

Applying the risk principle to sex offender treatment

Many correctional jurisdictions include treatment as a component of a comprehensive risk management plan for sex offenders. Unfortunately, only a few studies have demonstrated that treatment can lead to reduced recidivism.⁽²⁾ As a result, some jurisdictions are citing the lack of evidence that treatment "works" and imposing increasingly harsh (and very expensive) sentences on sex offenders and eliminating treatment programs. Researchers must, therefore, demonstrate the value of treating this politically sensitive population.

Current treatment and program evaluation designs may mask potential treatment effects. For example, despite the recognized diversity of sex offenders, many programs provide the same interventions for all sex offenders. Further, program evaluations typically determine whether the treatment package affects the release outcome of the entire group. It seems more likely that specific interventions might reduce recidivism in some, but not necessarily all, offenders.

Recent conclusions about the treatment that works with general criminal populations may provide a useful framework for improving our treatment and evaluation efforts with sex offenders. For example, higher-risk offenders seem to experience the greatest reductions in recidivism following appropriate treatment.⁽³⁾ This article examines recent sex offender treatment outcome data⁽⁴⁾ that illustrate this risk principle. The Clearwater program The Clearwater sex offender treatment program began operation in 1981 at the Correctional Service of Canada's Regional Psychiatric Centre (Prairies). Using a structured, cognitive-behavioural approach, the program has increasingly adopted a relapse prevention treatment framework.

A recent study examined the post-release outcome of 257 sex offenders who completed Clearwater treatment between 1981 and 1994, and were followed up for an average of 5.2 years. Of these offenders, 55% were rapists, 16% were pedophiles, 11% were incest offenders, and 18% had had both adult and child victims.

This article compares the post-release outcome of these offenders with a Service national sample of 1,164 sex offenders⁽⁵⁾ (see Table 1). The national sample was made up of all sex offenders released from Service institutions in 1988 (who were then followed up for three years). To remain consistent with the national data, the Clearwater study defined outcome as the offender's first post-release event that resulted in a return to custody.

Table 1

Post-release Outcome for the Clearwater (257 offenders) and National (1,164 offenders) samples			
Outcome	Clearwater sample	National sample	p value
Sexual reconviction	4.7%	6.2%	0.18
Non sexual reconviction	7.8%	13.6%	0.006

Conditional release revocation	23.3%	11.3%	0.000
No return to prison	64.2%	68.8	0.078

Treated (Clearwater) offenders were less likely to be convicted of non-sex offences, but more likely to have their conditional release revoked. Both groups did have low sexual reconviction rates, but there was no statistical advantage for treated offenders.

However, the application of the risk principle produces different results. Higher risk was defined as having previous sex offence conviction (because the national sample data only allowed for defining risk based on previous sex offences). Using this definition, higher-risk treated offenders were found to have significantly lower sexual reconviction rates, somewhat lower non- sexual reconviction rates, and were found to be less likely to return to prison for any reason (see Table 2).

Not all offenders were equally likely to be convicted of new sex offences. In the Clearwater sample, pedophiles (9.5%) were more likely to reoffend sexually than rapists (5%), offenders with adult and child victims (2.2%) or incest offenders (0%). In contrast, rapists (10.2%) and offenders whose victims were both adults and children (10.9%) were more likely to be convicted of non-sex offences than child molesters (0%). Unfortunately, the national sample did not identify offender subtypes, so we cannot complete group comparisons.

The definitions of recidivism and risk used in this comparison are admittedly limited. Further analyses will help define other outcome measures and dimensions that correlate with successful treatment outcome. However, these data seem to indicate that a structured cognitive-behavioural treatment program can contribute to reducing sexual recidivism, and that applying the risk principle can optimize treatment impact.

Table 2

Post-release Outcome for Higher Risk Offenders			
Outcome	Clearwater sample (80 offenders)	National sample (116 offenders)	p value
Sexual reconviction	6.0%	14.6%	0.022
Non sexual reconviction	8.6%	14.6%	0.093
Conditional release revocation	20.7%	21.9%	0.43
No return to prison	64.7%	48.8%	0.013

Applying the risk principle One strategy for applying the risk principle is to withhold treatment from all but higher-risk offenders. Based on the Clearwater data, this means that incest offenders would not receive treatment during incarceration.

However, this strategy has several drawbacks. First, treatment may benefit lower-risk offenders in ways

that are not necessarily captured by recidivism data, such as successful re-integration with their families.

Further, some victims (particularly incest victims) may be less likely to report offences and help prosecute offenders if they know that the offender will not receive treatment.

Finally, a clinician may not discover that an apparently low-risk incest offender actually has pedophilic interests until after a period of treatment. A better strategy might involve improving efficiency through use of the risk principle within a policy that offers treatment to all willing offenders.

There are several models for such an approach. For example, institutions might specialize in providing more or less intensive treatment to various types of sexual offenders. The Service has adopted this strategy, and offers the most intensive treatment to highest-risk offenders in psychiatric/treatment centres, while offering lower-intensity treatment in medium- and minimum-security facilities.

In contrast, the Twin Rivers Corrections Center in Washington State provides treatment of various intensities within a single, 200-bed program. In 1994, incest offenders required 28% less time to complete treatment than offenders who had sexually assaulted non-familial children.

Finally, Washington State has also developed a highly effective sentencing alternative for lower-risk, first-time sex offenders who admit their guilt.⁽⁶⁾ Eligible offenders may be sentenced to several years of lower-cost out-patient treatment in the community instead of incarceration. A variety of sentencing and treatment options should help match offender risk and needs with the most appropriate and cost-effective treatment, while still protecting the community. Practical considerations Higher-risk sex offenders can be difficult to treat. Such offenders can be more entrenched in their sexual deviance, more likely to minimize and defend their actions, and more resistant to seeing the world through the therapist's eyes. Most do not meet therapist expectations of articulateness, cooperation and motivation.

As a result, these offenders are often expelled from treatment.

Recent research suggests that failing to complete treatment may be a potent recidivism predictor.

For example, the 13% of the Clearwater participants who failed to complete treatment were 50% more likely to be convicted of a new sex offence. Pedophiles who did not complete treatment were twice as likely to reoffend.

Therapists must, therefore, persist with these hard-to-serve offenders. This requires great therapist dedication and even greater supervisor leadership.

Treating higher-risk clients may also carry a political cost. Although treatment may be more likely to reduce recidivism among these offenders, their risk level suggests that some will reoffend - even after treatment.

Unfortunately, the public and the media are not likely to be impressed with statistically significant treatment effects when some treatment graduates reoffend. As a result, many community treatment providers and some institutional programs may refuse to accept high-risk offenders.

It is not easy to choose between providing potentially effective services that may eventually close a program because of societal reaction to the recidivism of some high-risk sex offenders and providing low-impact services to lower-risk sex offenders who, as a group, will recidivate less often.

We argue that, as clinical professionals and/or public servants, we have a duty to provide the services that will have the greatest impact on offenders - treating higher-risk sex offenders.

We hope that this choice can be made easier by creating more realistic public and media expectations.

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(3)D. Andrews et al., "Does correctional treatment work? A clinically relevant and psychologically informed meta-analysis," *Criminology*, 28, 3 (1990): 369-404.

(4)T. Nicholaichuk and A. Gordon, *Outcome of the Clearwater Sex Offender Treatment Program*, Paper presented to the 14th annual Association for the Treatment of Sexual Abusers Research and Treatment Conference, New Orleans, 1995.

(5)A. Gordon and F. Porporino, *Managing the Treatment of Sex Offenders: A Canadian Perspective*, B-05 (Ottawa: Correctional Service of Canada, 1991).

(6)L. Berliner, D. Schram, L. Miller and C. D. Milloy, "A sentencing alternative for sexual offenders: A study of decision making and recidivism," *Journal of Interpersonal Violence*, 10, 4 (1995): 487-502.