Best Practices in the Management of Persons Who Have Sexually Offended

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Stakeholders

- People who have been or might be victimized, and those who advocate for them
- Citizens
- Law enforcement
- Courts and legal personnel
- Correctional and probation/parole personnel
- Mental health personnel
- Community groups (e.g., CoSA, Salvation Army, etc.)
- The media
- People who have sexually abused

Evidence-Based Interventions

Nothing Works?

Martinson (1974)

- Large-scale study of correctional interventions
- Found no clear evidence that efforts to rehabilitate offenders were "working"
  - Furby, Weinrott, & Blackshaw (1989) found the same with interventions for sexual offenders
- Repercussions still felt today, 40 years later
- Spurred many to conduct research into aspects of treatment/counseling/interventions that would lead to lower recidivism

Sanction vs. Human Service

Several very large-scale meta-analyses

- Smith, Goggin, & Gendreau (2002)
- Aos, Miller, & Drake (2006)
- Lipsey & Cullen (2007)

All arrived at the same conclusion:

Punishment **alone**
will not reduce bad behavior.

An answered question?

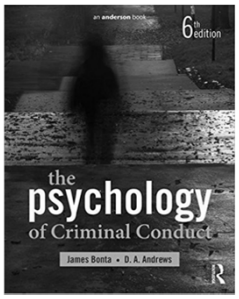
We are confident that, no matter how many studies are subsequently found, sanction studies will not produce results indicative of even modest suppression effects or results remotely approximating outcomes reported for certain types of treatment programs.

(Smith et al. 2002, p.19)

Bonta & Andrews (2016)

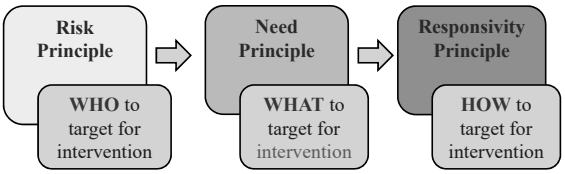
Three Principles:

- Risk
- Need
- Responsivity



RNR Principles

(Bonta & Andrews, 2016)



Overarching Risk Factors

There are two over-arching risk factors in the literature about risk for sexual violence

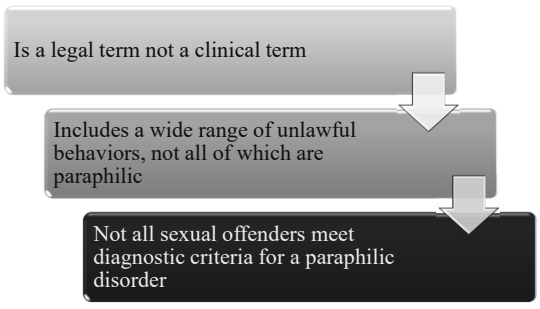
- Sexual deviance
  - Which may include some aspect of hypersexuality, either as a distinct or contributing factor (Etzler et al., 2018)
- Antisociality
  - Which may include some aspect of youthful nonsexual violence, either as a distinct or contributing factor (Brouillette-Alarie et al., 2016)

Connecticut

- The majority of interventions and processes in CT are RNR-informed and are mostly RNR-compliant
- Some attention is necessary in ensuring that the most stringent measures are applied to those offenders who need them most

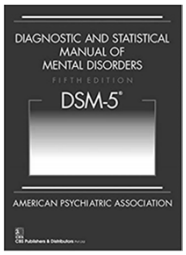
Sexual Deviance

"Sexual Offender" …



Sexually Deviant
vs.
Sexually Inappropriate
vs.
Socially Inappropriate

DSM-5 Definition of Paraphilias



"..any intense and persistent sexual interest other than sexual interest in genital stimulation or preparatory fondling with phenotypically normal, physically mature, consenting human partners"… or alternatively "sexual interests greater than or equal to normophilic sexual interests".

"A *paraphilic disorder* is a paraphilia that is currently causing distress or impairment to the individual or a paraphilia whose satisfaction has entailed personal harm, or risk of harm, to others"

What's in the DSM-5?

- **Voyeurism**
- **Exhibitionism**
- **Frotteurism**
- **Sexual Masochism**
- **Sexual Sadism**
- **Pedophilia**
- **Fetishism**
- **Transvestism**
- **Other Specified / Unspecified Paraphilia**

Connecticut

- The Hanson meta-analyses support a perspective that sexually deviant interests and preferences are risk-enhancing
- Not all sentencing practices in CT take this into account, although there is likely to be a reasonable correlation between some elements of offense-type and the deviance continuum

Risk Assessment

Why Assess Risk?

1. Importance of promoting public safety
2. Need to determine who receives routine interventions and who needs exceptional measures
3. Strategic use of scarce resources

18

Static Predictors (Static-99R)

- Male victims
- Ever lived with a lover
- Non-contact sex offenses
- Unrelated victims
- Stranger victims
- Prior sex offenses
- Current non-sex violence
- Prior non-sex violence
- 4+ sentencing dates
- Age

Dynamic Predictors (Stable-2007)

- Peer affiliations
- Intimate relationships
- Emotional congruence
- Hostility towards women
- Rejection & loneliness
- Lack of concern for others
- Impulsive
- Poor problem solving
- Negative emotionality
- Sexual Preoccupation
- Sexualized coping
- Deviant sexual interests
- Non-cooperation

Static-99R

- Most commonly used actuarial risk assessment instrument (ARAI) for sexual offenders
- Moderate predictive accuracy in 63 replications (Cohen's $d \approx .70$; Hanson & Morton-Bourgon, 2009)

Council of State Governments Justice Center Standardized Risk Levels

Level I
Level II
Level III
Level IV
Level V

Council of State Governments Justice Center's Levels for General Risk/Need

I	Prosocial, made mistake
II	Minor concerns
III	Typical problems for individuals in trouble with the law
IV	Chronic rule violation, few strengths
V	Virtually certain to reoffend

Standardized Levels for Sexual Recidivism

<table>
<tr><td>I
Very Low Risk</td><td colspan="2">Older, prosocial, made mistake in the past</td></tr>
<tr><td>II
Below Average</td><td colspan="2">Minor concerns</td></tr>
<tr><td>III
Average</td><td colspan="2">Typical problems for individuals with a sexual offense history</td></tr>
<tr><td>IVa
Above Average</td><td rowspan="2">History of rule violation, problems with sexual self-regulation, few strengths</td><td>Chronic problems</td></tr>
<tr><td>IVb
Well Above Average</td><td>More and more severe</td></tr>
</table>

Connecticut

- Personnel in CT use commonly endorsed risk assessment tools and practices (e.g., LSI-R, Static-99R, Stable-Acute-2007, SOTIPS)
- Use of such measures is critical to the development of risk-based practices (e.g., registration, notification, sentencing)

Treatment & Desistence

Stakeholders

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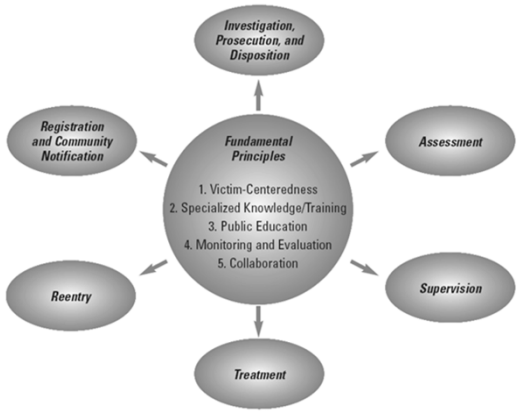


Treatment Tips – Marshall, 2005

- Warm
- Empathic
- Rewarding
- Directive

Problem: Many practitioners think they have these qualities, but actually don't.

Stages of Change

Phase	Presentation	Level of Motivation	Tips for Clinicians
Precontemplation	No acknowledgement of problem's existence	Defensive/unmotivated	Create dissonance; raise doubts
Contemplation	Acknowledgement that problem "might" exist	Vacillation between minimization and acknowledgement of the problem	Tip the decisional balance; evoke reasons for change (pros/cons); support change
Preparation	Recognition of the problem	Appearance of motivation	Explore best course of action
Action	Active engagement with the process of change	Good motivation	Take steps toward change
Maintenance	Maintenance of change through application of effective coping strategies	Good motivation	Identify and use adaptive coping strategies

Treatment Dosage Recommendations

I Very Low Risk	None Needed
II Below Average	Case Management
III Average	100+ Hours Intervention Change Focused Community Supervision
IVa Above Average	200-300 Hours of Changed Focused Intervention and Cascade of Services
IVb Well Above Average	

Connecticut

- Treatment in CT is RNR-informed and is generally in line with best practices
- Continued attention to issues of responsivity is necessary, but not uncommon in the US and elsewhere
- Greater continuity between institutional and community services is suggested
- Training is ongoing
- Some consideration regarding optimal use of polygraphy is suggested

Official Control

There are several "official" means by which to control offenders in the community …

- Specialized Community Protection Orders
- Community Notification
- Sex Offender Registries
- Residency Restrictions
- 1000/2000/2500 feet rules
- Electronic/GPS Monitoring

Paying Attention to RNR

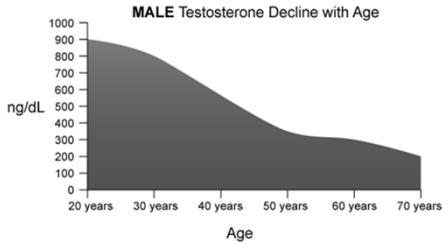
- I won't tell you that each and every one of these measures is inappropriate all the time.
- Clearly, there are some offenders on whom special attention must be focused, using the tools and risk management options available.
- However, it would be my contention that we consistently fail to apply risk and need considerations in regard to implementation, ultimately diminishing potential gains.

Effects of Aging on Risk

- Sex drive (libido) has two aspects
  - Cognitive (mind)
  - behavioral (body)
- Controlled by testosterone
  - Includes both aspects
    - Cognitive = urges, fantasies, thoughts
    - behavioral = potency, function

Effects of Aging on Risk

- Testosterone levels decrease as men age



Are high risk offenders high risk forever?

from Hanson et al. (2014)

- All estimates of reoffending are confounded by under-reporting.
- Approximately 70% of sexual offenders are at low to low-moderate risk to reoffend.
- Approximately 10% are at high risk to reoffend.

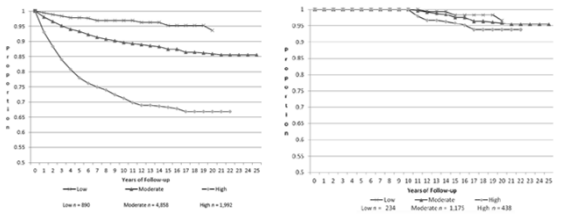
Are high risk offenders high risk forever?

from Hanson et al. (2014)

- If they are going to, most sexual offenders will reoffend within 5 years post-release.
- The longer they remain offense-free in the community, the more likely it is that they will continue to be offense-free.
- The effect is most pronounced with higher risk offenders.

Are high risk offenders high risk forever?

from Hanson et al. (2014)



Years to Desistance According to Initial Risk Levels

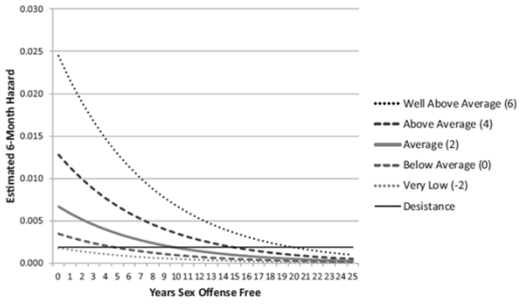


Figure 2. Years to desistance according to initial risk level based on selected Static-99R scores. Estimated hazard rates based on Model 5 (n = 7,225) for routine/complete samples. See the online article for the color version of this figure.

40

Connecticut

- Research has greatly informed practice in the past 10 years regarding how best to achieve desistance
- It appears that even clients assessed as "high-risk" can achieve desistance
- Exceedingly long-term follow-up (e.g., lifetime probation or terms exceeding 20 years) may not be necessary

Closing Thoughts

Research has clearly shown that a collaborative approach which includes representation from all stakeholders can assist considerably in enhancing public safety and offender accountability and reintegration potential. Working together, we can manage the risk.

Teamwork is the key,
and the community has an integral role
to play in public safety!!

Contact Information

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