progress in addressing those factors. It is imperative that the treatment provider develop a treatment plan that specifically identifies an offender's criminogenic risks and needs and document progress made in those identified areas.

It is important to note that treatment for sexual offenders has changed markedly in recent years. Most significantly, the research on the factors that most strongly predict reoffense has informed the targets of treatment in general. For example, research has shown that sexual deviance is strongly associated with recidivism. Therefore, for an individual who is sexually deviant, this factor becomes an important focus of treatment in order to mitigate risk. Additionally, the alliance between the treatment provider and offender is less punitive and more collaborative than in the past when confrontation was a predominant feature of treatment. At one time, Relapse Prevention (RP), a model adapted from the substance abuse treatment field, was the dominant theoretical approach used with sex offenders, with its emphasis on avoidance of problematic or "high risk" situations. More recently, RP has been joined by an equal emphasis on the development of positive alternatives to those "people, places, and things" offenders have been conditioned to avoid. In other words, the treatment literature supports a strength-based approach, which encourages offenders to develop greater motivation for remaining offense-free (i.e., giving offenders something to lose). This is not to imply that treatment does not still support the development of a relapse prevention plan; rather, treatment is enhanced with the addition of models that support skill-building and positive, healthy goal-setting.

Given these developments in treatment in recent years, those individuals who participated and even "completed" treatment or "graduated" treatment programs years ago have not benefitted from these new approaches. As such, it is likely that those individuals would not meet current standards for having achieved the treatment goals now recognized as essential in the reduction of reoffense risk. In these cases, individuals with past treatment experience should still be required to attend and demonstrate the level of knowledge and skill they may have acquired and maintained. The treatment

[1] The term "criminogenic" refers to the identified dynamic factors associated with the criminal conduct.

provider will then develop an appropriate treatment plan to target whatever the individual's specific needs may be identified based upon a current risk and needs assessment.

Sex offenders who drop out of treatment are considered "treatment failures." Generally, sex offenders who drop out do so because they lack a sense of responsibility, lack self-awareness, are overly confident, or do not see the need for treatment. Also, in some cases, sex offenders who adamantly deny their offense behavior(s) can be considered "treatment failures." Although denial of offense behavior has not been empirically correlated with an increased risk to reoffend, it is generally considered to be clinically significant to the extent that one cannot develop plans to avoid behaviors one does not admit to having, or develop skills needed to meet their underlying needs appropriately. However, it is important to be aware that in many cases, denial may not represent a treatment failure but rather an early stage in treatment engagement. That is, most offenders beginning in treatment deny at least some aspect of their offense behavior. It is through treatment that most begin to admit the behaviors that have been attributed to them, and therefore, begin to make progress in treatment. This is referred to as "stages of change," where it is commonly observed that individuals initially deny or minimize having a problem, and over time, begin to acknowledge the problem yet may lack the readiness to address it. With encouragement and support, most offenders develop self-awareness that a problem exists and needs to be addressed. Many take active steps to address the problems they have and some succeed in managing them effectively. For those individuals, periodic maintenance with a former provider during the "aftercare" phase ensures that they retain their treatment gains. In cases where an offender engages in inappropriate or concerning behavior following discharge from treatment, he or she should be required to return to treatment.

Last, it is the case at times that some individuals have impairments that prohibit them from benefitting from sex offense-specific treatment. Whether due to profound intellectual disability, dementia, medical compromise, or other extenuating circumstances, it is important to appreciate that some offenders will reach maximum benefit without achieving treatment goals. In circumstances such as this, a "containment model" that coordinates probation, treatment, and polygraphs, offers supervision as an external means toward managing an offender's risk.

Appendix A

Books

Handbook for Sexual Abuser Assessment & Treatment - Edited by Mark S. Carich, Ph.D. & Steven E. Mussack, Ph.D., Safer Society Press 2001

Applying the Good Lives & Self-Regulation Models to Sex Offender Treatment: A Practical Guide for Clinicians - Pamela Yates, Ph.D., R.D. Psych, David Prescott, LICSW, Tony Ward, Ph.D., Safer Society Press 2010

Web Resources

Association for the Treatment of Sexual Abusers http://www.atsa.com/
Center for Sex Offender Management http://csom.org/otherResources/index.htm
Good Lives Model http://www.goodlivesmodel.com/glm/Home.html
International Association for the Treatment of Sexual Offenders http://www.sexual-offender-treatment.org
Public Safety Canada http://www.publicsafety.gc.ca
Safer Society Press http://www.safersociety.org/prevention-treatment-info/