Executing an evidence-based treatment program:
Working with males and females

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Overview

Outline of the main tenets of an empirically-based program

- Assessment
  - Assessing risk level and factors with males
  - Assessing risk level and factors with females
- Treatment length
  - Intensity of interventions matched with risk level
    - Research findings for treatment intensity
- Treatment focus
  - Common criminogenic factors for males and females
  - Different risk levels, different gender… different needs
- Tending to curative factors of group treatment
  - Being responsive to client
    - Therapeutic and working alliance research
    - Group Cohesion

ATSA Guidelines

The ATSA Adult Practice Guidelines are presented within the evidence-based framework for effective interventions. This research indicates that interventions are most effective and resources are maximized when guided by the principles of risk, need, and responsivity (RNR):

Risk: level of service commensurate with client's assessed level of recidivism risk.

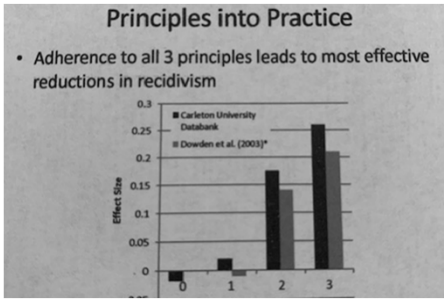
Need: focusing intervention on research-supported dynamic factors linked to recidivism or desistance that are present for the client.

Responsivity: using models of intervention that have empirical support and delivering services in a manner appropriate for the client.

Your practice or supervision

- How many principles does your program follow?
- List examples from each of the three principles.
- What are you doing best?
- Where is there room for improvement?
- Where do you come into conflict with other agencies?

The evidence



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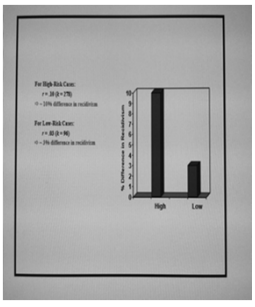

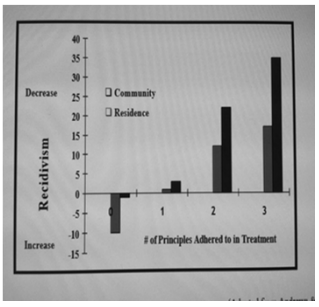

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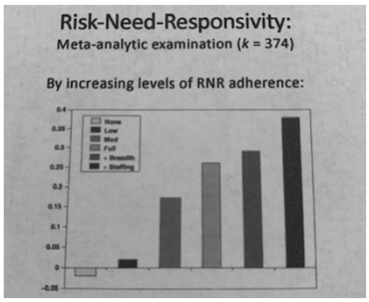


The evidence

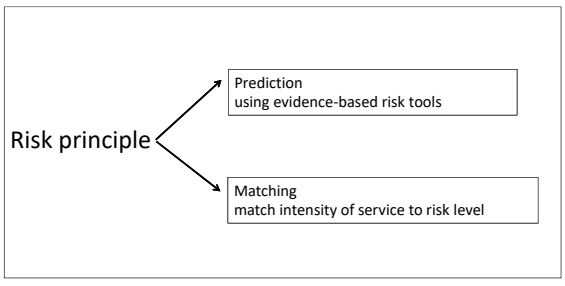
Table 2
A Sample of the Comparative Effectiveness for Selected Interventions

Intervention	Target	Mean effect size (*r*)
General psychotherapy	Child maltreatment	0.26
Psychological coping	Panic attacks	0.21
General psychotherapy	Youth depression	0.17
Offender treatment (RNR)	Recidivism	0.29
Medical interventions		
Aspirin	Cardiac event	0.03
Chemotherapy	Breast cancer	0.11
Bypass surgery	Cardiac event	0.15

Source: Andrews & Bonta, 2006; Clum, Clum, & Surls, 1993; Lipsey & Wilson, 1993; Skowron & Reinemann, 2005; Weisz, McCarty, & Valeri, 2006.

A Sample of the Comparative Effectiveness for Selected Interventions

Risk principle



Risk principle - Prediction

- Empirically supported instruments for males
  - Several options here
    - Static-99; STABLE 2007; VRS-SO; SOTIPS; SVR-20, etc.
  - One not necessarily better than the other as long as the tool is validated and used as intended.

- Kroner, Mills, & Reddon (2005) "the coffee can study"
- PCL-R, LSI-R, VRAG, and GSIR compared to 13 randomly drawn items from scales in a 'coffee can'
- No significant difference in sample of 1614 offenders
- Important to use in consistent manner
- Caution of applying overrides!
  - Clinical/Opinion overrides REDUCE predictive accuracy
  - Schmidt et al., 2016; Wormith et al., 2012

Risk principle - Prediction

- Important points
  - No one tool can assess all types of risk
  - Want to assess static, dynamic, and protective factors
  - When using multiple tools, there is direction
    - Disparity among measures (Jung et al., 2013)
    - Averaging between measures (Babschishin et al., 2012)
    - Be explicit in which approach used(Skeem & Monahan, 2011)
  - Moving towards common risk language (Hanson et al., 2017)

• Very low	0-5%	Category I
• Below average	6-13%	Category II
• Average	14-25%	Category III
• Above average	26-85%	Category IV
• >86%		non-existent

Risk principle - Matching

- Intensity of interventions matched to the level of risk posed by offender
  - Research has been conducted to guide appropriate levels treatment
    - Researchers have found between 120 and 300 contact hours (approximately 2 to 4 years of treatment) warranted for moderate and high risk sex offenders (Beech & Mann, 2002; Correctional services Canada, 2000; Marshall et al., 2006)
      - Others suggest
        - » 100 or less contact hours for low risk and few criminogenic needs (CAT 1)
        - » 100 to 200 contact hours for average risk (CAT II)
        - » 200 -300 contact hours for above average risk and multiple criminogenic needs (CAT III and IV)

Risk principle - Matching

- Intensity of supervision matched to the level of risk posed
- Few studies have examined supervision contact and sexual recidivism
  - Research has indicated that more intensive supervision reduces general recidivism with high risk offenders, but can increase rates of reoffending for low risk offenders
  - Studies have found that reduced supervision intensity for low-risk offenders (kiosk reporting) reduces recidivism (2% from 10%; Maryland DPS study, 2011)
  - Barnes et al. (2010) studied two groups of supervision for LR offenders
    - Experimental group – 323 offenders/caseload – met every 6 mos + 1 call
    - Control supervision group – 135 offenders/caseload – standard supervision
    - No significant differences between illegal behavior
  - With general offenders, reduced supervision intensity for low risk did NOT increase re-offense

Risk principle - Matching

- Intensity of interventions matched to the level of risk posed by offender
  - Few studies have examined supervision contact and compliance or recidivism
    - Most sex offenders on probation are low risk (80%)
    - Pederson & Miller (under review)
      - Examined compliance across risk levels and effects of overrides of SOs on community supervision
      - Compliance matched risk level; high risk less compliant
      - Overrides (violating RNR) increased non-compliance
  - We need supervision intensity studies with individuals on probation for a sexual offense!

Risk principle - Females

- NO validated risk tools for females who sexually offend
- Marshall, Miller, Cortoni, & Helmus (under review)
  - Do not use the Static-99 with females
- The prevalence of sexual recidivism for female sexual offenders
  - Cortoni and Hanson (2005); 380 females, 1%
  - Sandler and Freeman (2009); 1466 females, 1.8%
  - Miller and Marshall (2017); 255 females, 4%
  - Marshall and Miller (2019); 506 females, 3%
  - Overall sexual recidivism rate is 1-3%
    - Probably will never have effective risk tool for females
  - Cortoni et al., (2016); meta-analysis, 2-12% of sexual offenses by women
    - 17 samples from 12 countries
    - Proportion of female to male sex offenders
    - 2% from police records; 12% from victimization surveys
    - Higher % of female offenders in adolescent population

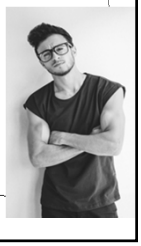
Risk principle - Females

- Assessing and assigning risk levels with females
  - Previous studies have suggested that FSO recidivists resemble general and chronic criminal offenders (Sandler & Freeman, 2009)
    - If FSO recidivate much more likely to recidivate with general offense
    - Can use general risk tool to obtain overall risk level
    - If wanting to assess for sexual recidivism, report LOW
  - Preliminary risk variables for sexual recidivism
    - Antisocial (Sandler & Freeman, 2009)
    - Prior sexual crimes (Miller & Marshall, 2018)
    - Prior child abuse (non sexual; Sander & Freeman, 2009)
    - Psychopathology (ANX, DEP; Marshall & Miller, 2019)

Case Example

- Brian, 28
- No priors, sexual or non-sexual
- One 15 yr old female victim, stranger
- Met online and tried to meet for sex
- Static-99R of 3

this is not really Brian



Case Example

- Sarah, 25
- No priors, sexual or non-sexual
- One 16 yr old male victim, friend of family
- Had ongoing sexual relationship

none of these are really Sarah

Need principle

- Supervision and treatment should explicitly target supported and appropriate criminogenic needs
  - Higher risk sex offenders have several criminogenic needs
  - Lower risk sex offenders have only a few criminogenic needs
  - Common criminogenic needs (dynamic risk) of male sex offenders:
    - Sexual deviance/sexual preoccupation/paraphilic interests
    - Substance abuse/other problematic coping
    - Relationship problems/emotional intimacy deficits
    - Negative social influences
    - Pornography use
    - Self-regulation problems
    - Unstable lifestyle
    - Cognitions supportive of abuse or assault

Need principle

- Common criminogenic** needs of females who sexually offend:
  - Past victimization history (as child and adult)
  - Mental health
  - Substance abuse
  - Relationship problems/intimacy issues (co-offender?)
  - Emotional regulation problems/poor coping
  - Unstable lifestyle/antisocial lifestyle
  - Cognitions supportive of abuse or assault

**possible. Most data for general re-offense rather than sexual re-offense.

Need principle

- In addition to ensuring empirically based criminogenic needs are addressed, this principle also means what we should NOT focus on
- Factors that are not significantly related to recidivism should NOT be emphasized in supervision or treatment
  - These are different for everyone… but many people believe that certain factors are *always* related or *never* related to recidivism. Clinical v. Criminogenic need.
  - Examples:
    - Victim empathy
    - Major mental illness
    - Self-esteem
    - Denial
    - Depression
    - Social skills deficits
    - Poor motivation for treatment
    - Loneliness

Need principle

- Empirically supported tools (not exhaustive)
  - Stable 2007/Acute 2007*
    - http://www.static99.org
  - SOTIPS*
    - http://robertmcgrath.us
  - ARMADILO (for DD clients)*
    - http://www.armidilo.net
  - SVR-20/RSVP*
    - http://proactive-resolutions.com/shop/
  - VRS-SO*
    - http://www.psynergy.ca/
  - IORNS**
    - https://www.parinc.com/Products/Pkey/207

* = males only
** = males and females

Need principle

- Implementation of the Need principle
  - Targeting needs – or – contributing factors
    - Modules specific to most common factors (examples)
      - Sexual self-regulation
      - Pro-offending attitudes
      - Peers
      - Problem solving skills
      - Effective coping
    - Rotating modules
    - Menu for treatment provider to choose from

Need principle

- Take home messages
  - Criminogenic needs come and go unlike static factors.
  - Clients may have many needs deserving of treatment, but not all may be related to their offending behavior.
  - Treatment focus should be based on empirical tools that assess true criminogenic needs for each individual.
  - This is more difficult with females.

Case Example

- Brian, 28
  - No priors, sexual or non-sexual
  - One 15 yr old female victim, stranger
  - Met online and tried to meet for sex
  - Static-99R of 3
- Has Autism Spectrum diagnosis
- What to use for dynamic needs?

this (still) is not really Brian

Case Example

- Sarah, 25
  - No priors, sexual or non-sexual
  - One 16 yr old male victim, friend of family
  - Had ongoing sexual relationship
- Reports significant history of own victimization
- What to do for assessment?
- How would you assess treatment focus?

none of these are (still) really Sarah

Responsivity principle

- Using the most effective approaches to facilitate change for each client

Two components

General Responsivity	Specific Responsivity
Treatment strategies: CBT Structured/manual Therapeutic Alliance Group Cohesion	Matching treatment to client characteristics

Responsivity principle

- Treatment is enhanced through several important factors
  - Examples of responsivity areas:
    - Language
    - Race
    - Learning style/cognitive functioning
    - Gender
    - Therapeutic/working alliance*
    - Group cohesion*

Responsivity principle

- Treatment outcome studies with individuals who have sexually offended have demonstrated small to moderate effect sizes
  - Can we increase our impact?
  - Decades of outcome studies for general psychotherapy have consistently demonstrated that certain process factors carry MORE importance in change than technique
- Therapeutic Alliance (individual and group)
- Group cohesion (group work)

Responsivity principle

- Therapeutic Alliance – what we know
  - Accounts for 30% of client improvement
  - Programs with confrontational or hostile therapists had ineffective outcomes or made clients worse Positive therapeutic relationship accounts for significant variance in treatment outcome
  - Therapist characteristics of empathy, respect, warmth, genuineness, firm-but-fair, confidence, and interest in client have been shown to maximize treatment gains

(Beech & Fordham, 1997; Fernandez et al., 2006; Hanson, 2009; Jennings & Deming, 2017; Mann et al., 2004; Marshall, 2005, Marshall et al., 1999, 2002, 2003, 2013; Miller, 1995; Witte et al., 2001;Yates, 2013)

Responsivity principle

- Group cohesion – what we know
  - The more the group members feel connected, open, and safe, the better the treatment outcome
  - When therapists work toward building cohesive groups, significantly more desired client changes are apparent
  - Group cohesion is directly related to responsibility-taking, conflict resolution, increased interpersonal functioning, and reduced anxiety related to change

Responsivity principle

- Relationship between therapeutic alliance (TA), group cohesion, and compliance
  - Miller & Eck (under construction)
  - Treatment programs, differing on treatment climate were compared on probated offender's compliance in treatment and supervision
  - Clients who attended treatment with more positive TA and Cohesion progressed faster in treatment and were more compliant with supervision rules (UAs, polygraphs, fees)
  - First study to examine these factors on compliance

Responsivity principle

- Alliance & Group cohesion – what we can do
  - Assess and research these factors!
  - Therapeutic Alliance
    - Working Alliance Inventory
    - Group Environment Scale
  - Group Cohesion
    - Group Environment Scale
    - Group Session Rating Scale
    - Therapeutic Factor Inventory – Cohesiveness Subscale

Thank you!

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