Sexual Abuse in Australia and New Zealand, January 2009; 1(2): 56-58

EDITORIAL

The second issue of the journal has led us into interesting territory. The papers in this issue continue the themes we have tried to establish of mixing assessment and treatment papers. The invited paper of Ogloff and Doyle outlines the yet modest limits of our professional competence in matters relating to expert assessment and the practical and scientific issues that surround such assessments. The article by Vess provides important data informing the debate on preventative detention and complements the work of Ogloff and Doyle in this issue. There is an urgent need for the quality evaluative research produced in New Zealand to be replicated in the Australian domain. Proeve's paper discusses the development of a brief actuarial tool for working with non-adjudicated offenders, and extends the debate about risk assessment into the vexatious area of the voluntary and civil domain. How to go about assessing risk and reductions in risk in the absence of collateral remains a controversial area and is a theme picked up by Collins, Peters & Lennings in their evaluation of a community treatment program. This evaluation highlights what seems to have been an unexpected theme in the current journal, the role of treatment and assessment in a community context and nicely flows into this year's theme of the ANZATSA Conference on safeguarding human rights. Our final paper is an understanding of sexual violence in a cross cultural sample. Chien, Wen-Yau, Beech and En-Chang seek to validate the pathways approach to offending and the role schemata play in motivating offending. For this issue Associate Professor Douglass Boer introduces an editorial comment on the role of expert in giving testimony – in particular what makes an expert an expert.

For those that are unaware, and for those who require a gentle reminder, the ANZATSA 5th Conference is on in Sydney between Thursday 5th and Saturday 7th of March. We are pleased that the New South Wales Department of Juvenile Justice and the New South Wales Corrective Services Department have agreed to be major sponsors of the conference. The Conference theme is Safeguarding Human Rights. Pre conference workshops are from Tuesday 3rd to Wednesday 4th of March. The Venue is the Sydney Masonic Centre and further information should be obtained from the ANZATSA website.

Finally, the 3rd issue of the Journal will be dedicated to research in treatment, and will be edited by Associate Professor Douglass Boer. All submissions for that issue should be sent to Douglass.

Christopher J. Lennings
The University of Sydney, Australia

Editorial Comment by Douglas P. Boer[1]

Expert Witness Testimony (NOS)[2]

Someone I met some years ago, who I prefer to leave anonymous, once said that "an expert witness is someone who says he (or she) is an expert in an area *(sic)*". Supported by this line of reasoning, the person in question told me that she was doing expert witness testimony (EWT) in the area of risk assessment, even though she had never written a risk assessment report and had no training in risk assessment. Her claim to expertise was that she was a journal editor – and had written in the area of EWT! Apparently, her editorial skills and academic knowledge gave her the acumen needed to judge the competency of a risk assessment report and comment upon it in Court. I suggested that she may as well be judging the accuracy of diagnostic reports by oncologists as well – after all real medical experts are more expensive than psychologists as experts. The irony was lost on her, but the audaciousness of her claims was not lost on me, and has bothered me ever since.

I hope my description is vague enough to hide the person's identity (I even chose the pronoun at random), while exposing the obvious paradox: an expert witness (EW) can only be an expert in an area they understand via specialized education, training, and practice. An expert in the area of EWT ought to know that – but as someone who does a bit of EWT – the lure of the financial rewards can be a siren call.

What is an expert then? There are loads of definitions.

The current source of common knowledge – Wikipedia – provides the following definition: "an expert witness or professional witness is a witness, who by virtue of education, training, skill, or experience, is believed to have knowledge in a particular subject beyond that of the average person, sufficient that others

[1] Address for correspondence: drdoug@waikato.ac.nz
[2] NOS – "not otherwise specified"

ISSN 0833-8488

may officially (and legally) rely upon the witness's specialized (scientific, technical or other) opinion about an evidence or fact issue within the scope of their expertise, referred to as the expert opinion, as an assistance to the fact-finder. Expert witnesses may also deliver expert evidence about facts from the domain of their expertise. At times, their testimony may be rebutted with a learned treatise, sometimes to the detriment of their reputations". But as I tell my students, Wikipedia may be a good place to start, but it is rarely a good place to end one's search for information.

The most basic rule regarding EWT is Rule 702 of the Federal Rules of Evidence (of the United States) which defined "testimony by experts" in the following manner: "if scientific, technical, or other specialized knowledge will assist the Trier of fact (the judge or jury) to understand the evidence or determine a fact in issue, a witness qualified as an expert (by the judge) by knowledge, skill, experience, training, or education, may testify thereto in the form of an opinion or otherwise, *if (1) the testimony is based upon sufficient facts or data, (2) the testimony is the product of reliable principles and methods, and (3) the witness has applied the principles and methods reliably to the facts of the case"*.

The following definition (from the Legal-Explanations.com website) of an EW is incomplete as it neglects the responsibility of the EW to the Trier of fact, but it is modernly honest and includes some of the procedural realities of EWT: "*n*. Specialist in a subject who may present their expert opinion without being a witness to the occurrence related to the lawsuit or criminal case. If the expert is qualified by evidence of their expertise, training, or special knowledge, they are an exception to the rule against providing an opinion as testimony. The attorney for the party calling the expert must show the expert's qualifications if they are challenged and the trial judge has the discretion to rule if he/she is qualified as an expert, or is limited on the subjects that they are an expert on. Typically, experts are paid handsomely for their services. In most jurisdictions, both sides exchange the names and addresses of proposed experts during the pre-trial depositions".

The above definitions are American in origin, but the Australian and New Zealand conceptions of an EW are similar. The "Guidelines for Expert Witnesses in Proceedings in the Federal Court of Australia" promulgated by Chief Justice Black in May of 2008 are probably the clearest and most explicit set of guidelines available for EWT. Again, the principles of specialized knowledge, experience and training are paramount – as well as the EW's duty to the Court (i.e., section 1.3, "An expert witness's paramount duty is to the Court and not to the person retaining the expert"). The guidelines for EWT promulgated in New Zealand are not prescriptive in the relatively new Evidence Act (2006). Perhaps because of the recentness of this Act, there are no similar sets of explicit guidelines (to my knowledge) for EWT in criminal matters in New Zealand to those used in Australia. However, the rules for EWT in New Zealand have similar standards to those described in the Australian guidelines as is made clear by recent case law (e.g., the Hutton case, *R v Hutton* [2008] NZCA 126) and civil law (N. Wilson, personal communication, January 3, 2009). For an example of the latter, the "duty to the court" is spelled out in the "Practice Notes (for) Expert Witnesses – Code of Conduct" promulgated by Principal Environment Judge Bollard (i.e., section 5.2.1, "An expert witness has an overriding duty to assist the Court impartially on relevant matters within the expert's area of expertise" and further, section 5.2.2, "An expert witness is not an advocate for the party who engages the witness".

It is my editorial, not expert, opinion that the most critical responsibility of EWT is that of the EW's duty to the Court, that is, to aid the Court "to understand the evidence or determine a fact in issue" (Federal Rules, 2000). It is also my opinion, that the most tricky and potentially dangerous aspect of EWT is that the EW is providing "opinion" to the Court (based on the EW's "knowledge, skill, experience, training, or education"). The Australian guidelines even give good advice on how to do the job of providing opinion objectively. At the most ethical end of the spectrum, an EW ought not care which side of the legal fence he/she is working for – his/her testimony ought to be the same – if it's objective.

The "NOS" (not otherwise specified) part of the title to this editorial is based on the unhappy reality of EWT in action. Often, it appears that EWs are not objective or even true experts – despite the standards for their work. There is not enough space in an editorial to cite examples of EWT problems, but one can "google" a myriad of examples of bias (see also the "allegiance effect") – both in criminal law and other areas. At the unethical end of the spectrum, EWs, it seems, provide opinions that are specified by the lawyers who hire them. The "NOS" appellation is merely a convenient term to identify EWs who are happy to give the opinion they are hired to give – these are the so-called "hired guns". And, like the diagnostic application of NOS, the lack of reliability of this term is what makes it similarly of limited usefulness in legal determinations.

In closing, if one is honest, reliable, and willing to provide an opinion that may or may not make the hiring attorney happy, then one is probably doing the job of an EW well. The reality is that you probably won't get hired as often as you might if your testimony was slanted for or against the defendant. The literature is

full of good suggestions on how to be a good EW – my advice is to know your area, report it objectively, relax, and remember: "it is the lawyer's job to win a case; it is the expert's job to answer questions as truthfully as possible" (Dvoskin & Guy, 2008).

References

Black, M.E.J. (2008). Guidelines for Expert Witnesses in Proceedings in the Federal Court of Australia: Practice Direction. Retrieved January 2, 2009, from http://www.fedcourt.gov.au/how/prac_direction.html #current

Bollard, R.J. (n.d.). Practice Notes - Expert Witnesses - Code of Conduct. Retrieved January 2, 2009, from http://justice.org.nz/enivronment/legilation-and-resources/practice-notes.asp?inline=expert-witness.as

Dvoskin, J.A. & Guy, L.S. (2008). On being an expert witness: it's not about you. *Psychiatry, Psychology and Law, 15(2),* 202-212.

Expert Witness. (n.d.). Retrieved January 2, 2009, from http://www.legal-explanations.com/definitions/expert-witness.html

Expert Witness. (n.d.). Retrieved January 2, 2009, from http://en.wikipedia.org/wiki/Expert_witness

Federal Rules of Evidence (FRE). 702.

R v Hutton [2008] NZCA 126

Douglas P. Boer
The University of Waikato, New Zealand

Sexual Abuse in Australia and New Zealand, January 2009; 1(2): 59-69

A Clarion Call: Caution and Humility Must be the Theme when Assessing Risk for Sexual Violence under Post-Sentence Laws

James R.P. Ogloff
Centre for Forensic Behavioural Science, Monash University

Dominic J. Doyle
Victorian Institute of Forensic Behavioural Science (Forensicare)

Introduction

"[It] is very difficult to predict alarming but infrequent sex crimes with any reasonable degree of certainty, no matter how much money is spent on doing so."
(Wollert, 2006, p. 81)

Fear of the sexual predator occupies a prominent position in the collective consciousness of society. Over the past generation, this fear has turned to outrage. It has changed our behaviour such that parents in many countries now routinely drive their children to school for fear of what might happen to them if they are left alone. Considerable media attention has been directed to some tragic and infamous incidents of re-offending by convicted child-sex offenders upon release (McSherry, Keyzer, & Freiberg, 2006; Sullivan, Mullen, & Pathé, 2005; Wood & Ogloff, 2006). In the aftermath of such incidents, the community demanded to be protected from such offenders and the risks they pose to sexually re-offend (La Fond, 2005; Wood & Ogloff, 2006).

In an effort to attenuate the publics' anxieties and reduce the risk of sexual recidivism, a growing number of jurisdictions, including many American states, and most recently New Zealand and a number of Australian states, have enacted exceptional legislative schemes targeting sexual offenders. The legislation enables either the continued detention or extended community supervision of a subclass of sex offenders whose sentences have expired but who are still considered to be 'dangerous' (Sentencing Advisory Council, 2006). The dominant purpose of these laws is to protect the community.

Post-sentence detention and supervision legislation represents a significant departure from traditional legal philosophy, from punishing offenders for offences already committed to restricting the liberty of offenders for offences they *might* commit in the future (Sentencing Advisory Council, 2006). Indeed, this legislation has received wide-ranging criticism from lawyers, libertarians, and treatment providers (Birgden, 2007; Ruschena, 2003; Sentencing Advisory Council, 2006; Sullivan et al., 2005).

However, of particular concern to the authors, is the role of mental health professionals in bringing these controversial laws into effect. In deciding whether to submit an offender to a post-sentence detention or supervision order, courts must consider assessments of risk of future sexual offending conducted by mental health professionals. However, predicting the future is very difficult and the pivotal role played by this clinical assessment of risk in the outcome of post-sentence hearings is cause for concern.

With recent advances in the field of risk assessment, the available methods to predict risk for future sexual offending are significantly better than chance but still relatively moderately accurate (Hanson & Morton-Bourgon, 2005; Wood & Ogloff, 2006). Indeed, as the opening quotation declares, predicting an event known to not occur with frequency cannot be done with any certainty (Wollert, 2006). Furthermore, there are a number of other clinical issues that limit the reliability and validity of risk prediction (e.g., Berlin, Galbreath, Geary, & McGlone, 2003; Hart, Michie, & Cooke, 2007; Wood & Ogloff, 2006). Taken together, these limitations highlight the danger of assigning clinical risk assessments to such a lead role in these high-stakes legal decisions. Simply, the role of risk assessment in post-sentence matters is far more precarious than assumed by both clinicians and the law.

In this article we consider the task of risk assessment in post-sentence supervision and detention proceedings, particularly in Australia and New Zealand where such proceedings occur within the criminal law. The article begins with a brief overview of these legislative initiatives in New Zealand and Australia and outlines the role of mental health professionals in their operation. The next section identifies and explores the clinical limitations of risk assessment and other issues that affect the precision of risk predictions. Following this, some recommendations for mental health

---

This article is based on a Keynote Address the first author presented at the 2006 Conference of the Australian and New Zealand Association for the Treatment of Sexual Abuse.

Correspondence: Centre for Forensic Behavioural Science, Thomas Embling Hospital, Locked Bag 10, Fairfield VIC 3078, Australia. Email: james.ogloff@med.monash.edu.au

ISSN 0833-8488

professionals performing assessments in this legal area are put forward. Finally, the article surveys the shortcomings of post-sentence legislation and outlines an alternative model to managing sex offending risk.

The purpose of this article is to sound a clarion call to mental health professionals requested to provide their expert opinion on risk for sexual violence in post-sentence matters. The assessment of risk for future sexual violence is a complex task demanding of a sophisticated approach. It is vital that mental health professionals burdened with the responsibility of assessing risk in this legal context are cognisant of the field's limits and the parameters of their expert opinion. In our view, clinicians have a useful role to play in these proceedings, but caution and humility must be the theme in preparing reports and presenting them to the courts.

The Emergence of Social Control Legislation for Sex Offenders in Australia and New Zealand

In recent years, a range of criminal justice policies directed exclusively at sexual offenders have emerged, such as enhanced sentencing schemes, community registration statutes, and community notification laws (Mercado & Ogloff, 2007; Smallbone & Ransley, 2005). The targeting of sexual offenders for such legislative attention is understood to have developed from an increased awareness of the prevalence and harmful consequences of sexual violence (Hart, Kropp, & Laws, 2003), coupled with a fear of crime that continues to pre-occupy Western societies (Mullen, 2007). Arguably, however, the most aggressive legislative initiative toward preventing repeat sexual violence has been the post-sentence schemes enacted in the Australian states of Queensland, New South Wales, Western Australia, and, to a lesser extent, Victoria and the country of New Zealand (Mercado & Ogloff, 2007).

In Australia and New Zealand post-sentence legislation consists of two types of schemes – those that allow for either continuing detention or extended community supervision, and those that allow only for extended community supervision, post-release.

Queensland was the first Australian state to introduce such a scheme with the enactment of the *Dangerous Prisoners (Sexual Offenders) Act 2003*. This Act enables the Attorney-General to apply to the Supreme Court for the continued detention, or supervised release, of sexual offenders whose terms of imprisonment are expiring, but who the State considers posing an unacceptably high risk to sexually re-offend. Following the High Court's decision to uphold the constitutional validity of Queensland's Act (*Fardon v. Attorney-General for the State of Queensland*, HCA 46, 2004), the states of Western Australia (*Dangerous Sexual Offenders Act 2006*), and New South Wales (*Crimes (Serious Sex Offenders) Act 2006*) introduced parallel legislation allowing for either the continued detention or supervised release of sexual offenders at the end of their prison terms. Alternatively, New Zealand (*Parole (Extended Supervision) Amendment Act 2004*) and Victoria (*Serious Sex Offenders Monitoring Act 2005*), introduced legislation allowing only for the community supervision of child-sex offenders post-release.[1]

Despite the differences in the scope of these laws, the objectives of these initiatives are equivalent. That is, the clear purpose of post-sentence legislation, as articulated in each Act, is to protect the community from the risks that sex offenders pose to sexually re-offend. Mental health professionals, particularly psychiatrists, are required to prepare reports that assess the level of risk or likelihood that the offender would commit further sexual offences if released or if not supervised.

Under post-sentence legislation the courts are statutorily required to take into account this clinical assessment of risk in deciding whether to impose a post-sentence order. While in some cases this risk assessment is not treated as decisive (see *Director of Public Prosecutions for Western Australia v. Mangolamara*, 2007), more commonly the court's judgment turns critically upon the mental health professional's clinical assessment of risk. However, an uncontroverted acceptance of risk assessment testimony is problematic. As the following section illustrates, there exist a number of factors that complicate the risk assessment task and limit the accuracy with which assessments of risk can be made. Indeed, these issues loom as considerable obstacles to a valid and reliable assessment of risk for future sexual violence.

Clinical Limitations of Assessing Risk for Sexual Violence

Historically, mental health professionals were unable to accurately predict violent behaviour, and as a result the practice was seen to be unethical (Ewing, 1991; Monahan, 1981). This was perhaps even more serious with sexual re-offending, given the fact that the base-rate of sexual re-offending is considerably lower than the base-rate of violent behaviour. It was found that clinicians exhibited a tendency to over-predict the likelihood of future violence (false positive predictions) and thus made conservative decisions in relation to release decision-making (Ogloff & Davis, 2005). Since

[1] Recently, the Victorian government amended the original Act and widened the scope of the legislation to include sexual offences against adults (*Justice Legislation Amendment Bill 2008*, s 24). Also, the Victorian government has formed the intention to introduce a detention scheme (Hansard, 17 April 2008).

this early finding a productive period of research has ensued. Currently, the forensic mental health disciplines have identified a range of validated risk factors for sexual recidivism (Hanson & Bussière, 1998; Hanson & Morton-Bourgon, 2005) and a myriad of empirically evaluated risk assessment instruments (McCarthy, 2001; Mercado & Ogloff, 2007). In fact, when required to provide assessments of risk for future sexual violence, mental health professionals now rely upon risk methods and tools that have a demonstrated reliability and predictive validity that considerably exceeds chance (Mercado & Ogloff, 2007).

Nevertheless, despite this improvement, the best available instruments remain only moderately accurate and are recommended to be considered "works in progress" (de Vogel, de Ruiter, van Beek, & Mead, 2004; Webster, Douglas, Eaves, & Hart, 1997). Indeed, there exist a number of factors that currently limit the precision with which clinicians can make predictions of risk. In what follows some recent research findings in the area of sex offender risk assessment and recidivism will be reviewed. Taken together, these findings suggest that the path to assessing risk for future sexual violence is far more hazardous than is commonly appreciated by mental health and legal professionals.

Base Rates[2] for Sexual Recidivism

The publicity surrounding tragic high-profile sexual crimes has led to the widespread belief amongst politicians and the public alike that most sex offenders sexually re-offend. However, a substantial body of research indicates that this prevailing perception is inaccurate (Matravers, 2003; Mercado & Ogloff, 2007). A number of large scale investigations have provided strong findings that suggest a low base rate for sexual re-offending. For example, Hanson and Morton-Bourgon (Hanson & Morton-Bourgon, 2005) conducted a meta-analysis of 82 recidivism studies on 29,450 sex offenders. The authors found that after a 5-6 year follow-up the rate of sexual recidivism was 13.7% (Hanson & Morton-Bourgon, 2005). A previous meta-analysis by Hanson and Bussière (1998) established a very similar rate of 13.8%. Furthermore, in both meta-analyses, sexual offenders were significantly more likely to commit a non-sexual offence than a sexual offence, suggesting also that sexual offenders may be less specialised in their offending patterns than commonly assumed (Mercado & Ogloff, 2007; for a review of this issue see Simon, 2000).

The research finding that the base rate for sexual recidivism is relatively low has two significant implications for the assessment of risk for future sexual violence that should be heeded by mental health professionals conducting such assessments. Firstly, in accordance with probability theory, the ability to predict a future event is greatly influenced by the event's base rate (Craig, Browne, Stringer, & Beech, 2004; Ogloff & Davis, 2005; Swets, 1992). Therefore the lower the base rate of sexual re-offending in the population, the less likely it is to accurately predict which individual will sexually re-offend (Doren, 1998; Ogloff & Davis, 2005). Consequently, post-sentence orders will, unavoidably, be erroneously imposed on numerous individuals who would not have gone on to re-offend. Clinicians, when requested to assess future risk in post-sentence matters, and courts when they consider the assessment results, would do well to keep in mind that the odds of correctly identifying a recidivist are not in their favour. When undertaking such assessments mental health professionals are faced with the reasonable likelihood that a false positive error may occur.

Secondly, base rates of sexual recidivism impact upon the predictive abilities of actuarial risk assessment instruments (Szmurkler, 2001; Wollert, 2006). This point was illustrated by an evaluation of the test performance of a popular actuarial tool - the Static-99 (Hanson & Thornton, 1999) - as a function of the base rate of sexual recidivism (Wollert, 2006). For the developmental sample of the Static-99, the sexual recidivism base rate was 25%, and those offenders considered high-risk (i.e., scoring 6 or above on the Static-99), were correctly identified as recidivists 52% of the time. However, when the recidivism base rate was reduced to 12%, Wollert's (2006) analysis revealed that the percentage of accurately identified recidivists in the high-risk category fell from 52% to only 31%. This resulted in the clear majority of sexual offenders (i.e., 69%), though classified as high risk, being non-recidivists.

Wollert's (2006) research has noteworthy implications for clinicians' providing assessments of risk based on actuarial instruments. The valid use of actuarial tools is dependent upon the similarity between the offender one is assessing and the developmental sample that was used to derive the original probability estimates (Prentky, Janus, Barbaree, Schwartz, & Kafka, 2006). Therefore, dissimilarity in the base rate of sexual recidivism between the sample the offender represents, and whose risk one is determining, and the original sample used to construct the actuarial tool, may negatively impact upon the accuracy of the actuarial prediction of sexual violence risk. Following from this, it is thus important for mental health professionals to have an understanding of the base rate of recidivism known to apply to the sample from which the subject of their assessment is drawn. This data will enable the

[2] The base rate refers to the true prevalence of the defined behaviour (i.e., sexual re-offending) within a defined population (i.e., sexual offenders) (Doren, 1998).

clinician to determine the validity of applying the risk category and its associated probability estimate from the actuarial instrument to the assessed offender.

The base rate of sexual recidivism for samples of sexual offenders is a valuable area of knowledge for mental health professionals conducting assessments of risk for the courts. Armed with this understanding clinicians are better able to appreciate the statistical uncertainty associated with predicting future offending, and that the precision of actuarial tools is undermined by a low base rate of sexual recidivism. Beyond matters of recidivism base rates, however, there remain further challenges to reliably assessing future risk for sexual violence.

On the Limits of Actuarial Predictions of Risk

The advent of empirically validated actuarial tools that can reliably place sex offenders into categories with known rates of risk for sexual re-offending is a significant evolution in the field of risk assessment. Actuarial tools are now commonly used to reach opinions about sexual violence risk (Doren, 2002; Hart et al., 2003), and have generally been associated with the strongest evidence for predictive accuracy (Dvoskin & Heilbrun, 2001). Despite all of this, while actuarial measures have acceptable degrees of predictive validity, they are far form perfect (for a meta-analytic review see Hanson & Morton-Bourgon, 2004, 2007). Indeed, interpreting the findings of actuarial instruments such as the Static-99 (Hanson & Thornton, 1999) and New Zealand's own Automated Sexual Recidivism Scale (ASRS) (Skelton, Riley, Wales, & Vess, 2006), is far less straightforward than assumed and thus the certainty with which clinicians can form decisions regarding the individual risk posed by an offender is curtailed.

One significant problem with the use of actuarial tools, as identified by Berlin, Galbreath, Geary, and McGlone (2003), is that the category of risk and associated re-offence rates that the assessed offender is judged to reflect, are derived from group data. This means that the estimates of re-offence risk apply not to the individual, but to the group in which they have been placed by virtue of their score. For example, an offender scoring 5 or above on New Zealand's ASRS reflects the fact that this offender shares specific characteristics with the 'high-risk' offenders who also scored 5 or above during the validation of this instrument. Moreover, this high-risk group was found to have a sexual recidivism rate of 50% after 10 years (Skelton et al., 2006). However, the instrument is unable to inform the risk assessor of which group the assessed offender actually falls (i.e., subsequent recidivist or subsequent nonrecidivist). That is, the score of 5 cannot tell us whether this specific offender belongs to the 50% of offenders who go on to commit a sexual offence, or to the 50% who do not (Wood & Ogloff, 2006). Therefore, despite being classified as a 'high-risk' sexual offender, an individual's score on an actuarial tool fails to be a reliable guide to that individual's actual risk to sexually re-offend.

Irrespective of this limitation, based on the ASRS, those offenders who fall in the high-risk category still remain two times more likely to re-offend than other sex offenders; thus the instrument can reliably identify those offenders who represent an increased re-offence risk relative to other sex offenders.

This uncertainty in moving from group to individual risk suggests that actuarial instruments such as the Static-99 and ASRS may be more appropriately used only to identify the risk category into which the offender falls on account of their risk score. However, there is some doubt over the accuracy with which actuarial instruments can perform even this task (Mullen, 2007). In an analysis of the precision of group estimates of actuarial instruments, Hart, Michie, and Cook (2007) calculated the 95% confidence limits of the group re-offence estimates for the Static-99. The analysis revealed an overlap among the risk categories such that the Static-99 "yielded only two distinct group estimates of risk: low (categories 0-3) and high (categories 4-6+)" (Hart et al., 2007, p. s62). Based on this finding it is arguably difficult to state with a high degree of certainty that one individual's risk is even higher than that of other individuals, based on their actuarially derived group score. While overlap of confidence limits is common to other areas of measurement, given the potential restrictions of liberty that may result from a post-sentence hearing, this overlap is less palatable.

Hart et al.'s (2007) findings highlight the importance of validating actuarial tools on large samples of sexual offenders. Confidence limits are inherently tied to sample size, such that an increase in the sample size will reduce and refine confidence limits. In turn, this will allow for actuarial measures and their associated risk categories to be applied with increased validity and greater confidence. To this end, the need to collect and compile recidivism data and risk scores across jurisdictions cannot be emphasised enough.

Altogether though, this research on the accuracy, or lack thereof, of actuarial risk assessment tools, supports the drawing of two distinct yet related conclusions: (1) actuarial instruments are significantly limited in their ability to identify individual-level risk for future sexual violence, and thus (2) mental health professionals should be extremely cautious when using these tools to draw inferences about an individual's risk for future sexual offending. In addition to concerns over the validity of actuarial tools to determine an individual's risk, the task of risk assessment is further complicated by the effects of ageing on recidivism risk potential.

On the Effect of Age on Risk Prediction

It is well known that in the general criminal population, rates of crime decrease with age (Hirschi & Gottfredson, 1983). In recent years, this age-crime pattern has been exclusively tested with respect to sexual offenders (see Barbaree, Blanchard, & Langton, 2003; Barbaree, Langton, & Blanchard, 2007; Hanson, 2005; Harris & Hanson, 2004). This research has found that not only does group-based sexual recidivism risk decrease with age, but that current actuarial tools may be of limited value for identifying older offenders who are likely to sexually re-offend (Saari & Saari, 2002).

For instance, with a combined sample of 4,673 sexual offenders, Hanson (2002) found that the rate of sexual recidivism declined steadily with age, even when the sample was differentiated along dimensions of offence type (i.e., rapists, incest offenders, and extrafamilial offenders). In a more recent study, Harris and Hanson (2004) compared the rate of sexual recidivism between two groups of sexual offenders: those aged under 50 years, and those aged over 50 years, upon release. Based on another large combined sample of 4,270 sexual offenders, the authors found that age had a substantial association with recidivism, with offenders older than age 50 at release re-offending at *half the rate* of those offenders younger than age 50 at release (Harris & Hanson, 2004).

Critically, this age-related reduction in risk to sexually re-offend amongst sex offenders occurs irrespective of their level of risk (Barbaree et al., 2003; Barbaree et al., 2007). For instance, in a later study, Hanson (2005) investigated the extent to which the Static-99 accounts for the decline in recidivism risk associated with increasing age. The study found that older offenders demonstrated lower rates of sexual recidivism than expected given their Static-99 risk categories (Hanson, 2005). That is, the age related decrease in risk was the same across risk levels. More recently, Barbaree, Langton, and Blanchard (2007) explored the relationship between actuarial prediction and age-related reductions in recidivism of sex offender and found that an offender's advancing age has a far more significant relationship to recidivism than currently captured by actuarial measures. This research indicates that actuarial instruments insufficiently capture the decline in recidivism risk associated with advanced age.

The limits of actuarial tools for predicting sexual recidivism among older offenders is highly relevant for mental health professionals conducting assessments of risk in post-sentence hearings. Many offenders being assessed under post-sentence legislation are older than 45 years; with a significant minority much older. Currently, actuarial measures will overestimate their re-offence risk. Therefore, it is incumbent upon risk assessors to integrate this information into their assessment of risk and acknowledge that the validity of actuarial tools is weakened when applied to older sexual offenders. A final set of issues that complicate the risk assessment task and are relevant considerations in any clinical assessment of risk, are set out below.

Additional Considerations for an Assessment of Sexual Violence Risk

When conducting assessments of risk for future sexual violence, other considerations bear upon the validity of the assessment. These considerations include the need to validate risk measures for the population of sex offenders upon which they are used, and the difficulty in evaluating change to an offender's risk on account of their behaviour in prison and treatment participation. These issues will be briefly considered in turn.

There are limited local data validating sexual offender risk instruments. Given that actuarial tools provide specific probability estimates for the population of offenders upon which the measures were validated, there is a need to ascertain the validity of those estimates for the samples upon which the measures are used (Ogloff & Davis, 2005). Recently, New Zealand's Department of Corrections published data on the validity of their newly developed Automated Sexual Recidivism Scale (Skelton et al., 2006). Based on a large sample of 1,133 male sexual offenders the instrument demonstrated predictive validity comparable to the Static-99 (i.e., AUC = .70 - .78). Given these findings, the ASRS can be applied to New Zealand's sex offenders with some confidence.

In Australia however, there has only been one published study validating actuarial measures for use with Australian sexual offenders (see Allan, Dawson, & Allan, 2006); and their findings provide equivocal support for their validity. While the Static-99 demonstrated moderate accuracy in classifying recidivists (AUC = .78), conversely, the RRASOR (Hanson, 1997) demonstrated predictive accuracy worse than chance (AUC = .46) when predicting violent sexual offending (Allan et al., 2006). The authors recommend that due to the very small sample size involved in the study that these results should be viewed with caution. There is a clear need to validate actuarial measures on very large samples of Australian sex offenders. While it is likely that the validity of the measures will ultimately be replicated in Australia, following their successful validation in Canada, the United States, the United Kingdom, and European countries, empirical evidence is required to justify the confidence with which such instruments are used in post-sentence proceedings.

The subject of an assessment in post-sentence proceedings has commonly spent many years in a custodial environment. Questions as to the effect of detention on the offender's recidivism potential are

often considered as part of a comprehensive assessment of risk. Recently, a method for evaluating risk in an institution has been devised. Termed 'offence paralleling behaviour' (OPB; Jones, 1997, 2000), OPB is defined as "any form of offence related behavioural (or fantasized behaviour) pattern that emerges at any point before or after an offence" (Jones, 2004, p. 38). According to Jones (2004) such behaviours do not have to result in an offence to be considered OPB, rather the behaviour only needs to bear a significant resemblance to the behaviours that may lead up to an offence.

Critically, for sexual offenders, it is difficult to evaluate whether their recidivism risk has changed throughout the period of their detention, because of the lack of opportunity to observe potential offence paralleling behaviours. For example, a sex offender may continue to indulge in his deviant sexual fantasies, and as unobservable phenomena, this offence paralleling behaviour can occur without detection. In another example, a child-sex offender's modus operandi may have included employing a range of strategies to gain the trust of children, their co-operation in sexual activity and to maintain their silence regarding the abuse. However, the absence of children in their custodial environment means that child-sex offenders have no opportunity to engage in the types of offence paralleling behaviours that they enacted as part of their offence cycle.

Consequently, clinicians' opinions as to the relationship between the offender's institutional behaviour and their risk potential are necessarily limited. Further, any assumptions that appropriate prison behaviour may translate into pro-social behaviour in the community are misguided.

Specifying the effect of treatment on recidivism risk will also be considered in a comprehensive assessment under post-sentence legislation. However, quantifying the effect of treatment on risk remains a speculative endeavour. Although there is considerable data about the relevant factors related to recidivism risk, such factors are typically static (e.g., sexual offence history) or highly enduring (e.g., personality disorder) in nature (Hanson, 2000). Given that the factors most reliably related to future risk are generally unchanging, risk assessors are far less capable of determining when an offender's risk level has actually changed (Mercado & Ogloff, 2007). Furthermore, the efficacy of sex offender treatment is yet to find robust empirical support (Hanson et al., 2002; Rice & Harris, 2003). Indeed, Hanson et al's (2002) meta-analysis of sex offender treatment studies found that while available evidence suggests that current treatments reduce recidivism, they warn that firm conclusions cannot be made until additional and improved research is conducted. Given this, clinicians must be cautious and provisional when considering whether an offender's participation in treatment has impacted on the level of risk they pose for future offending.

It is important to acknowledge, though, that while the composite reviews show little overall treatment effect, some individual treatment programs have produced very good treatment results. In a recent study, for example, Olver, Wong, and Nicholaichuk (2008) assessed the treatment effect of a long-standing and well-validated treatment program for sexual offenders. The "Clearwater Program" is a 48 bed treatment unit in a secure prison hospital in Saskatchewan, Canada delivered to moderate- to high-risk sexual offenders. The program is comprehensive, lasts for 6-9 months, and has approximately 20 hours (group and individual) of clinical contact per week. It uses a cognitive-behavioural approach, grounded in social learning theory and the "what works" principles (Andrews & Bonta, 2006). In a methodologically sophisticated study of almost 500 treated sex offenders, matched with untreated sex offenders, the results showed significant differences in re-offence rates over time after release (e.g., 13.6% untreated vs. 5.9% treated at 2 years to 32.3% untreated vs. 21.8% treated after 10 years). These results are quite dramatic with fewer treated prisoners re-offending as compared to the control group. However, not all treatment programs are equal in reducing offending risk, and even those that are effective may produce relatively modest results.

Under post-sentence legislation, mental health professionals are required to provide a comprehensive assessment of risk for future sexual offending. Furthermore, the courts will have questions relating to ways in which the offender's risk may have altered throughout the course of their detention. Unfortunately, the limits of our science are such that clear and unequivocal answers are currently unavailable. Mental health professionals must be confident to accurately represent the current state of knowledge in the field of risk assessment. Sometimes this will mean that the most appropriate answer is "the state of the research literature is such that we do not know" or, more simply, "I don't know."

Assessing Risk for Sexual Violence: Caution and Humility Must be the Theme

As noted previously, mental health professionals play a significant role in post-sentence hearings, by providing the court with assessments of risk for future sexual violence upon which the court's decision is reliant (Scott, 2008). However, while the available research indicates that clinicians are now armed with knowledge and tools to determine risk with some accuracy, the technology is far form perfect.

We have thus far reviewed a number of issues that limit the reliability and validity of clinical assessments of risk. The discussion revealed that the path to a

precise assessment of risk was muddied by: (1) the low base rate of sexual recidivism, (2) the margins of error associated with actuarial assessments of risk at both the individual and group levels, (3) the inability of actuarial tools to adequately account for the effect of advancing age on recidivism risk, (4) the need to make available published normative data for the use of actuarial measures in Australia, and (5) the equivocal effects that detention and treatment have on recidivism potential. Taken together, these clinical limitations and other issues should highlight to mental health professionals that the assessment of risk for future sexual violence is imbued with uncertainty. As a result, the efficacy of the clinician's input into any post-sentence hearing is necessarily limited and caution must be exercised by mental health professionals undertaking risk assessments under post-sentence legislation.

Despite the difficulty associated with predicting future behaviour, clinicians do have a useful role to play in post-sentence proceedings. In assessing risk it is recommended that mental health professionals develop their clinical decisions based on the best available methodology. As the research currently stands, empirically validated risk assessment instruments, such as actuarial and structured professional judgement measures, represent the most valid and reliable approach to assessing risk for sexual violence. Further, these tools also bring a transparency to the process of assessing risk and thus allow the courts to evaluate the strengths and weaknesses of the risk assessment procedure (Mercado & Ogloff, 2007; Ogloff & Davis, 2005). However, in preparing reports and presenting them to the courts, clinicians also need to keep in mind the limits of the science they utilise.

In summary, the assessment of risk for future sexual violence is a complex task requiring a sophisticated and judicious approach. While ultimately it is the role of the courts to decide whether an offender is suitable for post-sentence management, clinicians do have a useful role to play in these proceedings. Still, caution and humility must be the theme in providing expert opinion in this controversial area.

Lastly, statutes that limit expert opinion on risk for future sexual violence to psychiatrists are misguided. There is no evidence that suggests that psychiatrists can more accurately predict risk for sexual offending than psychologists. In fact, psychologists conduct the majority of research published in the risk prediction field, as well as develop many of the risk assessment measures currently available (Mercado & Ogloff, 2007). Instead of limiting post-sentence assessments to psychiatrists, it would seem prudent to include those psychologists appropriately trained and qualified in the practice of forensic mental health and the assessment of risk for future sexual violence. In the final section, an alternative model to managing sex offending risk is outlined.

Future Directions: Towards an Alternative Model to Manage Sex Crime Risk

Post-sentence legislation has been criticised on empirical, legal, human rights, resource, and therapeutic grounds (Birgden, 2007; Ruschena, 2003; Sullivan et al., 2005; Wood & Ogloff, 2006). For instance, there is the concern that these laws will be unable to meet their objectives because their success is reliant upon the accuracy of risk assessment technology which remains limited. The laws have also been criticised for violating traditional legal principles such as proportionality and finality of sentencing and lacking compatibility with local and international human rights declarations (McSherry et al., 2006). These laws are inordinately expensive to administer, given the costs of expert assessors, court time, and the cost of housing and supervising those sexual offenders captured by the legislation. As such, questions have been raised regarding the soundness of allocating enormous resources toward a small group of high-risk sex offenders when most sex offences are committed by those who do not have previous sexual offence convictions (Walker, 1996), and research has long indicated that the majority of sexual offences are perpetrated by family members and acquaintances, the majority of whom are not reported to the police (Australian Bureau of Statistics, 2005). While huge resources are allocated to try to accurately identify which particular offender is so risky to deserve post-sentence detention or supervision, relatively few resources have been allocated to comprehensively assessing and treating broad numbers of sexual offenders to reduce the overall level of re-offending. Fewer resources still are dedicated to bridging treatment/relapse prevention programs and community follow-up.

In short, these criticisms make room for the need to develop other ways to deal with the risks sex offenders pose to re-offend. While a full articulation of an alternative model to managing sexual offending risk is beyond the scope of this article, some suggestions for how sexual offending risk could be more soundly managed are set out below.

Post-sentence legislation represents a reactive tinkering at the margins of the criminal justice system and its management of sex offenders. Instead, the authors recommend an overhaul to the ways in which sexual offenders are assessed, sentenced, treated, supervised and managed in the community. Instead of allocating enormous resources toward the difficult, and error-prone, task of identifying the few sex offenders who pose the greatest danger, the authors recommend

the adoption of a public health approach to managing sex offence risk.

The public health approach is characterised by a focus on systematically reducing risk across the entire sex offending population, as well as efforts to prevent sexual offending initially. To this end, we would suggest that increased independent expert evidence is required at the time of sentencing. All sexual offenders should be assessed by a qualified psychologist or psychiatrist with relevant expertise prior to sentencing. This role would involve a comprehensive assessment of sexual deviance, the motivation for offending sexually, and risk for future sexual offending, followed by the development of a risk management plan for the offender's rehabilitation. This would assist the court in taking into account the treatment needs, prognosis, and risk of re-offending at the time of sentencing. After sentencing, and in accordance with well established principles of offender rehabilitation (Andrews & Bonta, 2006), sex offenders would receive treatment and management that is commensurate with the identified level of risk and need. Careful attention needs to be paid to offender's responsivity to treatment (including matters such as motivation, insight and characteristics such as intellectual impairment or psychopathy). This inclusive approach is aimed at reducing risk across the population of sex offenders. Its successful implementation would require both a shifting of resources to the front-end processes involved in sex offenders' first point of contact with the criminal justice system, as well as properly funded sex offender treatment and management programs in custodial and community settings.

We will provide two examples here to help illustrate the points being made. In the first example, we shall consider the practical effects of high-quality treatment programs on recidivism rates. In the second example, we shall demonstrate how difficult it is to accurately differentiate which offenders will or will not re-offend, and the concomitant errors that result. To begin, let us take for example the Clearwater treatment program results discussed above (Olver et al., 2008). Using those results, accredited treatment programs for sexual offending would produce re-offence reductions ranging from 57% in the first five years after release to 33% after 10 years. In concrete terms, if 500 offenders are treated, as they were in the Clearwater program, 30 would re-offend in the first 5 years and this number would rise to 109 over 10 years. However, if 500 offenders were not treated, 62 would re-offend after 5 years and 162 over 10 years. Thus, 53 fewer offenders would re-offend sexually. Even if each one who re-offended had only one victim, 53 fewer people would be victimized. Thus resources provided to treat offenders in high-quality programs can reduce re-offending. These results might have even been strengthened with a high-quality continuity of care and community-based bridging programs and further treatment.

Let us now turn to a consideration of the practical difficulty of trying to accurately identify which offenders will or will not re-offend sexually. For this example, we shall use recidivism rates from the Static 99 (Hanson & Thornton, 1999) and assume we had a sample of 500 offenders. Based on the outcome data from the Static-99 validation sample, for every 500 offenders assessed 126 would re-offend and 374 would not re-offend. Considering the levels of risk of the offenders, though, 310 will be "low risk" or "medium-low risk" and 195 will be "medium-high risk" or "high risk." Of the 310 identified in the low and medium low risk categories, 45 (14.5%) would go on to re-offend. By contrast, 124 of the 195 (63.6%) offenders found to be at medium high or high risk, would *not* re-offend. Making decisions on risk alone, therefore, would be fraught with difficulty. Even if the example is limited to the "high risk" group (i.e., with scores of six and greater), of the 60 offenders who would be assessed as being at high-risk, half of those will re-offend and half will not (31/60). Thus, if post-sentence detention was limited to those who fall into the high risk category, 29/60 (48%) of the group would be detained or subjected to post-sentence supervision when, in fact, they would not have re-offended. Taken together, using a sample of 500 offenders, 45 of those designated low or medium low risk would go on to re-offend while 28 people designated high risk would not re-offend. This example shows clearly how fraught with difficulty decision making is when based on risk assessment.

An alternative approach to managing sex crime risk also needs to increase the likelihood of protecting people in the community by ensuring that legislation motivates the offender to meaningfully participate in treatment. Unfortunately, under post-sentence laws, information obtained in treatment is now being used to identify high-risk offenders who may be eligible for continued detention or extended supervision (Sentencing Advisory Council, 2006). In point of fact, sex offenders might reveal their sexually deviant fantasies and desires to clinicians who treat them while they would not reveal the information to prison officers. Thus, it is partly from the treatment notes and reports that information about a particular offender's sexual deviations are identified. Under these circumstances, sexual offenders will be discouraged from candidly disclosing deviant thoughts and impulses (Sullivan et al., 2005), and this will likely be an impediment to effective offender rehabilitation. This is an unsound imposition upon the therapeutic process. Rather, sex offenders require incentive to address their sexual deviancy, anti-social attitudes, and cognitive distortions. Adhering to a therapeutic jurisprudential

approach to managing sex offenders will provide a better balance between individual autonomy and community protection (Birgden, 2007).

Lastly, the level of legal practice in this area must also be raised. Given that it is common for offenders to consent to post-sentence orders (at least initially in Victoria when they believed they would be in the community), there is little testing and scrutiny of the expert reports and evidence presented. The exception has been in Western Australia, which has seen more keenly contested hearings. Overall, though, increased legal attention paid to the assumptions underpinning clinical assessments of risk will contribute to the development of higher standards of practice in the mental health professions and provision of expert opinion.

Conclusions

The community has a heightened concern regarding the risks sex offenders pose to sexually re-offend. Within this culture of fear, perhaps it is understandable that New Zealand and a number of Australian governments have enacted legislation designed to protect the community from these risks. These laws require mental health professionals to present to the courts their assessment of the risk that offenders pose to sexually re-offend. As the article has articulated, there remain a number of clinical issues that limit the precision with which assessments can be made. In preparing reports and presenting them to the courts, mental health professionals must be aware of the limits of risk prediction technology and confident to point out the boundaries to the science upon which their expert opinion rests. As discussed, consideration needs to be given to alternative assessment and treatment models to provide further protection to the public from the broad range of sexual offenders, not just those identified in the post-sentence procedures as being a continued risk to the community.

References

Allan, A., Dawson, D., & Allan, M. M. (2006). Prediction of the risk of male sexual reoffending in Australia. *Australian Psychologist, 41*, 60-68.

Andrews, D. A., & Bonta, J. (2006). *The psychology of criminal conduct* (4th ed.). Newark, NJ: Anderson Publishing.

Australian Bureau of Statistics. (2005). *Personal safety survey*. Catalogue 4906.0.

Barbaree, H. E., Blanchard, R., & Langton, C. (2003). The development of sexual aggression through the lifespan. In R. A. Prentky, E. Janus & M. Seto (Eds.), *Annals of the New York Academy of Sciences: Vol. 989. Sexually coervice behaviour* (pp. 59-71). New York: New York Academy of Sciences.

Barbaree, H. E., Langton, C. M., & Blanchard, R. (2007). Predicting recidivism in sex offenders using the VRAG and SORAG: The contribution of age-at-release. *International Journal of Forensic Mental Health, 6*, 29-46.

Berlin, F. S., Galbreath, N. W., Geary, B., & McGlone, G. (2003). The use of actuarials at civil commitment hearings to predict the likelihood of future sexual violence. *Sexual Abuse: A Journal of Research and Treatment, 15*, 377-382.

Birgden, A. (2007). Serious Sex Offenders Monitoring Act 2005 (Vic): A therapeutic jurisprudence analysis. *Psychiatry, Psychology and Law, 14*, 78-94.

Craig, L. A., Browne, K. D., Stringer, I., & Beech, A. R. (2004). Limitations in actuarial risk assessment of sex offenders: A methodological note. *British Journal of Forensic Practice, 6*, 16-32.

de Vogel, V., de Ruiter, C., van Beek, D., & Mead, G. (2004). Predictive validity of the SVR-20 and Static-99 in a Dutch sample of treated sex offenders. *Law and Human Behavior, 28*, 235-251.

Doren, D. M. (1998). Recidivism base rates, predictions of sex offender recidivism, and the "Sexual Predator" commitment laws. *Behavioral Sciences & the Law. Vol, 16*, 97-114.

Doren, D. M. (2002). *Evaluating sex offenders: A manual for civil commitments and beyond*. Thousand Oaks: Sage.

Dvoskin, J. A., & Heilbrun, K. (2001). Risk assessment and release decision-making: Toward resolving the great debate. *Journal of the American Academy of Psychiatry and the Law, 29*, 6-10.

Ewing, C. (1991). Preventive detention and execution: The constitutionality of punishing future crimes. *Law and Human Behavior, 15*, 139–163.

Hanson, R. K. (1997). *The development of a brief actuarial risk scale for sexual offense recidivism. (User Report 97-04).* Ottawa: Department of the Solicitor General of Canada.

Hanson, R. K. (2000). Where should we intervene? Dynamic predictors of sex offence recidivism. *Criminal Justice and Behaviour, 27*, 6-35.

Hanson, R. K. (2002). Recidivism and age. *Journal of Interpersonal Violence, 17*, 1046-1062.

Hanson, R. K. (2005). *The validity of Static-99 with older sexual offenders*. Ottawa: Public Safety and Emergency Preparedness Canada.

Hanson, R. K., & Bussière, M. T. (1998). Predicting relapse: A meta-analysis of sexual offender recidivism studies. *Journal of Consulting and Clinical Psychology, 66*, 348-362.

Hanson, R. K., Gordon, A., Harris, A. J. R., Marques, J. K., Murphy, W., Quinsey, V. L., et al. (2002). First Report of the Collaborative Outcome Data Project on the Effectiveness of Psychological Treatment for Sex Offenders *Sexual Abuse: A Journal of Research and Treatment, 14*, 169-194.

Hanson, R. K., & Morton-Bourgon, K. E. (2004). *Predictors of sexual recidivism: An updated meta-analysis. (User Report 2004-02).* Ottawa: Public Safety and Emergency Preparedness Canada, Retrieved September 24, 2008 from http://ww2.pssp.gc.ca/publications/corrections/pdf/200402_e.pdf.

Hanson, R. K., & Morton-Bourgon, K. E. (2005). The characteristics of persistent sexual offenders: A meta-analysis of recidivism studies. *Journal of Consulting and Clinical Psychology, 73*, 1154-1163.

Hanson, R. K., & Morton-Bourgon, K. E. (2007). *The accuracy of recidivism risk assessments for sexual offenders: A meta-analysis. (User Report 2007-01).* Ottawa: Public Safety and Emergency Preparedness Canada.

Hanson, R. K., & Thornton, D. (1999). *Static-99: Improving actuarial risk assessments for sex offenders. (User Report 1999-02).* Ottawa: Department of the Solicitor General of Canada.

Harris, A. J. R., & Hanson, R. K. (2004). *Sex offender recidivism: A simple question* Ottawa: Public Safety and Emergency Preparedness Canada, Retrieved July 15, 2008 from http://ww2.ps-sp.gc.ca/publications/corrections/pdf/200403-2_e.pdf

Hart, S. D., Kropp, P. R., & Laws, D. R. (2003). *The risk for sexual violence protocol (RSVP): Structured professional guidelines for assessing risk of sexual violence*. British Columbia, Vancouver: Mental Health, Law, and Policy Institute, Simon Fraser University and British Columbia Institute on Family Violence.

Hart, S. D., Michie, C., & Cooke, D. J. (2007). Precision of actuarial risk assessment instruments. *British Journal of Psychiatry, 199*, s60-s65.

Hirschi, T., & Gottfredson, M. (1983). Age and the explanation of crime. *American Journal of Sociology, 89*, 522-584.

Jones, L. F. (1997). Developing models for managing treatment integrity and efficacy in a prison based TC: The Max Glatt Centre. In E. Cullen, L. Jones & R. Woodward (Eds.), *Therapuetic Communities for Offenders*. Chichester: Wiley.

Jones, L. F. (2000). Identifying and working with clinically relevant offence paralleling behaviour. Paper presented at Division of Clinical Psychology, Forensic Special Interest Group, Nottinghamshire.

Jones, L. F. (2004). Offence Paralleling Behaviour (OPB) as a framework for assessment and interventions with offenders. In A. Needs & G. Towl (Eds.), *Applying Psychology to Forensic Practice*. Oxford: Blackwell/British Psychological Society.

La Fond, J. Q. (2005). *Preventing sexual violence: How society should cope with sex offenders*. Washington, DC: American Psychological Association.

Matravers, A. (Ed.). (2003). *Sex offenders in the community : Managing and reducing the risks*. Cullomptom: Willan.

McCarthy, J. (2001). Risk assessment of sex offenders. *Psychiatry, Psychology and Law, 8*, 56 - 64.

McSherry, B., Keyzer, P., & Freiberg, A. (2006). *Preventive detention for 'dangerous' offenders in australia: A critical analysis and proposals for policy development*: Report to the Criminology Research Council, Retrieved 12 June, 2008, from http://www.criminologyresearchcouncil.gov.au/reports/200405-03.pdf.

Mercado, C. C., & Ogloff, J. R. (2007). Risk and the preventive detention of sex offenders in Australia and the United States. *International Journal of Law and Psychiatry, 30*, 49-59.

Monahan, J. (1981). *Predicting violent behavior: An assessment of clinical techniques*. Beverly Hills, California: Sage Publications.

Mullen, P. E. (2007). Dangerous and severe personality disorder and in need of treatment. *British Journal of Psychiatry, 190*, s3-s7.

Ogloff, J. R. P., & Davis, M. R. (2005). Assessing risk for violence in the Australian context. In D. Chappell & P. Wilson (Eds.), *Issues in Australian Crime and Criminal Justice* (pp. 301-338). Chatswood, NSW: LexisNexis, Butterworths.

Olver, M. E., Wong, S. C. P., & Nicholaichuk, T. P. (2008). Outcome evaluation of a high-intensity inpatient sex offender treatment program. *Journal of Interpersonal Violence*.

Prentky, R. A., Janus, E. S., Barbaree, H., Schwartz, B. K., & Kafka, M. P. (2006). Sexually violent predators in the courtroom: Science on trial. *Psychiatry, Psychology and Law, 12*, 357-393.

Rice, M. E., & Harris, G. T. (2003). The size and sign of treatment effects in sex offender therapy. *Annals of the New York Academy of Sciences, 989*, 428-440.

Ruschena, D. (2003). Determining dangerousness: Whatever happened to the rules of justice? *Psychiatry, Psychology and Law, 10*, 122-140.

Saari, R. J., & Saari, L. (2002). Actuarial risk assessment with elderly sex offenders: Should it be abandoned? *Sex Offender Law Report, 3*, 73-76.

Scott, R. (2008). Case commentary: Risk assessment and sentencing of serious sex offenders. *Psychiatry, Psychology and Law, 15*, 188-201.

Sentencing Advisory Council. (2006). *High-risk offenders: Continued detention and supervision options*. Melbourne, Victoria: Sentencing Advisory Council.

Simon, L. M. J. (2000). An examination of the assumptions of specialization, mental disorder, and dangerousness in sex offenders. *Behavioral Sciences and the Law, 18*, 275-308.

Skelton, A., Riley, D., Wales, D., & Vess, J. (2006). Assessing risk for sexual offenders in New Zealand: Development and validation of a computer-scored risk measure. *Journal of Sexual Aggression, 12*, 277-286.

Smallbone, S., & Ransley, J. (2005). Legal and psychological controversies in the preventive incapacitation of sexual offenders. *University of NSW Law Journal, 28*, 299-305.

Sullivan, D. H., Mullen, P. E., & Pathé, M. T. (2005). Legislation in Victoria on sexual offenders: issues for health professionals. *The Medical Journal of Australia, 183*, 318-320.

Swets, J. A. (1992). The science of choosing the right decision threshold in high-stakes diagnostics. *American Psychologist, 47*, 522-532.

Szmurkler, G. (2001). Violence risk prediction in practice. *British Journal of Psychiatry, 178*, 85-86.

Walker, N. (Ed.). (1996). *Dangerous people*. London: Blackstone Press.

Webster, C. D., Douglas, K. S., Eaves, D., & Hart, S. D. (1997). *HCR-20. Assessing the risk of violence. Version 2*. Burbanby, British Columbia, Canada: Simon Fraser University and Forensic Psychiatric Services Commission of British Columbia.

Wollert, R. (2006). Low base rates limit expert certainty when current actuarials are used to identify sexually violent predators: An application of Baye's theorem. *Psychology, Public Policy and Law, 12*, 56-85.

Wood, M., & Ogloff, J. R. (2006). Victoria's Serious Sex Offenders Monitoring Act 2005: Implications for the accuracy of sex offender risk assessment. *Psychiatry, Psychology and Law, 13*, 182-198.

Sexual Abuse in Australia and New Zealand, January 2009; 1(2): 70-78

Extended Supervision or Civil Commitment for Managing the Risk of Sexual Offenders: Public Safety and Individual Rights

James Vess
Owenia Victoria University of Wellington

Abstract

Since the early 1990's, there has been a proliferation of legislative initiatives in North America, the United Kingdom, and Australasia that are intended to improve public protection from high risk sexual offenders. These laws include extended supervision of sexual offenders once released from prison and indefinite involuntary civil commitment to secure treatment facilities following the expiration of a prison sentence. The enactment of these laws has sparked intense debate and numerous legal challenges on a variety of issues, including the need to strike a proper balance between public safety and the rights of individual offenders. Recent challenges to Extended Supervision Orders in New Zealand have included the assertion that this approach is inconsistent with the Bill of Rights Act. This article compares the use of Extended Supervision Orders in New Zealand to the use of civil commitment of Sexually Violent Predators in the United States, and particularly in California, which currently confines the largest number of offenders under this type of commitment. It is argued that Extended Supervision is more flexible, less intrusive, less punitive, and less costly than civil commitment. The degree to which it is effective in improving public safety remains an empirical question.

Introduction

The purpose of this article is to provide a comparative perspective between civil commitment initiatives in the United States and Extended Supervision Orders in New Zealand, where the question has recently been raised as to whether this legislation is inconsistent with the New Zealand Bill of Rights Act. At issue are several important questions involving public protection and individual rights. These include: Do the measures taken (e.g. extended supervision or involuntary civil commitment) serve a purpose sufficiently important to justify curtailment of freedom? Are the measures rationally connected with this purpose? Do the measures taken impair rights or freedom no more than is reasonably necessary for the sufficient achievement of this purpose? Are the limitations imposed in due proportion to the importance of the objective?

In order to provide a broadened perspective on these issues, information is presented regarding the nature of the Extended Supervision regime in New Zealand as it compares to civil commitment and supervision schemes in the United States, and particularly in California, where the largest number of sexual offenders are currently confined as Sexually Violent Predators.

A Brief History of Sexual Offender Laws in The United States

The use of indefinite civil commitment of sexual offenders in the United States began during the 1930's with the emergence of various Sexual Psychopath statutes. These laws typically mandated that individuals convicted of sexual offences who were found to be mentally disordered, to the extent that they could not control their sexual impulses, were committed for psychiatric treatment in lieu of incarceration. The goal of these laws was to protect society from future sexual offences by treating sexual offenders in order to cure the underlying mental disorder (Burdon and Gallagher, 2002). Such statutes fell out of favor during the 1970's and 1980's following criticisms they depended on diagnostic classifications which lacked scientific validity, that risk prediction methods were inaccurate, and that available treatment was ineffective (Janus, 2000). As American society shifted from an emphasis on rehabilitation to an emphasis on retribution in dealing with offenders, most of these laws were eventually repealed (American Psychiatric Association, 1999, as cited in Burdon and Gallagher 2002).

These changes in the approach taken to sexual offenders also reflect different prevailing models of society's statutory responses to dangerousness. Petrunik (2003) distinguishes between three models in the United States over time: the forensic-clinical, justice, and community protection models. The forensic-clinical model of dangerousness evolved in the early 1900's in reaction to classical liberal criminology, which had maintained that offenders should be held accountable through due process and penalties proportionate to the crime. The forensic-criminal model moved away from this position to advocate indeterminate confinement, so that there was adequate time for treating a disordered offender's condition, thereby reducing the risk sufficiently to permit release. This approach emphasized diagnosis of the underlying

Correspondence: James Vess, School of Psychology, Victoria University of Wellington, PO Box 600, Wellington New Zealand. Email: jim.vess@vuw.ac.nz

ISSN 0833-8488

mental disorder thought to cause sexual offending, treatment of that disorder, and prediction of risk.

The justice model emerged in the 1970's and re-emphasized determinate sentences in proportion to the seriousness of the offence. Because of increased attention to due process in the criminal justice system and broader concerns about the civil rights of the mentally ill, lengthy involuntary civil commitments became more difficult to obtain (Petrunik 2003).

Most recently, the community protection model emerged during the late 1980's and early 1990's in response to perceived inadequacies in the forensic-clinical and justice models to provide for public safety. As compared to the justice model, the community protection approach attempted to strike a different balance between public safety and concerns over due process, the proportionality of punishment to the crime, and the protection of offenders' rights. In contrast to the forensic-clinical model, it is less concerned about treatment or rehabilitation of offenders intended to reduce recidivism or facilitate community reintegration. The primary goal of the community protection model is the incapacitation of sexual offenders for the sake of public safety. This model has gained support most emphatically in the United States, but also to various degrees in Canada, the United Kingdom, Australia, and New Zealand (Petrunik 2003).

The Sexually Violent Predator Commitment in California

California implemented its Sexually Violent Predator (SVP) law in 1996, and has since become the state with the largest SVP population, with over 550 offenders currently committed (California Department of Mental Health, 2007). The following description of the SVP programme is based on available documentation within the California Department of Mental Health and from the author's professional involvement as a staff member of Atascadero State Hospital, the facility until recently designated to confine and treat the SVP population in California.

In establishing the SVP Act, the California Legislature declared that there is a small group of extremely dangerous sexual predators who have diagnosable mental disorders and can be readily identified while incarcerated. It further declared that these individuals are not safe to be at large in the community and represent a danger to the health and safety of others if they are released. It is the intent of the legislation that such Sexually Violent Predators (SVP's) be confined and treated until they no longer present a threat to society. The aim of this law is to confine these individuals only as long as their disorders continue to present a danger to the health and safety of others, and not for any punitive purposes. The legislature determined that these "persons shall be treated, not as criminals, but as sick persons." (California Assembly Bill 888, 1995).

Commitment Criteria

California's Welfare & Institutions Code 6600 establishes three major criteria to define a Sexually Violent Predator:

1. The offender has been convicted of a sexually violent offense (penal code offenses are listed in statute; offenses usually include either child molestation or rape.)
2. The offender has had two or more victims as a result of these sex offense convictions.
3. The person has a diagnosed mental disorder that makes him likely to engage in future sexually violent predatory behavior (predatory is defined as a crime against a stranger, a person of casual acquaintance, or a person whose relationship is established for the purpose of sexually offending). Although major mental illnesses such as schizophrenia, bipolar disorder, or organic brain syndrome qualify as mental disorders, many SVP's suffer from some type of paraphilia.

Paraphilic disorders are diagnosable conditions characterized by deviant sexual urges, fantasies or behaviors involving humiliation of others, sexual activity with children and/or other non-consenting persons, which occur over a period of at least six months. These deviant sexual urges are sufficiently intense that they cause significant distress or impairment in important areas of functioning.

The Commitment Process

Individuals are identified for potential commitment while they are incarcerated in the California Department of Corrections. Usually this process begins six months prior to the inmate's scheduled release from prison. Cases are referred to the Sex Offender Commitment Program (SOCP) Evaluation Unit of the Department of Mental Health, where they are re-screened to ensure they meet the legal criteria established in statute. At this stage, background data regarding convictions are gathered. This information is used by clinical evaluators in making risk assessments of sex offenders, as well as by district attorneys if the case is referred for civil commitment.

Once the review of records determines that an inmate may meet the SVP criteria, the SOCP Evaluation Unit assigns two clinicians to perform an in-depth psychological evaluation. These clinicians are either licensed clinical psychologists or psychiatrists with experience in the diagnosis and treatment of mental disorders. They evaluate the offender to determine if he has a diagnosable mental disorder and if, as a result of this disorder, he presents a likelihood of committing

new sexually violent predatory acts when released. The evaluation utilizes an adjusted actuarial approach consisting of actuarial factors empirically linked to recidivism using an actuarial risk assessment tool, currently the Static 99 (Hanson & Thornton, 2000), and consideration of other risk factors associated with sexual offending. If the two evaluators agree that the inmate does not meet the requisite criteria, the SVP commitment process terminates at this point, and the person is released from prison, usually to parole. If both evaluators agree the inmate does meet the SVP criteria, his case is referred to the district attorney for SVP commitment proceedings. If there is disagreement between the two initial evaluators, the case is referred to two additional independent evaluators who must agree the inmate meets all criteria before the case can be referred to the district attorney for filing a commitment petition.

If the district attorney decides to file the petition, a probable cause hearing is held before a judge to determine if the facts of the case warrant a full commitment trial. The individual has a right to a trial by jury, although the trial may be heard before a judge if the district attorney and the subject of the petition agree. If the court or a unanimous jury determines beyond a reasonable doubt that the person is a Sexually Violent Predator, he is committed to the State Department of Mental Health for a period of two years for appropriate treatment in a secure facility.

If at any point during the period of commitment the Department of Mental Health determines the offender no longer meets the SVP criteria, it must seek review by the committing Superior Court. In addition, annual examinations are conducted on the offender's risk status and reported to the Court. At the time of the annual examination, the offender has a right to a file a writ for a hearing to determine if his condition has changed so that he is no longer a danger to the health and safety of others if discharged. If the Court rules for the committed person, he is unconditionally discharged. If, however, the Court rules against the committed person, the term of commitment will run for another two years.

At the conclusion of a two-year commitment, DMH may seek an extension by filing a new petition if evaluations conclude that the offender continues to meet all of the SVP criteria. There is no limit to the number of these two year extensions that can be imposed. After a minimum of one year of confinement, SVP's have the right to petition the Court for conditional release. If the Court determines the person would not present a danger to others while under supervision and treatment in the community, the Court will order his placement in an appropriate state-operated forensic Conditional Release Program in the community. To date, seven SVPs have been given conditional release into the community on the recommendation of the California Department of Mental Health (Parrilla, 2007).

Individual rights issues

SVP laws such as the one enacted in California present several controversial and potentially troubling aspects. Legal controversy remains over due process, double jeopardy, proportionality, and ex post facto challenges (Janus, 2000; La Fond 2000). Concern has been expressed over the precedent set by the expanded use of civil commitment as an expression of the state's police power for public protection, and the eventual effectiveness of this approach has yet to be demonstrated for significantly reducing rates of sexual offending (Burdon & Gallagher, 2002; La Fond, 2000; Levenson, 2004; Levesque, 2000). It has therefore been argued that the laws themselves raise important concerns about human rights. Even if such laws are more effective for increasing public safety than less restrictive approaches, some question whether they are morally or legally justifiable (see e.g. Doren, 2002; Nash, 2006).

Another important issue arises from the fact that, unlike determinate sentences following conviction for a criminal offense, current community protection laws provide for the imposition of legal and civil sanctions against sex offenders based on the risk of future offences. Therefore the primary concerns about human rights in relation to judicial decisions under such laws derive from the limited accuracy of current measures to predict the likelihood of sexual reoffending. There is ample opportunity for confusion on this issue in the evidence provided to the Court through risk assessment reports and expert testimony. This will make it difficult for the Court to draw clear conclusions about the accuracy of risk assessment findings, and therefore to decide the proper weight to place on the available evidence.

A detailed analysis of the predictive accuracy of current risk assessment measures is beyond the scope of this article, and has been presented elsewhere (see e.g. Campbell, 2003; Vess, in press). The focus here is how potential threats to individual rights stemming from the limited accuracy of available measures are manifested in the SVP law as implemented in California. One potential safeguard is the requirement for two independent evaluators to assess and report the individual offender's risk for sexual re-offending. However, this safeguard may not be as robust as it might seem. The service provider panel of experts who contract with the state to conduct SVP evaluations, and the psychologists working for the state psychiatric hospital who conduct the annual assessments, may all be seen as employees, and therefore agents or representatives, of the state. Although the state provides ongoing training to maintain the expertise of

these practitioners, and thereby helps to ensure adequate knowledge for the proper use of available risk assessment procedures, this expertise is largely concentrated in the cadre of state-sponsored experts. This is balanced, at least to some degree, by the large and diverse professional community available in California, a state with over 36,000,000 residents. Within this population, there are at least a small number of experts, some formerly employed and trained by the state, who are available to provide independent risk assessment expertise for the defense in SVP proceedings.

Another aspect of this large population, and the associated volume of the SVP assessments and hearings that are conducted, is that an active legal sub-community has developed with increasingly sophisticated knowledge of the strengths and limitations of current sex offender risk assessment procedures. A number of attorneys who participate in SVP commitment hearings now have a detailed understanding of this area of forensic practice, and are capable of vigorous and effective cross-examination of an expert's findings. The greater availability of forensic and legal expertise represents one of the differences between community protection efforts in California as compared to New Zealand.

Contrast with New Zealand's Extended Supervision Order

New Zealand recently introduced the Parole (Extended Supervision) Amendment Act 2004 (www.legislation.govt.nz), which allows for supervision in the community of high risk sexual offenders with child victims for up to ten years after their release from prison (Watson & Vess, 2007). Under the Parole (Extended Supervision) Amendment Act 2004 any offender considered eligible for an Extended Supervision Order is assessed by a Health Assessor, specified to be a clinician experienced in the field of forensic risk assessment. The clinician must provide the Court with a report that specifies an offender's risk of sexually reoffending against children under the age of 16 once they are released. The report must stipulate "the nature of any likely future sexual offending by the offender, including the age and sex of likely victims, the offender's ability to control his or her sexual impulses, the offender's predilection and proclivity for sexual offending, the offender's acceptance of responsibility and remorse for past offending, and any other relevant factors" (Parole (Extended Supervision) Amendment Act, 2004, section 107 (F) (2)). The writing of this report is informed by the use of an actuarial measure, the Automated Sexual Recidivism Scale (ASRS). The ASRS was developed by the New Zealand Department of Corrections and normed on large samples of sexual offenders released to the community for periods of up to 15 years. It has shown levels of predictive validity similar to other internationally recognized actuarial measures (Skelton, Wales, Riley, & Vess, 2006). The risk assessments for extended supervision also routinely include a measure of dynamic risk factors, the Sex Offender Need Assessment Rating, or SONAR (Hanson & Harris, 2000; 2004).

There are several issues inherent in the civil commitment schemes for protecting the public from SVP's in the United States which distinguish them from Extended Supervision for sexual offenders in New Zealand. One difference is that when an offender is found to present sufficiently high risk to be committed under an SVP law, he is not released to the community until such time as his risk is found to be such that he no longer poses a significant threat to the safety of the public. In contrast, a high risk offender in New Zealand is released into the community, albeit under an extended period of supervision. This contrast serves to amplify the issues inherent in the limited accuracy of our current risk assessment procedures. The consequences of a false positive finding, in which an offender is predicted to reoffend when in fact he would not, are higher under an SVP act, because the unnecessary loss of freedom is substantially greater with indefinite, involuntary commitment to a secure facility. Under either regime, the costs associated with false negatives accrue to public safety, whereby an offender is predicted not to reoffend (and available interventions are not applied), when in fact he does commit a subsequent sexual offence, and new victims are created.

Another issue is linking risk to a diagnosis of mental disorder for SVPs. Available information indicates that more than 90% of SVP commitments do not suffer from any form of psychosis (the traditional definition of mental disorder in most legal contexts), and that the most common diagnosis is one of the paraphilia disorders, reflecting an abnormality of sexual behaviour, with or without a comorbid diagnosis of some type of personality disorder. In the case of sexual offenders against children, the diagnosis is typically *paedophilia*, and with rapist it is *paraphilia not otherwise specified*, as there is no diagnosis specific to those who commit rape.

A common criticism against the use of these diagnoses is that the behavioural diagnostic criteria are seen as circular to the offending behaviour that initially lead to conviction and incarceration. Furthermore, paraphilias and personality disorders do not typically involve the loss of contact with reality that are a key feature of psychotic disorders, and have typically served as a source of diminished capacity or responsibility in criminal offending. Several experts in

the area of sexual offenders and related legislative initiatives suggest that in such cases the law is relying on the weakest aspects of psychodiagnosis (see e.g. Zander, 2005), and have made a dangerous departure from established legal precedent in matters of mental illness and judicial decision-making.

An issue related to diagnosis is the intent in most SVP laws to provide treatment to sexual offenders in order to reduce their risk of re-offending and thereby reduce the risk to public safety. While recent analyses of extensive collections of outcome data indicate that treatment reduces risk in large samples of sexual offenders, it is also clear that treatment is not effective for all offenders. This issue has been addressed in landmark cases involving SVPs in the United States such as *Kansas v. Hendricks*, in which it was found that while treatment must be provided, treatments proven to be effective need not be available, nor is it necessary that the individual offender is likely to benefit from current treatments, for the laws to stand. Thus indefinite detention of offenders as SVPs need not hold out much hope for a positive treatment response and a corresponding reduction in risk that will result in the offenders eventual release to the community. In fact, California's experience to date suggests that very few SVPs will be released from involuntary treatment as an inpatient in the state's new maximum security state psychiatric hospital any time soon.

Eric Janus, a noted legal expert in SVP cases in the United States, points out that the Court's discussion in *Kansas v. Hendricks* suggests that for civil commitments based on the state's police power to protect the public, treatment is not the constitutional justification for confinement. Rather, when the state uses civil commitment to deprive a person of liberty for the benefit of society, one source of justification is the danger posed by the person, such that commitment is limited to a narrow class of particularly dangerous individuals (Janus, 2003). In California, approximately 730 registered sexual offenders are released from state prison each month, so that between the start of the SVP Act in 1996 and July, 2003, about 65,000 sexual offenders were released. Less than 1% of these sexual offenders were civilly committed as SVPs (Vess, Murphy & Arkowitz, 2004).

Extended Supervision Orders in New Zealand appear to apply to a similarly narrow class of particularly dangerous sex offenders as those identified under the California's SVP legislation. Empirical research findings have established that when properly conducted, current methods of risk assessment with sexual offenders can reliably place individuals within groups of offenders with similar characteristics for whom there are known rates of sexual recidivism. The limitations of current risk assessment practices based on actuarial assessment using empirically validated static and dynamic risk assessment have been alluded to above; the specific properties of the measures used in New Zealand have been presented elsewhere (Skelton, Riley, Wales, & Vess, 2006; Vess, 2006; Watson & Vess, in press). The primary argument here is that a relatively small subset of high risk sexual offenders can be identified through current assessment procedures, and that these offenders can be considered by the Court for special measures such as Extended Supervision.

This approach avoids the problem inherent in less discriminating mandatory minimum sentencing laws, which are overinclusive by identifying high risk offenders based on criminal history alone rather than more specific risk assessment procedures. Such sentencing laws can also be underinclusive by failing to confine offenders who would be found to pose a high risk of sexual recidivism if proper risk assessment techniques were used (LaFond, 2005). Because Extended Supervision in New Zealand is based specifically on empirically validated risk assessment procedures, it is directly linked to the level of risk presented by the individual offender. Like the SVP commitment scheme, it is not based on overly-broad categories of offenders. It is designed so as to identify those offenders who, once released from prison, warrant longer periods of supervision in order to provide additional public safety.

In fact, New Zealand's Extended Supervision scheme applies to a more narrowly defined group of offenders, in that it is limited to sex offenders with child victims, whereas California's SVP law applies to those with either child or adult victims. Yet there may be little difference between these groups in terms of the threat for sexual reoffending. Figures reported from the meta-analysis conducted by Hanson and Bussiere (1998) indicated an average sexual recidivism rate of 18.9% for rapists and 12.7% for child molesters. In a meta-analysis with a total combined sample of 4,724 sexual offenders producing sexual recidivism estimates for periods of up to 15 years, Harris and Hanson (2004) report that the combined overall recidivism rates for all offenders (14% after 5 years, 20% after 10 years and 24% after 15 years) were similar to rapists (14%, 21% and 24%) and the combined group of child molesters (13%, 18% and 23%). Furthermore, recent research in New Zealand indicates that a significant portion of offenders who sexually reoffend do so in a way that is not "true to type", such that 37% of those with prior offence history that included only adult victims sexually reoffended against a child (Vess & Skelton, 2008). Such findings suggest that if the primary intent is to protect the public from the risk of sexual offending, relevant laws should include those who sexually offend against adults as well as children.

Individual rights issues

The integrity of this process depends of course on the adequacy of the expertise applied in the assessment of risk in any given case. As currently implemented, a psychologist from the New Zealand Department of Corrections Psychological Service assesses each offender, and makes a recommendation as to whether the level of risk is considered sufficiently high for the Department to proceed with an application to the Court for an Extended Supervision Order. The assessment reports and recommendations are routinely reviewed by senior Psychological Service management to ensure that best practice standards have been followed.

The concerns noted earlier regarding the limited accuracy of currently available risk assessment procedures are relevant. These concerns are potentially magnified in New Zealand in that typically there is only one risk assessment provided to the court in such cases, and this assessment comes from a Department of Corrections Psychologist. This is not meant to imply that departmental psychologists do not strive to take an impartial approach to risk assessment based on best practice standards. Rather, the issue here involves the scope of the professional roles assumed by a psychologist employed by the government department that will be seeking a specific judicial decision. Bush, Connell, and Denney (2006) present several relevant distinctions, including the issue of objectivity and whether expert opinion reflects advocacy of a particular belief or consistently favours the retaining party, in this case the department. This distinction becomes particularly important at the point that the department's psychologist becomes an advocate for the legal outcome desired by the department, such as the goal of obtaining an order for extended supervision.

A related issue concerns the threshold of risk used to determine when to make an Extended Supervision Order application. There are different perspectives on how high the risk should be before Extended Supervision is warranted, but it is the Department of Correction's standard that ultimately determines the initiation of this process, and often the only opinion provided to the court is based on this standard. In the current context, there is relatively little independent risk assessment expertise available to offenders (i.e. few experienced experts who do not work for the Department of Corrections), so that there are limited opportunities to effectively challenge the recommendations of the department on the basis of assessed risk. This raises a concern about adequate checks and balances in the administration of the Extended Supervision scheme.

Nevertheless, New Zealand's Parole (Extended Supervision) Amendment Act 2004 avoids or minimises several of the most problematic issues associated with the SVP laws of the United States. It does not involve a consideration of mental disorder or psychiatric diagnosis. It does not require that risk be causally linked to a diagnosable mental disorder, and does not involve the issue of treatment availability or treatment effectiveness. Perhaps most significantly, Extended Supervision in the community following release from prison is substantially less restrictive of the freedom of the offender than indefinite involuntary commitment in a secure facility as a psychiatric inpatient. From this perspective, Extended Supervision appears less punitive, in both intent and impact, than initiatives such as SVP legislation, which have nonetheless been upheld at the state and national Supreme Court level in the United States.

Best Alternative for Managing Risk

Monitoring dynamic risk

Extended periods of intensive supervision in the community after release may also offer the best mechanism for enhancing public safety. This approach offers several potential advantages over indefinite detention. Experts in the field have often noted that risk is affected by dynamic factors that change over time and in different environments. One of the difficulties of assessing risk while the offender is incarcerated involves not knowing what these environmental factors will be, and not knowing with certainty how the offender will respond until he encounters these factors. Extended Supervision allows for an individualized assessment of risk that follows the offender in the community over time, and can respond flexibly to changes in risk associated with environmental contingencies and known dynamic risk factors.

Cost Effectiveness

Another set of issues in the comparison of civil commitment in a treatment facility with Extended Supervision in the community is cost effectiveness. Housing and treating SVP's in California is expensive, both in terms of money and clinical resources. Currently the average cost per year to incarcerate someone in state prison is approximately $26,000, compared to $110,000 per year at Atascadero State Hospital. The state has built a new 1,500 bed facility dedicated exclusively to the confinement and treatment of SVP's at a cost of $388 million, with an estimated ongoing operational cost of about $150 million annually (California Department of Mental Health, 2006). Beyond these financial considerations, there are concerns about redirecting limited treatment resources from the traditional mentally ill populations served by the state to attempts at treatment of an often unwilling, and potentially unresponsive, SVP population.

The costs and implementation problems associated with the SVP initiative are avoided with Extended Supervision. Regular incarceration in prison for a determinate sentence is much less extensive than commitment to a secure treatment facility, and therapeutic resources can be made available to those who demonstrate the inclination and capacity to engage in treatment. Release to the community under Extended Supervision is substantially less costly than ongoing confinement, and offers the advantages of a flexible approach to risk assessment and intervention after release.

Effective Public Protection

Referring to the recent trend in sex offender legislation in the United States, English, Jones and Patrick (2003) offer the following conclusion:

"The new legal responses to sexually dangerous offenders cannot succeed in isolating and incapacitating all potential recidivists from the community. Nor can inpatient sex offender treatment succeed in changing the behavior patterns of sex offenders. How offenders behave in institutional settings does not always predict how they will behave once released to the community. Given the inevitability that many sex offenders will be released to the community from prison and from the hospital, we need to develop systematic ways of monitoring their behavior in the community that manage the risk that many will continue to present and that provide postinstitutional treatment opportunities that can increase the likelihood of rehabilitation when the individual is subjected to the stresses and temptations of resuming life in society" (p. 277).

Some experts have gone so far as to propose lifetime community supervision for sexual offenders following their release from prison (see e.g. English, Pullen & Jones, 1996). In comparison to the aggressive approach taken to the confinement and supervision of sexual offenders in a number of U.S. states, one concern is whether the Extended Supervision scheme in New Zealand offers enough intervention to ensure public safety. A recent review of data available on 89 offenders under Extended Supervision Orders over a period of up to 28 months showed a 23.6% rate of general recidivism (i.e. including all offence types), and more specifically, that 4.5% (four individuals) reoffended sexually (Watson & Vess, 2007b). A comparison group of sexual offenders matched by assessed level of risk but released prior to the enactment of the ESO Act showed a 38.2% general recidivism rate and a 17.6% sexual reoffence rate. So while it appears that Extended Supervision may contribute to a reduction in general and sexual recidivism, it does not completely eliminate sexual offending among this high risk group.

As previously described, SVP commitment results in a population that poses unique challenges for patient management and security (Vess et al, 2004). Extended Supervision Orders provide the judiciary with a mechanism that is responsive to changes in risk resulting from dynamic risk factors and environmental contingencies in the community following release. If effectively implemented, this approach can enhance public safety in high risk cases with minimal restrictions of the offender's liberty.

Conclusions

It is recognized that current risk assessment procedures have limited accuracy for identifying which individuals will reoffend. Risk is contingent on a variety of relevant factors, and can be best assessed by monitoring dynamic risk factors that change over time. The factors that will influence risk in the community cannot effectively be approximated and assessed in a controlled institutional environment. Furthermore, the effectiveness of inpatient treatment programs is limited, and appears to reduce risk for some offenders but not for others (Hanson et al., 2002; Losel & Schmucker, 2005). Each of these issues bears directly on the question of whether special sexual offending legislative initiatives may excessively impair the rights of offenders in pursuit of public protection.

Returning to the initial questions posed in this article, it is argued that protecting the public from high risk sex offenders is clearly a sufficiently important purpose to justify curtailment of individual freedom. Both civil commitment and extended supervision are rationally connected to this purpose. Yet the curtailment of freedom is substantially less severe under extended supervision than indefinite confinement under involuntary civil commitment. Extended supervision may therefore be said to curtail the rights and freedom of offenders no more than is reasonably necessary for the sufficient achievement of community protection, if this proves to be an effective approach. The limitations on rights imposed by extended supervision in the community, which may last up to 10 years, appear to be more proportional to the offences for which offenders have been convicted and already served their sentence than the indefinite, potentially lifelong, confinement that results from commitment as an SVP. At this stage in its development, the effectiveness of extended supervision for protecting the community remains an empirical question requiring ongoing investigation. However, based on the current rate at which SVPs are being released into the community, it will take many years and a great expenditure of resources before we will have much information on the success of an involuntary confinement approach with far more impact on individual rights.

References

American Psychiatric Association (1999). Dangerous sex offenders: A task force report of the American Psychiatric Association. Washington, DC: Author.

Burdon, W.M., & Gallagher, C.A. (2002). Coercion and sex offenders: Controlling sex-offending behavior through incapacitation and treatment. *Criminal Justice and Behavior*, *29*, 87-109.

Bush, S.S., Connell, M.A., & Denney, R.L. (2006*). Ethical practice in forensic psychology: A systematic model for decision making*. Washington D.C.

American Psychological Association. California Assembly Bill 888. (1995). § 6250.

California Department of Mental Health (2006). *Coalinga State Hospital: Director's message*. Retrieved June 22, 2006 from the California Department of Mental Health Web site: http://www.dmh.ca.gov/Statehospitals/Coalinga.

California Department of Mental Health (2007). Sex Offender Commitment Program web site: http://www.dmh.ca.gov/socp.

Campbell, T.W. (2003). Sex offenders and actuarial risk assessments: Ethical considerations. *Behavioral Sciences and the Law, 21*, 269-279.

Doren, D. (2002). *Evaluating sex offenders: A manual for civil commitments and beyond.* London: Sage Publications.

English, K., Jones, L., & Patrick, D. (2003). Community containment of sex offender risk: A promising approach. In B.J. Winick & J.Q. LaFond (Eds.), *Protecting society from sexually dangerous offenders* (pp. 265 – 279). Washington DC: American Psychological Society.

English, K., Pullen, S., & Jones, L. (Eds.) 1996). *Managing adult sex offenders: A containment approach*. Lexington, Kentucky: American Probation and Parole Association.

Hanson, R.K., & Bussiere, M.T. (1998). Predicting relapse: A meta-analysis of sexual offender recidivism studies. *Journal of Consulting and Clinical Psychology*, *66*, 348-362.

Hanson, R.K., Gordon, A., Harris, A.J.R., Marques, J.K., Murphy, W.D., Quinsey, V.L., & Seto, M.C. (2002). First report of the Collaborative Outcome Data Project on the Effectiveness of Psychological Treatment of Sex Offenders. *Sexual Abuse: A Journal of Research and Treatment*, *14*, 169 – 195.

Hanson, R.K., & Harris, A. (2000). *The sex offender need assessment rating (SONAR): A method for measuring change in risk levels.* Ottawa: Department of the Solicitor General of Canada.

Hanson, R.K. & Harris, A. (2004). A structured approach to evaluating change among sexual offenders. *Sexual Abuse: A Journal of Research and Treatment*, *13*, 105-122.

Hanson, R.K. & Thornton, D. (2000). Improving risk assessment for sex offenders: A comparison of three actuarial scales. *Law and Human Behavior*, *24*, 119 – 136.

Harris, A.J.R., & Hanson, R.K. (2004). Sex offender recidivism: A simple question. Retrieved August 23, 2005, from Public Safety and Emergency Preparedness Canada's Web site: http://www.psepcsppcc.gc.ca/ publications/corrections/200403-2_e.asp

Janus, E.S. (2000). Sexual predator commitment laws: Lessons for law and the behavioral sciences. *Behavioral Sciences and the Law*, *18*, 5-21.

Janus, E.S. (2003). Treatment and the civil commitment of sex offenders. In B.J. Winick & J.Q. LaFond (Eds.), *Protecting society from sexually dangerous offenders* (pp. 119 – 130). Washington DC: American Psychological Society.

La Fond, J.Q. (2000). The future of involuntary civil commitment in the U.S.A. after *Kansas v. Hendricks*. *Behavioral Sciences and the Law*, *18*, 153-167.

LaFond, J.Q. (2005). *Preventing sexual violence: How society should cope with sex offenders*. Washington DC: American Psychological Association.

Levenson, J.S. (2004). Sexual predator civil commitment: A comparison of selected and released offenders. *International Journal of Offender Therapy and Comparative Criminology*, *48*, 638-648.

Levesque, R.J.L. (2000). Sentencing sex crimes against children: An empirical and policy analysis. *Behavioral Sciences and the Law*, *18*, 331-341.

Losel, F., & Schmucker, M. (2005). The effectiveness of treatment of sexual offenders: A comprehensive meta-analysis. *Journal of Experimental Criminology*, *1*, 1 – 29.

Nash, M. (2006). *Public protection and the criminal justice process*. New York: Oxford University Press.

Parole (Extended Supervision) Amendment Act 2004, number 67, 7 July 2004. Accessed through www.legislation.govt.nz, 12 January 2005.

Parrilla, L. (2007). *ASH sex offender set to move to trailer near SLO*. Retrieved November 19 2007 from http://www.sanluisobispo.com/news/local/story/130362.html.

Petrunik, M. (2003). The hare and the tortoise: Dangerousness and sex offender policy in the United States and Canada. *Canadian Journal of Criminology and Criminal Justice*, *45*, 43-57. Retrieved April 14, 2004, from the ProQuest database.

Skelton, A., Riley, D., Wales, D., & Vess, J. (2006). Assessing risk for sexual offenders in New Zealand: Development and validation of a computer scored risk measure. *Journal of Sexual Aggression*, *12*, 277 – 286.

Vess, J. (2006). Preparing practitioners for assessing and managing risk. In L. Bakker, & K. McMaster (Eds.), *Will they do it again: Assessing and managing*

risk (pp. 162 – 177). Lyttelton, New Zealand: Hall McMaster & Associates.

Vess, J. (in press). Sex offender risk assessment: Consideration of human rights in community protection legislation. *Legal and Criminological Psychology*.

Vess, J., Murphy, C., & Arkowitz, S. (2004). Clinical and demographic differences between sexually violent predators and other commitment types in a state forensic hospital. *Journal of Forensic Psychiatry and Psychology*, *15*, 669-681.

Vess, J. & Skelton, A. (2008). *Sexual and violent recidivism by offender type and actuarial risk: Reoffending rates for rapists, child molesters and mixed-victim offenders.* Manuscript submitted for publication.

Watson, T.K., & Vess, J. (2007a). Risk assessment of child-victim sex offenders for extended supervision in New Zealand. *Journal of Forensic Psychiatry and Psychology*, *18*, 235 – 247.

Watson, T. & Vess, J. (2008). Short term reoffending by child victim sex offenders in New Zealand: A comparison of those with and without extended supervision. *Sexual Abuse in Australia and New Zealand: An Interdisciplinary Journal, 1(1),* 44-52.

Zander, T.K. (2005). Civil commitment without psychosis: The law's reliance on the weakest links in psychodiagnosis. *Journal of Sexual Offender Civil Commitment: Science and the Law*, *1*, 17-82.

Sexual Abuse in Australia and New Zealand, January 2009; 1(2): 79-86

Identifying Offense Pathways and Associated Implicit Theories in a Taiwanese Sample of Convicted Rapists

Chien Huang
National Taiwan University, Taiwan

Wen-Yau Hsu
National Chengchi University and Research Center for Mind, Brain, and Learning, Taiwan

Anthony R. Beech
Centre for Forensic and Family Psychology, University of Birmingham, U.K.

En-Chang Wu
National Taiwan University, Taiwan

Abstract

The study aims were to test two psychological models of offending in a sample of Taiwanese rapists. First, the applicability of Ward and Hudson's (1998) relapse prevention pathways model was tested out in the sample; second whether different offense-related schemas, suggested and termed Implicit Theories by Ward (2000) could be identified in the sample. The results of the study identified the pathways originally reported by Ward and Hudson with the overwhelming majority of the sample (82%) identified as having positive goals to offending. As for the schema/IT analysis, the same motivational schemas were found in the study, that have been previously found in samples in New Zealand and the U.K, with no new (culturally specific) motivational schemas/ITs being identified. These results are discussed in terms of the relative levels of these schemas/ITs, in comparison to those reported in samples from New Zealand and the U.K.

Introduction

In Taiwan, as in other countries, sexual offending and sexual recidivism is a serious concern, for police and criminal justice systems and for the public at large. From the records of prisons in the Northern area of Taiwan, the recidivism rate of 385 sexual offenders released in 1995 was 11.5% for sexual violence (Chen & Chou, 2004), which is broadly similar to recidivism rates reported elsewhere (e.g., Craig, Thornton, Beech & Browne, 2007; Hanson and Morton-Bourgon, 2004). These observations suggest that a greater understanding of why individuals recidivate is important in understanding the treatment needs of sexual offenders in Taiwan.

As for why individuals commit, and carry on committing, sexual offenses, Ward and Hudson (1998) suggest that there are distinct offense and relapse pathways, each associated with different psychological characteristics and clinical issues. These pathways are further defined by an individual offender's goal towards deviant sex (approach or avoidance)[1]. Here, *approach* goals concern the successful achievement of a particular state or situation regarding the successful commission of a sexual offense. *Avoidant* goals, on the other hand, are aimed at the reduction of a particular state, or situation, and thus involve avoiding offending in the first instance (Cochran & Tesser, 1996). Once an offense-related goal to offend has been established in approach or avoidant goal offenders (where the latter are in the situation where they are struggling to cope with non-offending), the next stage in the process is the selection of strategies to achieve the desired goal. The decision to offend for the approach goal offender may involve the *active* use of strategies to bring about the desired state of offending. Or, alternatively, *automatic* strategies may be activated as a result of well-learned behaviors, or behavioral scripts, that will lead an offender to commit a sexual offense if activated. For the avoidant goal abuser, attempts to avoid re-offending will be derailed by the use of *active*, but inappropriate, strategies to prevent offending (such as masturbating to deviant fantasies), paradoxically leading to 'ironical effects' where there is a greater likelihood of offending. Alternatively, the avoidant offenders may not use any

[1] Here it should be noted that these terms are employed somewhat differently from the general therapeutic literature where approach and avoidant goals are seen as different approaches to the attainment of the same outcome (Elliott & Church, 1997).

Correspondence: Professor Anthony Beech, Centre for Forensic and Family Psychology, School of Psychology, University of Birmingham, Edgbaston, Birmingham, B15 2TT, U.K. Email: a.r.beech@bham.ac.uk

ISSN 0833-8488

strategies at all to avoid re-offending, and may *passively*, go with 'the flow' in high-risk situations.

Support for Ward and Hudson's ideas have been provided by Bickley and Beech (2002, 2003), in the U.K., in intra- and extra-familial child molesters; Webster (2005), in the U.K. in rapists; Yates and Kingston (2006), in Canada, in a mixed group of intra- and extra-familial child molesters and rapists; Keeling, Rose and Beech (2006) in intellectually disabled sexual offenders in Australia; and in female sexual offenders in the U.K. (Beech, Parrett, Fisher & Ward, in press). From these studies it is also clear that approach goal offenders are more likely to evidence beliefs that justify offending behaviours (cognitive distortions) which relate to motivational, or value preferences towards their goals and the positive anticipation of these results (Karoly, 1993).

As to why individuals commit sexual offences, there has been a lot of focus on the distorted attitudes such men possess which motivate them to offend. The nature of these distorted attitudes or 'cognitive distortions', have become the subject of much debate in recent years, as they have been identified as both 'giving the offender permission to offend' and as such are causative (Ward & Siegert, 2002), but have also been described as arising after the offense to 'make the offender feel better about the offense' by justifying, excusing or externalizing blame to others, thereby minimising self-blame and guilt (Finkelhor, 1984). These observations raise the question as to whether there is any value in assessing and treating the type of cognitive distortions that can be seen as operating as excuses or justifications for offending, and instead the focus in assessment, and treatment, should be more on the deeper level causal processes, or deep cognitions' (Kwon & Oei, 1994) that can only be assessed indirectly via the 'cognitive products' to which they give rise.

Deep level cognitions have been labeled as 'schemas', defined by Beck (1964) as cognitive structures used for assessing, screening and encoding incoming stimuli. In this model, a schema is defined as a structure containing beliefs or attitudes that follow a similar theme or pattern, which has developed as a result of trying to make sense of early life experiences. They contain fundamental assumptions about an individual and their relationship with others and the world, and are an organising framework for processing new information, particularly social and interpersonal information (Mann & Beech, 2003). Mann and Beech note that such schemas are stable structures, which are chronically accessible and are particularly relied upon to draw inferences in ambiguous or threatening situations, where they focus attention and interpretative resources upon schema-relevant cues.

In the sex offender field, Ward (2000) has used the term *Implicit Theory* (IT), rather than schema, because this term suggests the complexity and dynamic nature of such systems, and because ITs contain integrated sets of cognitions and desires that influence which goals are salient in the interpretation of interpersonal phenomena. As for the types of ITs identified in rapists, Polaschek and Ward (2002) suggest that the following can be identified: *Women as sexual objects, Male sex drive is uncontrollable, Dangerous world, Women are unknowable* and *Entitlement*). To describe each of these ITs briefly:

Entitlement – In this IT men believe that they should have their needs, including their sexual needs, met on demand. For example, men might be viewed as more powerful and important than women, and therefore have the right to have their sexual needs met when they want, and with whom they want. In this implicit theory the desires and beliefs of the offender are paramount and those of the victim ignored or viewed as only of secondary importance.

Dangerous world – In this IT the world is seen as a dangerous place and other people are thought likely to behave in an abusive and rejecting manner in order to promote their own interests. Therefore if women are perceived as threats and in need of retribution, they may become victims of sexual abuse. The beliefs and desires of other people are a focus of this implicit theory, particularly those signifying malevolent intentions. Therefore, the content of this theory refers to the desires of other people to dominate or hurt the offender. In addition, the offender views himself as capable of retaliation and asserting his dominance over others.

Women as sex objects – In this IT, women are seen to exist in a constant state of sexual reception. They were created to meet the sexual needs of men, and women's most significant needs and desires centre around the sexual domain. From these propositions, it follows that women will constantly desire sex, even if it is coerced or violent, and that as sexual entities, women should always be receptive to and available to meet men's sexual needs, when they arise. One implication of this theory is that there is often a discrepancy between what women say and what they actually want. This inconsistency arises because their sexual needs may be unknown to them. Thus women don't deliberately deceive men; instead they simply don't know that they are fundamentally sex objects. They are unaware of the unconscious messages their bodies are emitting.

Male sex drive is uncontrollable –In this IT men's sexual energy is seen as difficult to manage and that women have a key role in its loss of control. Men who rape adult women attribute the causes of their offending to external factors (i.e., external to the self, and personal responsibility). These factors can be

located in the victim or in other features of the environment (e.g., availability of alcohol). Serious involuntary sexual deprivation is usually attributed to insufficient access to women and therefore it follows that a woman denying reasonable sexual access is one cause of loss of control for men.

Women are unknowable/dangerous – This IT proposes that either because of biology or socialisation, women are inherently different from men, and that men cannot readily understand these differences. One variant of this theory that is less benign occurs with the addition of the corollary that women are unable or unwilling to communicate honestly with men. Here women are portrayed as inherently deceptive (see Malamuth & Brown, 1994 for discussion of this). Supposedly, they know that their own desires and needs are incompatible with those of men and so they do not communicate these desires and needs directly, but instead present them in a disguised manner.

Evidence for these types of schema/implicit theories in rapists has been reported both by Beech, Fisher and Ward (2006) in a U.K. sample of rapists, Polaschek and Gannon (2004) in a sample of New Zealand rapists, and Beech, Ward and Fisher (2005) in a sample of U.K. sexual murderers. Some of the ITs in Beech et al.'s (2005) sample were relatively common (Dangerous world found in 79% of their sample; Women as sex objects 51%; Entitlement, 44%), while others were rare (Male sex drive is uncontrollable 15%; Women are unknowable 9%).

As neither the offense pathway implicit theory, nor an implicit theory analysis, has been carried out in a non-Western sample of men who had assaulted adult women the aim of the current study was:

(1) To assess the applicability of Ward and Hudson's model in identifying offense pathways in Taiwanese rapists;
(2) To assess the level of the five ITs originally identified by Polaschek and Ward (2002) with the associated hypothesis that these would be identified in a sample of Taiwanese rapists.

Method

Setting

Any offenders who had committed a sexual offense were referred to one of three special areas for managing sexual offenders during imprisonment in Taiwan. In the current study, all of the participants came from the North Correctional Centre of Taiwan. This is a prison-based program, where participants attend assessment and treatment programs to address their offending behaviours.

Participants

The study was advertised in the North Correctional Centre of Taiwan. A total number of 143 adult sex offenders volunteered to take part in the study, and of these 56 were chosen to participate. These were specifically chosen as they all had offended *exclusively* against female adults. All of these agreed to take part in the study and filled out a consent form to this effect. The mean age of this sample was 33.05 (SD= 6.72, range 22 to 49 years old); their average number of years in full-time education was 11.23 years (SD = 3.08). As for the type of offenses committed, 42 men (75% of the sample) had offended against strangers, 13 (23%) had offended against acquaintances, while one offender had offended against both stranger and acquaintances. The number of sexual offenses committed by men in the sample ranged from 1 to 13 (M = 2.18, SD = 2.68). The age of first conviction of the men in the sample ranged from 14 and 41 (M = 26.68, SD = 7.21). The age of their latest conviction ranged from 17 to 43 (M = 28.25, SD = 7.04). This age range seems broadly comparable with other recent studies, such as Beech et al. (2006) who report an average age of an incarcerated sample of 41 rapists of 33.60 (SD 7.20). Only 25% (N =14) were in a relationship at the time of the commission the index sexual offense. As for the veracity of the participants' accounts: 37 (66% of the sample) participants' self-reports were open and honest about the details of their offenses (in that their reports were congruent with official reports and victim statements); 9 (16%) were in partial denial of their offending behaviours; while 10 men (18%) were in complete denial (i.e., they denied they had committed their offenses).

Procedure

The interviewer first examined the official record of the offenders, which included basic information about the participants' offenses, their criminal histories, and witness statements from their victims. Next, the first author met with each participant who had agreed to take part in the research, explained the aim of the study to the participants, and if they were happy to proceed the participants filled out an informed consent form. Following this, interviews were conducted in a private room within the prison. Each interview was approximately two hours in length. The interview procedure consisted of four parts: (1) distal background information about the life of the offender leading up to offense; (2) the proximal build-up to the offense over 6 months; (3) the offending process itself; (4) post-offense reactions. The interviewing questions were based on those reported by Ward, Bickley, Webster, Fisher, Beech and Eldridge (2004) (see Appendix A which contains the questions used in this interview). Each interview was recorded on a digital dictaphone.

All interviews were transcribed verbatim. To ascertain the reliability of this coding process, 20 offense process descriptions of the participants were rated by the first author and by two other licensed clinical psychologists who worked in the prison setting, and who had been trained by the first author in both offense pathway and IT identification.

Offense pathway and implicit theory identification

An offense pathway was coded from official documents and by interview for each participant in the study. As for IT identification, the first author and the other two licensed clinical psychologists (working independently) read through each transcript and, using the five IT coding categories, ascertained whether any of these were evident in each transcript. This analysis essentially consisted of identifying the themes evident in the transcripts, consulting a description of each IT, and making a judgment as to whether there was any evidence for a specific IT. The implicit theories were regarded as *a priori* categories for the purposes of the study and therefore the method was essentially that of category allocation. Once the coding was completed the transcripts were examined again to see if there were any offense supportive beliefs of significance, in addition to the five rapist ITs previously identified. If any of these were identified they were placed into a 'miscellaneous' category. The presence of this miscellaneous category meant that any evidence for new ITs could be gathered and, if appropriate, provide the conceptual material basis for the formation of new ITs.

When there were discrepancies a fourth rater identified whether an IT was present or not. Inter-rater reliability was assessed using Cohen's kappa. These kappas were interpreted using a set of guidelines originally proposed by Fliess (1981). Fleiss suggests that kappas between 0.4 and 0.6 are 'fair', between 0.6 and 0.75 are 'good', and over 0.75 are 'excellent'.

Results

Test of Hypothesis 1: Pathway analysis

The overall agreement of offense pathways was 95% overall, kappa = .95 [excellent], T = 11.68, $p < .0001$. Overall, a significantly higher proportion of the sample ($\chi^2 = 26.86$, $p < .001$) of the sample (82%, N = 46) were in the two approach categories (approach explicit: 32%, N = 18; approach automatic: 50%, N = 28) and 18% (N = 10) were in the two avoidant categories (avoidant active 11%, N = 6; avoidant passive 7%, N = 4). Therefore these results suggest strong evidence for Hypothesis 1. Table 1 shows the differences in demographic information across the four pathways.

Table 1: Offense-related Information in the Four Different Pathways

	Avoidant Passive	Avoidant Active	Approach Automatic	Approach Explicit	Significance
Years full-time in education [a]	15.00 (2.16)	11.67 (4.76)	10.68 (2.64)	11.11 (2.85)	ns.
Mean age at last conviction [a]	28.00 (10.52)	30.33 (8.87)	27.79 (6.79)	28.33 (6.53)	ns.
Mean age at first conviction [a]	25.25 (5.56)	30.17 (8.67)	26.86 (7.21)	25.56 (7.22)	ns.
Number of index offenses [a]	3.00 (3.67)	1.50 (1.23)	1.32 (.55)	3.56 (4.09)	p< .05
Length of sexual offending career [a]	2.75 (5.50)	.17 (.41)	.92 (2.14)	2.78 (4.32)	ns.
Marital status at offense [b]					ns.
Not in relationship	3(75)	5(83)	21(75)	13(72)	
Married/long-term relationship	1(25)	1(17)	7(25)	5(28)	
Sexual pre-conviction [b]					ns.
Yes	3(75)	5(83)	24(86)	12(67)	
No	1(25)	1(17)	4(14)	6(33)	
Violent pre-conviction [b]					ns.
Yes	0(0)	2(33)	12(43)	6(33)	
No	4(100)	4(67)	16(57)	12(67)	
Property pre-conviction [b]					p< .05
Yes	0(0)	0(0)	13(46)	10(56)	
No	4(100)	6(100)	15(54)	8(44)	

[a] The data showed Mean and SD with parenthesis in each cell.

[b] The data showed Number and percentage with parenthesis in each cell.

It can be seen from Table 1 that there were no significant differences between any of the variables, apart from number of index offences and property pre-conviction, between the different pathways.

Test of Hypothesis 2: Implicit theory analysis

All five ITs found in previous studies (e.g., Beech et al., 2005, 2006; Polaschek & Gannon, 2004) were identified in the current sample. The inter-rater agreements by IT category by strength of agreement were as follows: *Women are unknowable,* 95% agreement, kappa = .92 [excellent], T = 7.15, $p < .0001$; *Women are sex objects*, 95% agreement, kappa = .89 [excellent], T = 6.88, $p < .0001$; *Male sex drive is uncontrollable,* 85% agreement, kappa = .70 [good], T = 5.46, $p < .0001$; *Entitlement*, 80% agreement, kappa = .67 [good], T = 5.20, $p < .0001$; *Dangerous world*, 95% agreement, kappa = .93 [excellent], T = 7.23, $p < .0001$). Overall, The ITs all had good inter-rater reliability. Although the inter-rater reliability of the *Male sex drive is uncontrollable* and *Entitlement* ITs were slightly lower than the others, these kappa values can still be regarded as 'good' by Fliess' criteria.

We will now report each of the ITs by how common they were in the sample.

Women are sex objects
This was the most common of the ITs being found in 86% (N = 48) of the sample, where women are reported as being there merely to satisfy men's sexual needs.

Examples
"…they [women] are only the tools to relieve my tensions…" (Offender #3).

"…because I saw how she looked, and lived in that kind of place, and the way she dressed…first I thought she was specially doing sex deals, then later she told me that she worked in a bar. To me they are all the same…they [women] sell their body, when there is money." (Offender #16)

Women are unknowable/Women are dangerous
This was the second most common IT, being found in 77% (N = 43) of the sample. Here women were described in the sample as being manipulative and out to con.

Examples
"…I thought it was not possible that I could be drunk, from only two glasses [of alcohol], I thought in my mind that it was all faked, purposely to seduce me to have sex with her, then come later for money… I felt that she had set me up…" (Offender # 44).

Even now, I believe that she had sex with me under her personal volition all the while…" (Offender #37).

Male sex drive is uncontrollable
This IT was also very common, being identified in 71% of the sample. Men holding this IT believe that the males' sexual impulsivity is a hard-to-control state, especially after drinking or using drugs, making them easily sexually aroused.

Example
"…maybe because I had had a drink, and had become braver…it just happened that she's in my car so there is the chance [to have sex], and it happened because there is this chance…" (Offender #5).

Entitlement
This IT was found in 70% of the sample. The content of this IT, in men in the sample, was that reported that they felt entitled to have sex when ever they wanted it.

Example
"…I had been living with my girl friend for months; she lived in my house [for free], I paid for everything, I thought that I treated her so well that she should satisfy me, with all the sex that I deserved to have.…" (Offender #6).

Dangerous world
This was the least common IT, being identified in 61% of the sample. Here, participants portray a general hostility and a need to be careful of others.

Examples
"…before, I think highly of friends, trusting them, but once is O.K, twice three times of betrayal makes me think that I don't want to share things with friends any more… my trust in people [has] become less positive…" (Offender #15).

"…we are drinking, and the people at the next table are murmuring, then I would start to think, ...[and] suspect them of talking behind my back, then it becomes easy to get into an argument…" (Offender #3).

Miscellaneous
No cognitions were identified that could not be coded into the five ITs.

Discussion

Both the results of the pathway and IT analysis broadly concur with previous research. The pathway analysis part of the study found the great majority of the sample (83%) were approach offenders. These results are similar to those reported by both Bickley and Beech (2002) and Yates et al. (2003), who found that the

majority of their participants fell into the approach categories (i.e., Bickley & Beech = 80%; Yates et al. = 94%). This result suggests the usefulness in identifying relapse pathways in Taiwanese rapists both for risk assessment purposes, and an indication of treatment targets in order to design different programs to meet therapeutic needs and expand the effectiveness of treatment in Taiwan.

A detailed description of these treatment targets for the differing offense trajectories is beyond the scope of this paper, but we would note that Ward, Yates and Long (2007) describe treatment pathways for each of the self-regulation pathways groups. Here, they suggest that a focus on a Good Lives approach (Ward & Gannon, 2006), which emphasizes building upon strengths, as well as targeting risk factors is the way forward in providing tailored interventions for each of the self-regulation pathways. Specifically, this approach involves therapeutic tasks managing the balance between the *approach* goal of promoting offender goods and the *avoidance* goal of reducing risk (Ward, Collie, & Bourke, 2008). Ward et al. also note that in the Good Lives approach there should be some degree of tailoring of therapy to match individual offenders' particular good lives plan and their associated risk factors, so that therapy is tailored to each offender while being administered in a systematic and structured way. That is to say, a more 'holistic' treatment perspective is taken, based on the core idea that the best way to reduce risk is by helping offenders lead more fulfilling lives (Ward et al., 2008), which certainly may be the case for approach orientated offenders.

As for the IT analysis, the research clearly shows that all of the ITs identified by Polaschek and Gannon (2004), and Beech et al. (2006). We were also able to examine, in a general way, Huang's (2001a,b) idea that some ITs are *culturally specific* to Western society, *viz*., Women are sexual objects (WSO) and Women are unknowable (WAU) and therefore may be less often observed than in Western countries. However, it is clear from the data reported above that the levels of these two ITs (WSO = 86%; WAU = 77%) are a lot higher than those reported in Beech et al. (WSO = 32%; WAU = 18%), but are similar to the levels reported by Polaschek and Gannon (WSO = 70%; WAU = 65%).

The level of Entitlement found in this study (ENT = 70%) was far higher than that reported by Beech et al. (2006) (ENT = 43%) and almost the same as that reported by Polaschek and Gannon (2004) (ENT = 68%). Therefore, no strong argument could be made that any cultural differences in these ITs, as Huang (2001a,b) has suggested that Entitlement (ENT) would be more likely to be found in Western, as opposed to Chinese society. In Chinese society there is generally an emphasis upon supportive and cooperative attitudes, and the harmony of society is a core value (Hall, Sue, Narang, & Lilly, 2000; Markus & Kitayama, 1994). Huang (2001a,b) also suggested that the Male sex drive is uncontrollable (MSU) and Dangerous world ITs (DW) are culturally non-specific, in that notions of the 'all powerful' male, and the world being a perilous place, are readily recognized in Chinese culture. However, in terms of the relative presence of these ITs in the current sample (MSU = 71%; DW = 61%), they were found to be broadly similar to the levels reported by Beech et al. (2006) (MSU = 71%; DW = 79%), but a lot higher than those reported by Polaschek and Gannon (MSU = 16%; DW = 19%).

Limitations and future directions

The study has a number of limitations. First and second, we would note that the sample was derived from one facility in Taiwan and the men in the sample were exclusively rapists. Further work in the area obviously needs to examine other types of sex offenders (i.e., child molesters; sexual murderers); and to examine whether the offense pathways and categories of motivational schemas/ITs (sexual, violent, entitlement) exist in these groups.

Third, the quality of the data collected was somewhat dependent on the honesty of responding by participants. In any future research it might be worth considering assessing the level of faking good responding using something like the Balanced Inventory of Social Desirable Responding (Paulus, 1998). The employment of follow-up interviews for participants to give an updated account of their offenses might also glean further information in any future work.

Conclusions

Although both the self-regulation model and the notion of a small number of ITs underlying rapists' cognitions are starting to have a robust research-base in the Western world, whether such concepts are applicable in a non-Western, specifically a Taiwanese, cultural context had not been tested until the current study. Overall the paper found that the self-regulation model and the schema/IT approach appears useful for understanding both the offense process itself and the motivations for why Taiwanese rapists commit their offenses. Given the lack of differences between Taiwanese and western samples we would ask the question whether these results imply that globalisation is having its effect upon Taiwanese culture? Obviously this is a difficult question to answer, and is beyond the scope of this piece of research, but we would note that Hall et al. (2000) found that the sexual aggression of Asian-American men was subject to both the influence from intra- and inter-personal determinants. Thus, we would suggest that the studies in sexual crimes need to consider the culture and social context, as well as how

cognitive structures affect motivation, emotion, and action (Gong, 2003; Markus & Kitayama, 1991, 1994).

References

Beck, A. T. (1964). Thinking and depression. II. Theory and therapy. *Archives of General Psychiatry*, ***10***, 561-571.

Beech, A.R., Fisher, D., & Ward, T. (2005). Sexual murders' implicit theories. *Journal of Interpersonal Violence, 20*, 1366-1389.

Beech, A.R. Parrett, N., Fisher, D. & Ward, T. (in press). Assessing female offenders' motivations and cognitions: An exploratory study. *Psychology, Crime and Law*.

Beech, A., Ward, T., & Fisher, D. (2006). The identification of sexual and violent motivations in men who assault women: Implications for treatment. *Journal of Interpersonal Violence,* 21,1635-1653.

Bickley, J.A. & Beech, A.R. (2002). An investigation of the Ward and Hudson pathways model of the sexual offense process with child abusers. *Journal of Interpersonal violence, 17*, 371-393.

Bickley, J.A. & Beech, A.R. (2003). Implications for Treatment of Sexual Offenders of the Ward and Hudson Model of Relapse. *Sexual Abuse: A Journal of Research and Treatment, 15(2)*, 121-134.

Chen, C.H. & Chou, S.Y. (2004). The recidivism rate among sexual offenders and factors of risk assessment for sexual recidivism (*User Report 93062*). Taipei, Taiwan: Department of Health.

Cochran, W. & Tesser, A. (1996). The "What the hell" effect: Some effects of goal proximity and goal framing on performance. In L.L.Martin & A.Tesser (Eds.), *Striving and feeling: Interaction amongst goals, affect and self-regulation*. New York: Lawrence Erlbaum.

Craig, L.A., Thornton, D., Beech, A.R. & Browne, K.D. (2007). The relationship of statistical and psychological risk markers to sexual reconviction. *Criminal Justice and Behavior*, *34*, 314-329.

Elliott, A.J., & Church, M.A. (1997). A hierarchical model of approach and avoidant achievement motivation. Journal of Personality and Social Psychology, 72, 218-232.

Finkelhor, D. (1984). Child Sexual Abuse: New Theory and Research. New York: The Free Press.

Fleiss, J.L. (1981). Statistical methods for rates and proportions, second edition. New York: Wiley.

Gong, J.J. (2003). A paradox of erotic "subjectivity": Epistemological and ethical predicaments in prostitution studies. In A.B. Yu (Ed.), *Sentiment, desire and culture* (pp. 83-108). Taipei, Taiwan: Institute of Ethnology, Academia Sinica.

Hall, G.C.N., Sue, S., Narang, D.S., & Lilly, R.S. (2000). Cultural-specific models of men's sexual coercion: Intra- and interpersonal determinants. *Cultural Diversity and Ethnic Minority Psychology, 6*, 252-267.

Hanson, R.K., & Morton-Bourgon, K. (2004). *Predictors of sexual offender recidivism: An updated meta-analysis*. (User Report 2004-04). Ottawa: Department of Solicitor General of Canada.

Huang, J.Y. (2001a). The sociocultural and psychodynamic processes involved in rape behavior: I. Theoretical analysis. *Indigenous Psychological Research in Chinese Societies, 13*, 1-54.

Huang, J.Y. (2001b). The sociocultural and psychodynamic processes involved in rape behavior: II. Empirical testing. *Indigenous Psychological Research in Chinese Societies, 13,* 55-126.

Karoly, P. (1993). Mechanisms of self-regulation: A systems view. *Annual Review of Psychology, 44,* 23–52.

Keeling, J., Rose, J.L. & Beech, A.R. (2006). A comparison of the application of the self-regulation model of the relapse process for mainstream and special needs sexual offenders. *Sexual Abuse: A Journal of Research and Treatment,* 18, 373-382.

Kwon, S. M. & Oei, T. P. S. (1994). The roles of two levels of cognition in the development, maintenance and treatment of depression. *Clinical Psychology Review, **14***, 5, 331-358.

Malamuth, N.M., & Brown, L.M. (1994). Sexually aggressive men's perceptions of women's communications: Testing three explanations. *Journal of Personality and Social Psychology*, *67*, 699–712.

Mann, R & Beech. A. R. (2003). Cognitive distortions, schemas and implicit theories. In T. Ward, D. R.. Laws & S. M. Hudson (Eds.), *Sexual deviance: Issues and controversies*. (pp. 135-153). London: Sage.

Markus, H.R. & Kitayama, S. (1991). Culture and the self: Implications for cognition, emotion, and motivation. *Psychological Review, 98*, 224-253.

Markus, H.R. & Kitayama, S. (1994). The cultural construction of self and emotion: Implications for social behavior. In S. Kitayama & H.R. Markus (Eds.), *Emotion and culture: Empirical studies of mutual influence* (pp. 89-130). Washington, DC: American Psychological Association.

Paulhus, D.L. (1998). *Paulhus Deception Scales: User's manual*. New York/Ontario: Multi-Health Systems Inc.

Polaschek, D.L.L. & Gannon, T.A. (2004). The implicit theories of rapists: What convicted offenders tell us. *Sexual Abuse: A Journal of Research and Treatment*, *16,* 299–314.

Polaschek, D.L.L. & Ward, T. (2002). The implicit theories of potential rapists: What our questionnaires tell us. *Aggression and Violent Behavior*, *7,* 385–406.

Ward, T. (2000). Sexual offenders' cognitive distortions as implicit theories. *Aggression and Violent Behavior, 5*, 491-507.

Ward, T., Bickley, J., Webster, S., Fisher, D., Beech, A.R., & Eldridge, H.J. (2004). *The self-regulation model of the offense and relapse process*. Victoria,

BC, Canada: Pacific Psychological Associate Corporation.

Ward, T., Collie, R., & Bourke, P. (2008). Models of offender rehabilitation: the good lives model and the risk-need-responsivity model. In A.R. Beech, L.A. Craig & K.D. Browne (Eds), *Assessment and treatment of sex offenders* (pp. 293-310). Oxford: Wiley/Blackwell.

Ward, T. & Gannon, T. (2006). Rehabilitation, etiology, and self-regulation: The Good Lives Model of sexual offender treatment. *Aggression and Violent Behavior*, *11*, 77–94.

Ward, T. & Hudson, S.M. (1998). A model of the relapse process in sexual offenders. *Journal of Interpersonal Violence*, *13*, 400-425.

Ward, T., & Siegert, R. J. (2002). Toward a comprehensive theory of child sexual abuse: A theory knitting perspective. *Psychology, Crime, & Law,* **9***,* 319-351.

Webster, S.D. (2005). Pathways to sexual offense recidivism following treatment: An examination of the Ward and Hudson self-regulation model of relapse. *Journal of Interpersonal Violence, 20*, 1175-1196.

Yates, P.M. & Kingston, D.A. (2006). Pathways to sexual offending: Relationship to static and dynamic risk among treated sexual offenders. *Sexual Abuse: A Journal of Research and Treatment*, *18*, 259-270.

Yen, H.W. (2004). *Sex, gender relationships and sexuality education*. Taipei, Taiwan: Psychological Publishing Company Ltd.

Sexual Abuse in Australia and New Zealand, January 2009; 1(2): 87-97

Community Intervention with Sex Offenders: Do Dynamic Risk Factors Change with Treatment?

Emma Collins
Department of Psychology, Macquarie University, Sydney, Australia

Lorna Peters
Department of Psychology, Macquarie University, Sydney, Australia

Christopher Lennings
Discipline of Behavioural and Social Sciences in Health, The University of Sydney, Australia

Abstract

The present study evaluates the effectiveness of a community based group sex offender treatment program, by exploring which dynamic risk factors change following treatment. Participants (n = 33) had been charged with or had admitted to a sexual offence against a child victim and had participated in a Sydney based community treatment program that runs for up to three years, and is based on cognitive-behavioural treatment but within a Christian theology framework. These offenders were retrospectively rated on the SONAR dynamic stable and acute factors at pre- and post-treatment, and results were examined for change. There was a significant change in total SONAR scores from pre-treatment (M = 3.94; SD = 2.15) to post (M = .82; SD = 3.15). The individual dynamic factors on which offenders made significant improvements were ratings of intimacy and relationships, social influences and supports, self-regulation to supervision and treatment, reduction in substance abuse, and negative mood. Factors on which participants did not significantly change were sexual attitudes, sexual self-regulation, hostility and opportunity for victim access. The significant reduction in SONAR scores also meant that the risk classification ratings changed considerably. Initially 17 (51%) offenders were categorised as low risk, but this number increased to 28 (84%) post-treatment. The results add to the increasing literature detailing the value of dynamic factors, in combination with other static risk factors, as informing risk prediction and treatment needs of sex offenders in the community.

Introduction

Sex offender treatment effectiveness has long been a controversial area. Methodological issues such as inconsistent methodology, small sample sizes, failure to use random allocation, and inappropriate generalisation from limited results frustrated the early attempts to evaluate programs (Blair & Lanyon, 1981; Quinsey et al., 1993). Following a review based on methodologically selected criteria, Furby et al. (1989) concluded that studies to date had not produced evidence of the effectiveness of sex offender treatment. As a consequence, randomised controlled treatment trials were set as the 'gold-standard' for evaluating treatment efficacy by the American Association for the Treatment of Sexual Abusers (ATSA) (Hanson et al., 2002).

Over the last two decades, meta-analyses have been used to explore the efficacy of sex offender treatments. Some of the early reviews (Hall, 1995; Alexander, 1999) were criticised for using studies with too much methodological variance, combining treatment completers with drop-outs (Hanson et al., 2002). A more recent review by Losel and Schmucker (2005), which used more rigorous review standards, noted that overall treatment reduced recidivism by approximately 37% as compared with controls, however they reported that biological treatments (i.e. chemical 'castration') were more efficacious than therapeutic treatments. The Losel and Schmucker paper acknowledged great variability between the studies used by way of sample size and methodological strengths, and noted that the results should be interpreted with a degree of caution. To this end, meta-analyses do not overcome methodological difficulties encountered in this area, although they do provide more conclusive information about the efficacy of treatment.

In recent years, studies have attempted to overcome methodological problems by using more rigid design criteria. One such example of a randomised study that examined recidivism is the California Sex Offender Treatment and Evaluation Project, (SOTEP) (Marques et al., 2005). Marques et al. compared randomly allocated treated and untreated participants on reconviction rates over an eight-year follow-up period. Despite early promising indications, SOTEP did not find significant differences in reoffending rates between treated and untreated participants after the total follow-up period. Moreover, the finding at pre-treatment that those allocated to treatment as opposed to comparison group had high risk levels introduced a bias into the

Correspondence: Emma Collins, Department of Psychology, Macquarie University, NSW, 2109, Australia. Email: emma.collins@psy.mq.edu.au

ISSN 0833-8488

results. Similarly the design of the study (in 1984) predates the greater sophistication that has typified more recent sex offender programs and hence may not provide good grounds for comparison with more recent studies.

Despite the contradictory findings a consensus emerged that sex offender treatments have some, albeit variable, degree of efficacy. It is known that most of the more efficacious studies were based on higher risk offenders (e.g., Schweitzer and Dwyer, 2003), and often in corrective settings or following a period of institutional treatment as compared with lower risk offenders (Quinsey et al., 1995). Less is known about the effectiveness of community based sex offender treatments in comparison.

Community findings

Most community based programs have taken the form of aftercare following custodial treatment. There is now more recognition for the need for 'maintenance' support and treatment, to assist the individual upon release from gaol / custodial treatment program (Cumming & McGrath, 2000).

For example, McGrath et al., (2003) reviewed 195 offenders following custodial treatment. 90 did not participate in any aftercare treatment, 49 completed some aftercare treatment (but were either terminated or dropped-out during treatment), and the remaining 56 completed treatment. This latter group received both a mix of community supervision by correctional services and outpatient aftercare treatment as compared with the other two groups. They found that after a mean follow-up period of almost 6 years, 16 participants (14%) who received some form of aftercare reoffended as compared with 29 participants (35%) who were not receiving any aftercare. Sexual recidivism was significantly related to lack of aftercare, and conversely the rate of recidivism decreased the longer their participants remained in the community. Although there were some methodological problems that largely resulted from this study having been completed retrospectively and some obvious issues in the small sample size, it nonetheless showed promising results for the need for ongoing aftercare treatment.

Contrastingly, Hanson et al., (2004) evaluated an outpatient aftercare program facilitated through the Canadian correctional service. They provided more detail on controlling for a number of factors, such as static risk, of a large sample of treated (403 participants) and untreated (321 participants) sex offenders, with no selection bias, who were released between 1980 and 1992. The treatment was poorly defined, but comprised a mix of cognitive-behavioural therapy (CBT) and psychodynamic treatments. Hanson et al. found an overall sexual recidivism rate of 21.1% of treated offenders as compared with 21.8% of untreated offenders over a mean 12-year follow-up. In considering this non-significant result, they postulated that "no single study is sufficient to determine whether treatment works or not" (p. 94). However, this result may have also been influenced by the varying types of treatment provided, and the authors acknowledged the role that poor treatment quality could have had upon outcome.

Table 1: Community Sex Offender Treatment Outcome Studies

Author	Date	Sample size	Follow up length	Recidivism outcomes
Marshall & Barbaree (Canada)	1988 & 1991	68 Tx completers, 58 did not complete	1 to 11 years	Tx completers = 13.2% Tx uncompleted = 34.5%
Dwyer & Mayer (USA)	1990	Data returned on 61/153, no comparison group	Used literature to gauge success	Claimed significant improvement for treatment
Bingham & Turner (USA)	1995	N=202	Mixed CBT Tx program	Claimed on 2% recidivism, looks good but not clear what this is based on.
Procter (UK)	1996	54 Tx matched with 54 supervision only	5 year evaluation	3/54 offended in the Tx group, 9/54 in the control group, but not significant due to small sample size
Lee et al. (Victoria, Australia)	1996	Data available on 35 of 58 participants	1 year	8.1%. No comparison group and recidivism rate looks high compared to literature.
Lambie & Stewart (NZ)	2003	175 in 3 groups. 79 complete Tx, 5 fail Tx and 91 still in Tx. Compared to 181 probation only (for previous 5 years)		Tx rate = 7.2% , control = 16%
Bates (UK)	2004	183 offenders, no control	4 years (used CBT Tx)	5.4% after four years.

In comparison, there are only a handful of studies on 'genuine' community based treatment programs. Table 1 gives an overview of the findings from these studies, and provides inconsistent results. A number of the studies were poorly described, and had a poor level of experimental control. Studies did not control for diagnostic groups (e.g. Marshall and Barbaree, 1991 used clients convicted for exposure whilst Lambie and Stewart, 2003 report on child molesters). At best the data so far indicates there is some promise in the findings but there is as yet no coherent literature that allows for authoritative conclusions. So far, there is an insufficient set of studies to indicate that community based treatment for high-risk sexual offenders is effective. By the same set of standards, the alternate is not shown either. Probably the most influential of the studies, Lambie and Stewart, (2003) indicates some hope but a longer follow-up rate will be necessary to draw firm conclusions from it. To date the research highlights that community treatments may have potential but too little is known to draw firm conclusions. More studies are needed before meta-analytic procedures can be effectively used on community studies (Proctor, 1996).

Outcome should not be the only focus of treatment effectiveness research. Research that examines what are the critical treatment factors is also necessary in informing which treatment works for sexual offenders. That is, we need to identify the important variables that could influence treatment outcome. Such research then does not simply depend upon comparison of treatment outcome, but rather on identifying the factors that change through treatment. The aim of such research is therefore to enhance change through the identification of such variables, in order to inform and improve future treatment programs.

Importantly, process evaluations are concerned with the dynamic factors (as opposed to static factors) that might change as a result of treatment (Marshall, Anderson, & Fernandez, 1999). Dynamic factors can be subdivided into those that are stable and enduring (lasting for six to twelve months, such as attitudes or emotional regulation), or more acute (e.g., substance use), which can change episodically and are often relevant with regards to the timing of an offence (Hudson et al., 2002). Dynamic factors have been developed into actuarial measures, which include the currently used Sex Offender Need Assessment Rating (SONAR; Hanson & Harris, 2000).

Dynamic factors can inform program evaluation and treatment development by allowing assessment of how an individual changed over the course of treatment as well as adding to the overall prediction of risk. Specific dynamic factors, such as deviant attitudes, are important treatment goals that cannot be ignored (Beech et al., 2002). Thornton (2002) found that recidivists and 'one-off' offenders could be distinguished through the use of stable dynamic factors, commonly used in a range of stable actuarial measures. Beech et al. (2002) found similar results. Hudson et al. (2002) commented on the advantage of assessing acute dynamic factors for those who are responsible for supervising offenders in the community, with regards to making decisions about release. Nonetheless, whilst the Hudson et al. results provide growing support for the assessment of stable dynamic factors, there are other studies that have found only small non-significant changes in dynamic factors following treatment (for example, Miller et al., 2005). Therefore, further exploration of change in acute dynamic items is required.

Hanson et al. (2007) examined the use of both stable and acute dynamic factors in order to inform client supervision, and to explore the role dynamic factors play with regards to recidivism. Their aim was also to develop other empirically based actuarial measures of stable and acute risk, building on the SONAR. Their findings, achieved over an average 3.5 year follow-up, showed that the combination of static, stable and acute dynamic factors add meaningful information to the *prediction* of recidivism risk. That is, supervising (probationary) officers were able to identify the contemporary individual dynamic characteristics related to recidivism. However, Hanson et al. found that actual changes on acute factors, and some dynamic factors, were not necessarily related to risk. Given the mixed findings from Hanson et al.'s (2007) research, the aim of the current study was to assess what changes occurred with regards to dynamic risk in a community based sex offender treatment program. The current study is exploratory in that it attempts to provide new data on a community program with lower risk offenders with little or no history of either treatment or incarceration.

Method

Participants

Participants consisted of 33 males who were aged 18 and over (M = 44.2; SD = 12.2), who had commenced the program from August 1996, and had dropped out of, or completed treatment up to early 2007. The participants were all charged with, or had reported, child-related sex offences, and no offenders with sexually abusive behaviour against adults (unless there were child-related charges also) were accepted. The program runs at a facility operated by the Uniting Care Church based in North Parramatta, Sydney. The majority of participants were referred by Probation and Parole / Corrective Services (13 / 39.4%), or referred from gaol following treatment (1 / 3.0%); 7 (21.2%) were Church-referred, and 5 (15.2%) through child

protection services. 2 (6.1%) self-referred; 3 (9.1%) were referred by family or friends, and 2 (6.1%) by a clinician or lawyer (respectively). The participant referred from gaol had received approximately thirty-four weeks of sex offender treatment. He was one of 4 participants (12.1%) that had documented prior treatment, although details as to the treatment of the remaining three participants are unknown.

All participants completed an initial interview to assess their eligibility for inclusion in the program. Prospective participants were only excluded if they could not participate in the program as a result of intellectual disability, active drug and alcohol dependence, or current psychosis. However, as no-one has ever been excluded from the program, the abovementioned criteria have never had to be applied. Thirty-one of the participants were of Anglo-Australian background (93.9%), with 1 Indigenous male (3.0%) and 1 male of European descent (3.0%). Overall, 5 had education at least to Year 10 (15.1%), with 4 of these (12.1%) to Year 12 equivalent, and 18 (54.5%) to tertiary level. 10 (30.3%) had less than Year 10 equivalent education. Over half were married at the time of entering the program (19 / 57.6%), and 8 (24.2%) were single, 4 (12.1%) separated and 2 (6.1%) divorced.

Offences involving penetration were recorded for 13 (39.4%) of the participants, whereas 16 (48.9%) involved other forms of sexual contact, and 4 (12.1%) were non-contact (including child pornography and exhibitionism). Twenty-seven (81.8%) of the participants had multiples offences, and 25 (75.8%) of the group were charged with their offences. Twenty-seven participants (81.8%) had current offences.

Outcome Measures

Static Risk: For the purpose of this research, each participant was assessed using the STATIC-99 (Harris et al., 2003), which measures static or historical factors. The STATIC-99 is a ten-item measure that is clinician-rated. The items include information about the offenders' conviction history, types of victims, in addition to their age and marital status. It makes an assessment as to the offenders' risk status, providing an overall score related to risk of recidivism that ranges from 0 (low risk) to 12. Scores of 6 or more are rated as high risk. Some participants were rated upon entry into the program, others were retrospectively assigned Static-99 ratings based on file information as their risk stood at the time they joined the program. The STATIC-99 has been shown by Harris and colleagues to distinguish sexual recidivists (r = .33; ROC AUC .71) and violent recidivists (r = .32; ROC AUC: .69) from non-recidivists for similar crimes.

Dynamic Risk: The participants were assessed against the Sex Offender Need Assessment Rating – SONAR (Hanson and Harris, 2000). This is a tool which measures dynamic factors that are amenable to change. The SONAR is a nine-item measure that is split into five stable items, which are longer standing (intimacy deficits, negative social influences, attitudes tolerant of sexual offending, sexual self-regulation, and general self-regulation), in addition to four shorter-term and more acute factors (substance abuse, negative mood, anger, and access to victims). Five of the 'stable' items are scored on each item between 0 and 3, and the four remaining 'acute' items are each rated between -1 to 1. Unless otherwise specified, the total items are rated over a twelve-month preceding period. After scoring all the items, the total scores can range from -4 to 14. The following nominal categories with regard to risk of recidivism were identified: -4 – 3 is considered low risk, 4 - 5 is low-moderate, 6 - 7 is moderate risk, 8 – 9 is moderate-high, and 10 – 14 is high risk.

The SONAR shows reasonable internal consistency for research purposes (alpha = .67). Participants were retrospectively assessed against the SONAR, upon entry to the program from pre-assessment data, and also following their completion or drop out, on the basis of their documented progress during the group, in order to assess for any change over the process of treatment.

Treatment

The Sex Offender Treatment Program is run by male facilitators with training in both psychology and theology. It is a 78-hour program with sessions of two-hour duration predominantly on a weekly basis, but with school-holiday breaks, which means that a standard program can run for up to three years. Approximately 27 sessions are held per year. The program content is built on a CBT framework but with a basis in Christian doctrine. The program encompasses modules on victim empathy, cognitive distortions and removing fantasies, improving social behaviour through training in assertiveness, coping skills, and appropriate relationships. It focuses on the triggers to an offence cycle and implementing appropriate control and self-management strategies. There are references to theology throughout the program to reinforce learning. Participants are not required to be currently practising Christians, but they must be respectful of the theology inherent within the program. The program is cyclical and module based, and so new participants enter at the beginning of a module. Hence participants may take modules in varying sequences depending on their point of entry, although modules are only repeated if the participants remain in the program after the completion date. There are also aftercare meetings, approximately twice yearly for willing participants, although no formal data is kept on this unless a risk issue arises. Referrals

for the program have been steadily increasing since its inception.

Procedure

As part of a larger battery of assessments, clients underwent an assessment conducted by the principal psychologist conducting the program, either at the treatment offices or at gaol. Participants were retrospectively assessed against the STATIC-99 as at commencement of the program, and also retrospectively on the SONAR on the basis of pre-assessment data, and at the end or their termination in the program. All of the SONAR ratings were completed retrospectively because this was a new measure that was added to the program evaluation project. The senior author, not associated with the program discussed ten of the ratings with the principal rating clinician to ensure reliability in assessment on the STATIC-99 and the SONAR, thus setting a benchmark for rating the other clients.

Results

Treatment completion

There were a significant number of participants who did not complete the program: 15 participants left the program early (45.5%). 2 (6.1%) of these had completed their parole requirements, 2 (6.1%) were gaoled on their prior (index) offences, whereas the remaining 11 (33.3%) left for other reasons. Of these 15 participants, the amount of time spent in treatment ranged between 7 and 55 sessions (median = 27 sessions). The mean amount of time for the treatment dropout group spent in treatment was 28.33 sessions (SD = 17.25).

Of the 18 (54.5%) that completed the full program, 10 (30.3%) of these remained in the program some time after they had officially completed the program. The mean amount of time spent in treatment for completers was 82.5 sessions (SD = 13.89), with a median of 78 sessions. Analyses have been conducted both with and without treatment dropouts, so that the results are not further inflated by only those who completed the program. The amount of time spent in treatment for both treatment completers and drop-outs is shown in Table 2.

Table 2: Time spent in treatment (by sessions)

	Treatment completers $N = 18$	Treatment dropouts $N = 15$	Total sample $N = 33$
Mean	82.5	28.33	57.88
SD	13.89	17.25	31.35
Median	78	27	78

Descriptive statistics for the two groups were also compared to assess for any disparity. No significant differences were found between the groups in relation to age (t = -.123 NS); ethnicity ($\chi^2(2, N = 33) = 0.362$, NS); education ($\chi^2(4, N = 33) = 0.473$, NS); marital status ($\chi^2(3, N = 33) = 0.347$, NS), and offence type ($\chi^2(2, N = 33) = 0.295$, NS).

Static Risk

The mean total score for the participants was 1.97 (SD = 2.56). Over half (19 (57.6%) fell within the low risk range; 7 (21.2%) in the moderate-low range; 4 (12.1%) in the moderate-high, and 3 (9.1%) in the high range. These results indicate the low risk status of the current sample, which is not surprising given their community status and the fact that some participants had not been charged with their offences. The results have been further separated into treatment completers and dropouts, as noted in Table 3. There was no significant difference between treatment dropouts and completers when the STATIC-99 scores were compared. This is not surprising given that only one participant from the high risk group dropped out of the program, albeit after eighteen months of treatment, and one participant from the moderate-high group, once he had satisfied his parole requirements (two years of treatment).

Table 3: STATIC-99 scores as separated by whether or not completed treatment

	Treatment completers $N = 18$	Treatment dropouts $N = 15$	Total sample $N = 33$
Mean	2.06	1.87	1.97
SD	2.69	2.48	2.56
Median	1.00	1.00	1.00

Relationship between Static and Dynamic Risk

Given that ratings on the STATIC-99 were available, a brief analysis was performed to see whether there was any correlation between the total STATIC-99 scores and the pre-treatment SONAR scores. This was done to assess whether measuring dynamic factors gives information over and above measuring the static factors alone. An analysis using Pearson's correlation coefficient was not significant. That is, it seems the SONAR provides information about the offenders that is independent of static risk factors.

Dynamic Risk

Analysis of the total SONAR scores completed on each of the 33 participants showed that pre-treatment-SONAR scores were significantly higher (M = 3.94; SD = 2.15) as compared with the post-treatment SONAR scores (M = .82; SD = 3.15; t = 5.784; df = 32; p = <.001). The results have been further separated into treatment completers and dropouts, as noted in Table 4.

When the analysis was performed with only treatment completers, a significant result remained (t = 6.175; df = 17; p = <.001). The treatment completers and treatment dropouts were not significantly different when the pre-treatment scores were compared.

Table 4: SONAR pre and post-treatment scores for treatment completers and drop-outs

	SONAR pre-treatment		SONAR post-treatment	
	Treatment completers N = 18	Treatment dropouts N = 15	Treatment completers N = 18	Treatment dropouts N = 15
Mean	4.00	3.87	-.50	2.40
SD	1.88	2.50	2.09	3.52
Median	4.00	3.00	-1.00	1.00

Given the significant result, the second analysis performed was to descriptively assess the degree of change for participants in their rated categories of risk at the pre and post level. These are detailed in Table 5. Since most clinicians use rating classifications over total scores, it was felt that assessing the degree of change in risk classification would be important.

Table 5: Pre and post SONAR risk category change

Pre scores	Post scores: Low	Low-Mod	Mod	Mod - High	TOTAL
Low	15	1	1	0	*17*
Low-Mod	9	0	0	0	*9*
Moderate	3	0	1	0	*4*
Mod - High	1	0	1	1	*3*
TOTAL	*28*	*1*	*3*	*1*	*33*

Table 5 shows that whilst 17 participants scored in the low risk category at pre-treatment, 28 were rated at low risk upon completion of the program. It was not possible to calculate a meaningful chi-square for the participants by each risk level due the large number of empty cells. However, a chi square comparing the proportions that change from or into the low risk group by treatment end was significant ($\chi^2(1, N = 33) = 16.26$, p = .62). No-one in the program, either prior to or following treatment, were rated in the highest risk category (scoring 10 +) despite two people scoring in the high risk on the STATIC-99. This probably indicates the predominately lower risk nature of the participants, in that high risk offenders are generally incarcerated and not initially given the opportunity for community treatment due to their risk status.

Table 6: Individual dynamic factors (n = 33)

SONAR factors	***Score***	***Pre-treatment (%)***	***Post-treatment (%)***	***df***	**Pearson value**	**Significance**
Intimacy deficits	0	6.1	51.5	4	15.18	.004
	1	48.5	15.2			
	2	45.5	33.3			
Social influences	0	42.4	75.8	4	21.86	.000
	1	33.3	9.1			
	2	24.2	15.2			
Attitudes	0	97	100	Not computed due to empty cells		
	1	0	0			
	2	3	0			
Sexual regulation	0	27.3	93.9	2	1.41	NS
	1	51.5	6.1			
	2	21.2	0			
General regulation	0	45.5	60.6	4	24.47	.000
	1	42.4	27.3			
	2	12.4	12.1			
Substance abuse	better	6.1	6.1	4	24.24	.000
	same	90.9	90.9			
	worse	3	3			
Negative mood	better	0	48.5	2	10.50	.005
	same	42.4	39.4			
	worse	57.6	12.1			
Anger / hostility	better	0	15.2	2	5.89	.053
	same	81.8	72.7			
	worse	18.2	12.1			
Victim access	better	72.7	60.6	4	1.30	NS
	same	21.2	33.3			
	worse	6.1	6.1			

A further analysis explored change on individual factors captured by the SONAR. As individual factors are rated on an essentially categorical scale (for each item, participants are given a numerical score which corresponds to a category of risk), individual factors were compared at pre- and post-treatment via chi square tests. The results are detailed in Table 6.

With regards to intimacy deficits, most of the participants moved from a pre-treatment score of 2 to 0 at post treatment. Comparable results were found on the remaining stable factors of social influences and general self-regulation. On the factor substance abuse most scores remained at 0, and with regards to the negative mood factor, participants moved from 0 and 1 scores to 0 and -1 scores respectively. Factors on which participants did not significantly change were sexual attitudes, sexual self-regulation, hostility and opportunity for victim access.

All of the analyses were repeated without treatment drop-outs (completers only), and the results achieved mostly remained the same. That is, there remained a significant difference between pre-SONAR and post-SONAR treatment scores as noted earlier. With regards to the individual SONAR factors, four of the five factors for the whole treatment sample remained significant. The only result that changed was that the intimacy deficits item, which became non-significant once treatment dropouts were excluded. The new results are summarised in Table 7.

Table 7: Significant individual dynamic factors re-analysed (n = 18)

SONAR factors	***df***	**Pearson value**	**Significance**
Intimacy deficits	4	3.62	NS
Social influences	4	10.50	.033
General regulation	2	7.20	.027
Substance abuse	2	18.00	.000
Negative mood	2	9.66	.000

Discussion

The current study adds to the increasing acknowledgement of the importance of dynamic risk factors in sex offender treatment. The non-significant correlation between the STATIC-99 and SONAR pre-treatment scores indicates that they do not tap into the same domains of information with regards to participant risk factors. That is, the results indicate that the STATIC-99 and SONAR measures are quite different and hence the SONAR can add particular value to risk assessment. This is consistent with findings that document the merit in using dynamic factors in addition to static factors (Thornton, 2002; Beech et al., 2002).

There were statistically significant differences between pre- and post-SONAR ratings, which led to more offenders being rated at low risk of recidivism following treatment than before treatment. The individual factors that significantly changed were improvements in intimacy and relationships; social influences and supports; self-regulation to supervision and treatment; reduction in substance abuse, and changes to negative mood. Once treatment drop-outs were removed, the only change in results was that intimacy deficits became non-significant. It is possible that this change could have resulted from the smaller sample group and less power to detect a real difference.

It is not surprising that these abovementioned factors in particular changed significantly given the CBT focus in the current treatment. These findings were generally consistent with other studies that showed the significance of dynamic factors in informing treatment and risk information for sex offenders (Beech et al., 2002; Thornton, 2002; Hanson et al., 2007). Given dynamic factors are shown to predict recidivism rates, it is heartening that the community based program changed factors such that the predicted risk of recidivism is reduced. Further research is necessary however to explore whether these results are maintained over time, given that there is limited information about the continuation of dynamic change.

Factors on which participants did not significantly change were sexual attitudes, sexual self-regulation, hostility and opportunity for victim access. Some of these non-significant results were surprising, particularly with regards to attitudes, which has been shown to be important pertaining to recidivism (Hanson et al., 2007) and highlights the necessity for longer-term evaluation. Hanson and colleagues believed that their non-significant result with regards to attitudes may have resulted from the fact that there is no one good method to assess sexual attitudes. Certainly, given the broad nature of sexual attitudes and how important this is in the treatment process, an additional measure of this kind as opposed to facilitator-rated alone could have provided more meaning to the current findings. However, the current finding may result from the small sample size and lack of variance in the pre and post scores obtained.

The lack of change on hostility and sexual self-regulation factors was also unanticipated. It may result from the fact that hostility is not addressed in the treatment program per se, however one would expect that sexual regulation would have changed as this is a treatment focus. Again, with a larger sample size, perhaps different results could be anticipated. However, given the presumed importance for self-regulation in offending, the lack of change indicates the need for longer-term follow-ups than was possible for the current study.

Opportunity for victim access was not a surprising non-significant result in this case. It is known that many of the participants were made to limit their access to

victims (leaving home, reduce contact with potential victims such as coaching sports teams etc.) prior to treatment, and this was encouraged throughout the program. To this end, this factor did not change much over time as it was mostly at a desirable level, and hence accounts for the non-significant result.

Policy Implications

The current paper shows community-based treatment results in a change in risk factors immediately following treatment, and may thereby moderate recidivism. The findings, lend support to the growing literature arguing for community based programs (see Table 1). There are many offenders who are receiving community based orders or less time incarcerated with some degree of supervision in the community, and so the need for outpatient treatment has increased in recent years. If such changes could be maintained then there would be stronger evidence for the effectiveness of community based treatment. It is imperative that community based programs put in systems that allow for post-treatment completion tracking of participants, although to date a combination of privacy laws, ethics committee rules, and participants seeking to distance themselves from their past once their 'time' in treatment has been completed make such procedures difficult.

McGrath (1998) raises the issue of overcrowding in gaols and the scarcity of places in treatment programs, which is also a reality here in Australia. To this end, in order to meet the supply and demand of all sexual offenders, treatment should be readily available in the community (Brown, 2005). Brown also comments that lower-risk offenders or those with escalating but not convicted sexual abusive behaviour may be willing to access outpatient treatment on a voluntary basis. This was certainly the case for many of the current participants, some of whom had not been charged per se but had come forward with the help of family and friends, in order to attempt to address their sexual abuse behaviour. Moreover, there is the genuine issue that some offenders are convicted only once and many are rated as lower risk (Quinsey et al, 1995), as is the case again for many of the current lower-risk participants. Such low-risk clients frequently receive community-based orders, and so there is need to reach as many offenders as possible who remain in the community.

This study aimed to explore dynamic factors through an evaluation of a community based treatment program. To date encouraging changes in risk have been identified. Whilst it would be preferable for an evaluation to include a lengthy follow-up, the merits of a short-term evaluation cannot be ignored with respect to trying to identify how to improve treatment and build towards more evidence-based practice. Short-term evaluations represent a base line against which change over time can be effectively measured. Also, the other issue is that since low risk offenders tend to show low rates of recidivism and as most of the offenders were low risk, recidivism rates should be correspondingly low. Nonetheless, there is an urgent need to extend the follow-up time, since research has consistently shown that risk increases with time post-release from gaol. Despite the lack of recidivism data an advantage of an outcome evaluation such as this is that it provides formative feedback to the program allowing it to adapt and improve upon its treatment methods. Given the lack of guidance in establishing community programs such formative evaluations are useful in improving program integrity and providing benchmarking studies. Longer-term follow-up data is required (and being planned) to assess the extent to which changes have been consolidated.

A significant limitation of this study is the fact that we do not have recidivism data for these 33 participants (based on reconviction data). We are only aware that three participants reoffended – all of whom had not completed the full program. Unfortunately, the researchers entered into this evaluation at a later time, when it was impossible to objectively collect such reconviction data due to some participants having left up to ten years ago and their whereabouts are unknown. Ideally, future studies will gain the cooperation of the Departments of Corrective Services and Attorney Generals to provide recidivism data to complement the evaluation interviews.

Additionally, it is acknowledged that the lack of inter-rater reliability significantly limits the conclusions reached although attempts were made to ensure a standardised assessment of risk took place. The results obtained here should also be considered exploratory given the small sample size. Further, we have not controlled for other factors that could have resulted in the changes in dynamic risk factors other than the treatment delivered, such as maturation, other external supports and services etc. Preferably, if available to us, we would have used a controlled sample to match with these participants on a number of required variables. This would have helped attribute dynamic risk changes to the CBT program. Again, unfortunately, a comparison group was unobtainable.

Despite these shortcomings, we remain firm in our belief that the results of the current are important: the data obtained has helped reinforce literature in the area on the increasing weight being placed on dynamic risk factors in sex offender treatment programs. The importance of static risk has been established, however studies show that dynamic factors represent an essential aspect of offender risk assessment and treatment need information. Additionally, such risk factors help demonstrate how treatment is effective in assessing the degree of individual change observed. This research has

allowed us to infer that this community treatment program has helped address some of the criminogenic needs of the current sample. To this end, this small 'jigsaw piece' (Proctor, 1996) research has helped illustrate why community based treatment programs are needed, and why the importance is upon treatment change. As such, we continue to move away from the early 'nothing works' research in order to further explore and better understand exactly 'what works'.

References

Alexander, M. A. (1999). Sexual offender treatment efficacy revisited. *Sexual Abuse: A Journal of Research and Treatment, 11,* 101-116.

Bingham, J. E., & Turner, B. W. (1995). Treatment of sexual offenders in an outpatient community-based program. *Psychological Report, 76*, 1195-1200.

Beech, A., Friendship, C., Erikson, M., & Hanson, R. K. (2002). The relationship between static and dynamic risk factors and reconviction in a sample of U.K. child abusers. *Sexual Abuse: A Journal of Research and Treatment, 14*, 155-167.

Blair, C. D., and Lanyon, R. I. (1981). Exhibitionism: Etiology and treatment. *Psychological Bulletin, 89,* 439-463.

Brown, S. (2005). *Treating sex offenders: An introduction to sex offender treatment programmes*. Devon, United Kingdom: Willan Publishing.

Furby, L., Weinrott, M.R., and Blackshaw, L. (1989). Sex offender recidivism: A review. *Psychological Bulletin, 105*, 3-30.

Hall, G. C. N. (1995). Sexual offender recidivism revisited: A meta-analysis of recent treatment studies. *Journal of Consulting and Clinical Psychology, 63*, 802-809.

Hanson, R. K., & Bussière, M. T. (1998). Predicting relapse: A meta-analysis of sexual offender recidivism studies. *Journal of Consulting and Clinical Psychology, 66*, 348-362.

Hanson, R. K., & Harris, A. (2000). *The Sex Offender Need Assessment Rating (SONAR): A method for measuring change in risk levels.* User Report 2000-01. Ottawa: Public Safety and Emergency Preparedness Canada.

Hanson, R. K., & Morton-Bourgon, K. E. (2005). The characteristics of persistent sexual offenders: A meta-analysis of recidivism studies. *Journal of Consulting and Clinical Psychology, 73*, 1154-1163.

Hanson, R. K., & Thornton, D. (2000). Improving risk assessments for sex offenders: A comparison of three actuarial scales. *Law and Human Behaviour, 24*, 119-136.

Hanson, R. K., Broom, I., & Stephenson, M. (2004). Evaluating community sex offender treatment programs: A 12-year follow-up of 724 offenders. *Canadian Journal of Behavioural Science, 36,* 87-96.

Hanson, R. K., Gordon, A., Harris, A. J. R., Marques, J. K., Murphy, W., Quinsey, V. L., & Seto, M. C. (2002). First report of the collaborative outcome data project on the effectiveness of psychological treatment for sex offenders. *Sexual Abuse: A Journal of Research and Treatment, 14*, 169-193.

Hanson, R. K., Harris, A. J. R., Scott, T., & Helmus, L. (2007). *Assessing the risk of sexual offenders on community supervision: The Dynamic Supervision Project.* User Report 2007. Ottawa: Public Safety Canada. (Available from www.publicsafety.gc.ca under "publications", "corrections", then "reports and manuals".)

Harris, A., Phenix, A., Hanson, R. K., and Thornton, D. (2003). *STATIC-99 Coding Rules Revised – 2003*. www.sgc.gc.ca (click on Corrections reports for 2003).

Hudson, S. M., Wales, D. S., Bakker, L., & Ward, T. (2002). Dynamic risk factors: The Kia Marama evaluation. *Sexual Abuse: A Journal of Research and Treatment, 14*, 104 – 119.

Lambie, I. D., & Stewart, M. W. (2003). *Community Solutions for the Community's Problem: An outcome evaluation of three New Zealand community child sex offender treatment programmes.* Wellington: New Zealand Department of Corrections.

Lee, J. K. P., Proeve, M. J., Lancaster, M., & Jackson, H. J. (1996). An evaluation and 1-year follow-up study of a community-based treatment for sex offenders. *Australian Psychologist, 31*, 147-152.

Losel, F., & Schmucker, M. (2005). The effectiveness of treatment for sexual offenders: A comprehensive meta-analysis. *Journal of Experimental Criminology, 1*, 117-146.

Marques, J. K., Wiederanders, M., Day, D. M., Nelson, C., & Van-Ommeren, A. (2005). Effects of a relapse prevention program on sexual recidivism: Final results from California's Sex Offender Treatment and Evaluation Project (SOTEP). *Sexual Abuse: A Journal of Research and Treatment, 17,* 79-107.

Marshall, W. L., & Barbaree, H. E. (1988). The long-term evaluation of a behavioural treatment program for child molesters. *Behaviour Research and Therapy, 26*, 499-511.

Marshall, W. L., Anderson, D., & Fernandez, Y. (1999). *Cognitive behavioural treatment of sexual offenders.* Chichester: Wiley.

McGrath, R. J., Cumming, G., Livingston, J. A., & Hoke, S. E. (2003). Outcome of a treatment program for adult sex offenders: from prison to community. *Journal of Interpersonal Violence, 18*, 3-18.

McGrath, R. J., Hoke, S. E., & Vojtisek, J. E. (1998). Cognitive-behavioural treatment of sex offenders: A treatment comparison and long-term follow-up study. *Criminal Justice and Behaviour, 25*, 203-246.

Miller, H. A., Young, B. A., Torres, A., McCoy, W., & Kwartner, P. (2005). *The utility of the Sexual Offender Needs Assessment Rating scale (SONAR) in*

a prison-based treatment program. Presentation at the 24th Annual Research and Treatment Conference of the Association for the Treatment of Sexual Abusers, Salt Lake City, UT.

Procter, E. (1996). A five year outcome evaluation of a community-based treatment programme for convicted sexual offenders run by the probation service. *Journal of Sexual Aggression, 2*, 3-16.

Quinsey, V. L., Harris, G. T., Rice, M. E., & Lalumiere, M. L. (1993). Assessing the treatment efficacy in outcome studies of sex offenders. *Journal of Interpersonal Violence, 8,* 512-523.

Quinsey, V. L., Rice, M. E., & Harris, G. T. (1995). Actuarial prediction of sexual recidivism. *Journal of Interpersonal Violence. 10,* 85-105.

Schweitzer, R., & Dwyer, J. (2003). Sex crime recidivism: Evaluation of a sexual offender treatment program. *Journal of Interpersonal Violence, 18*, 1292-1310.

Thornton, D. (2002). Constructing and testing a framework for dynamic risk assessment. *Sexual Abuse: A Journal of Research and Treatment, 14*, 139-153.

Sexual Abuse in Australia and New Zealand, January 2009; 1(2): 98-101

A Minimal Scale for Assessment of Multiple Offending Risk in Sexual Offenders Against Children

Michael Proeve
School of Psychology, University of South Australia

Abstract

The development of a four-item scale for the prediction of sexual offending against multiple victims is described. The scale is scored from offender age and details of the victim's age, gender, and relationship to victim. The scale showed high inter-rater reliability for the individual items and the scale as a whole. Validity in predicting multiple offending in a community sample of sexual offenders against children and in a sub-sample of voluntarily-referred offenders was moderate. The scale had a positive and moderately large correlation with the RRASOR. The scale may be useful for risk assessment of child molesters in circumstances where minimal collaborative information about sexual offending is available.

Introduction

Considerable research efforts have been directed towards identifying those factors that are associated with sexual recidivism (e.g., Hanson & Bussiere, 1998; Hanson & Thornton, 1999; Hanson & Harris, 2001). As a result of these efforts, promising risk assessment measures designed specifically for use with perpetrators of sexual offences have been developed.

Of available actuarial instruments, the *Rapid Risk Assessment for Sexual Offense Recidivism* (RRASOR; Hanson, 1997) and Static-99 (Hanson & Thornton, 1999) are well supported by predictive validity studies. The RRASOR has high inter-rater reliability and considerable evidence of predictive validity from at least seventeen studies (Doren, 2002). The *Static-99* was developed by adding additional static risk factors to the RRASOR in an attempt to improve coverage of risk variables. The Static-99 has high inter-rater reliability and evidence of predictive validity from at least fifteen studies (Doren, 2002).

The structured guideline approach to risk assessment is an alternative to actuarial instruments. The *Sexual Violence Risk-20* (SVR-20; Boer, Hart, Kropp, & Webster, 1997) is a structured clinical guideline instrument that includes both static and dynamic risk factors. The SVR-20 has been found in one study to predict sexual recidivism more accurately than the Static-99 (de Vogel, de Ruiter, van Beek, & Mead, 2004).

Sexual offender risk assessment instruments such as the Static-99 are validated against official recidivism records of convicted sexual offenders in correctional institutions. Although a great deal of assessment of sexual offending risk concerns convicted offenders in institutional or community settings, assessment of non-convicted individuals may be required on some occasions. For example, risk assessment of individuals who have been charged but not convicted of sexual offences may be requested by child protection agencies that make decisions about access to other children.

This article concerns the development of a brief scale for assessing risk of offences against multiple child victims in sexual offenders who have not necessarily been previously convicted of sexual offences. The data were drawn from a database which is reported in more detail in Proeve, Day, Mohr, and Hawkins (2006), from a community-based treatment service that primarily assesses and treats adults who offend sexually against children and adolescents. The program provides services for both mandated clients (who attend as a condition of parole or at the discretion of their supervising officer) and voluntary clients. Voluntary clients are defined as those with no legal compulsion to attend. Voluntary clients may be referred to the program by family services agencies, police, community health agencies, or by self-referral.

Although referred mandated clients may be accompanied by considerable documentation relating to offences, voluntary clients are typically accompanied by considerably less information. For this reason, it may be necessary to rely on client self-report for information about previous offending, which is necessary to score instruments such as the Static-99. Self-reported information about previous offending may be unreliable, which may result in underestimation of risk when standard risk instruments are used. This article reflects an attempt to develop a risk assessment instrument for circumstances in which little documentation about previous offending is available. The instrument described does not rely on previous offending information, but rather concerns only details about the most recent victim and uncontroversial information about the offender.

Correspondence: Michael Proeve, School of Psychology, University of South Australia, City East Campus, GPO Box 2471, Adelaide SA 5001, Australia. Email: Michael.proeve@unisa.edu.au

ISSN 0833-8488

As part of the original study by Proeve et al. (2006), predictors of offending against more than one victim were obtained. This outcome includes recidivistic offending but is not the same as recidivism. *Recidivism* concerns sexual offending following disclosure, charges, punishment and perhaps treatment. *Multiple offending* concerns sexual offending against more than one victim, which may have taken place prior to disclosure. By assessing multiple offending, the authors were able to assess predictive variables against a higher proportion of multiple offenders than would have been possible had the outcome criterion of recidivism been used.

Interestingly, the factors found by Proeve, Day, Mohr, and Hawkins (2006) to predict multiple offending included age of offender less than 25, any unrelated victims, any male victims, and sexual abuse in childhood. These variables are also found in the Static-99, which predicts recidivism, with the exception of experiencing sexual abuse.

The scale reported in this article was created for the assessment of likely multiple offending in circumstances where limited information is available to corroborate offender self-report. It is not intended to replace the Static-99, which is a moderately good predictor of recidivism with a great deal of research support. Where the Static-99 can be used, it should be used. However, the Static-99 requires information about previous offending. In circumstances where risk assessment is required for clients who present with no information about previous offending aside from their own uncorroborated report, this scale may be useful. When a client's scale score suggests that multiple offending is likely, the assessor may make more cautious recommendations concerning the client's access to children or may recommend a treatment program of greater intensity.

Method

Participants

Case files for 324 sexual offenders were obtained in 2002-2003 from a South Australian community-based treatment service primarily for adults who offend sexually against children and adolescents, including both clients mandated to attend and voluntary clients. Voluntary clients included all those who were not mandated to attend the service. They included clients who had been arrested or charged by police for sexual offences against children but not convicted, clients referred by family welfare, community health, or mental health agencies, as well as self-referred clients. In accordance with local laws relating to mandatory reporting of child abuse, voluntary participants were advised at the time of assessment that undeclared offences against children would be reported to the relevant child protection agency.

The mean age of the sample at the time of the earliest offence was 42.4 years (SD = 12.5). Two hundred and twenty-six clients (69.8%) were mandated to attend the service due to parole or bond conditions, while 98 clients (30.2%) were attending voluntarily, often prior to charges or convictions being laid or following completion of a parole mandate. Offenders with more than one victim comprised 36.4% (n = 118) of the sample. Two hundred and thirty-two offenders (72.2%) in the sample had female victims only, 19.1% (n = 62) had only male victims and 7.4% (n = 24) had both male and female victims. Of the total sample, 48.5% of offenders (n = 157) had familial victims only, 42.0% (n = 136) had only non-familial victims and 8.6% (n = 28) had victims in both relationship categories. A large proportion of participants (41.4%) had a history of non-sexual offending. The most common types of non-sexual offences were property-related offences and traffic offences.

Procedure

Variables coded from client files in the original study included offender demographic details at time of assessment and at the time of the offence(s), offending history variables, developmental variables and relationship variables. Variables were coded from client assessment reports, as well as from supplementary information (for example, sentencing remarks or other professional reports). Details of sexual and non-sexual offending were coded according to the main categories used by police for legally charging an individual in South Australia. Sexual offending was, therefore, separated into rape, indecent assault, unlawful sexual intercourse, indecent exposure or behaviour, and other sexual offending (such as gross indecency and prurient interest).

A victim was counted if there was a conviction, charge, or allegation supported by substantial details. This inclusive criterion for counting victims was adopted because of underestimation of sexual offending in official records of charges and convictions (Heil, Ahlmeyer, & Simons, 2003). Analysis was confined to those cases in which the first known offence resulted in referral to the service prior to 2002. This selection aimed at giving all cases some opportunity to re-offend, 2 years being chosen as a modest time frame for this purpose.

Thirty cases were scored independently to assess inter-rater reliability as part of the Proeve et al. (2006) study. For the offender categories, reliabilities ranged from excellent to moderate (Kraemer, 1992). For categorical variables, mean inter-rater reliability was κ = .74, ranging from 1.00 to .64.

In order to develop the scale reported in this study, only variables concerned with basic and uncontroversial demographic information about the client and about his most recent child victim were considered. All items were found to be reliably coded. The items considered for the scale were included if they were (a) coded categorically as present or absent; (b) easily ascertained and likely to be reliable; (c) correlated significantly with multiple offending.

Results

Four items which met the criteria of being easily obtainable, categorically coded, and correlated significantly with multiple offending were obtained. These items are shown in Table 1, and instructions for coding are shown in Appendix A. The four items were combined in an additive scale with the acronym AGVAR, for *A*ge of offender at time of assessment, *G*ender of most recent victim, *V*ictim *A*ge at time of first offence, and *R*elationship to victim. Inter-rater reliabilities were calculated for the four items, based on 30 cases. Results are shown in Table 1. Reliability, measured by the Kappa statistic, was high for the AGVAR items, ranging from .77 to 1.00. Inter-rater reliability for the AGVAR total score, measured by Pearson's correlation, was high at r (30) = .92.

The correlations of the four variables with multiple offending correlated from .13 for victim age to .24 for age of offender and relationship to victim. The total scale score correlated .32 with multiple offending. Receiver Operating Curve analysis on the scale score showed moderate predictive validity. Area under the curve (AUC) was .68 +/- .03 with 95% confidence intervals of .62 to .74.

Table 1. Relationship of AGVAR scale variables to offending against multiple victims and inter-rater reliability of variables

Variable	χ^2	Φ	Reliability
Age of offender	17.42***	.24	1.00†
Gender of victim	7.35**	.15	1.00†
Victim age	5.15*	.13	.77†
Relationship to victim	18.09***	.24	.92†
Scale Score	31.72***	.32	.92‡

* $p < .05$, ** $p < .01$, *** $p < .001$. † measured by κ; ‡ measured by r.

Table 2 shows the percentage of multiple offenders at each score level. With increasing score, there was an increase in the percentage of multiple offenders, from 14.3% of those who obtained a score of 0, to 72.7 % of those who obtained a score of 4.

Table 2. Relationship of AGVAR scale scores to the proportion of offenders against multiple victims

Score	Multiple victim offenders (all offenders)	%	Multiple victim offenders (voluntary)	%
0	5/35	14.3	2/12	16.7
1	31/123	25.2	10/40	25.0
2	43/103	41.7	13/31	41.9
3	28/48	58.3	11/11	100.0
4	8/11	72.7	1/2	50.0

For the group of voluntary offenders only (n = 96), the total scale score correlated .49 with multiple offending. Receiver Operating Curve analysis on the scale score showed moderate predictive validity. The AUC was .73 +/- .06 with 95% confidence intervals of .62 to .84.

Table 2 also shows the percentage of multiple offenders at each score level for voluntary offenders only. With increasing scores, there was an increase in the percentage of multiple offenders, from 16.7% of those who obtained a score of 0 to 100% of those who obtained a score of 3. Of the two voluntary offenders with a score of 4, one had multiple victims.

In order to assess convergent validity of the AGVAR scale, scores on the Rapid Risk Assessment for Sexual Recidivism (RRASOR) were calculated from variables in the database for mandated offenders. Scores on the RRASOR were correlated significantly with scores on the AGVAR total score, r (224) = .63, $p < .001$.

Discussion

The present study found that a simple additive scale (AGVAR), based on offender age and three easily obtainable characteristics of victims of child sexual abuse, showed moderate ability to predict offending against multiple victims in a community-based service for the assessment and treatment of sexual offenders. Predictive validity was as strong for voluntarily-referred offenders as for the entire group of mandated and voluntary offenders.

The items of the AGVAR overlap with variables that have previously been found to predict sexual recidivism and are included in established risk assessment instruments. The AGVAR includes age of offender,

which is also an item in the RRASOR and the Static-99. In addition, items concerning victim gender and relationship to offender are included in the RRASOR and the Static-99, although they are applied to any victims in these instruments, but are applied to the most recent victim in the AGVAR. Victim age is the sole AGVAR item not included in these established risk instruments. The inclusion of similar items in the RRASOR and the AGVAR is likely to account for the high correlation found for mandated offenders in the present study between scores on the RRASOR and on the AGVAR scales.

It is not suggested that the AGVAR scale should replace more comprehensive and better validated risk assessment instruments. However, the scale could prove useful in circumstances where insufficient information is available to complete one of the more established instruments without relying solely on offender self-report. For example, a voluntarily-referred offender aged 20 years, who admits to sexually abusing a female acquaintance aged 10 years, but no other victims, would receive a score of 3. All of the offenders in this group in the present study had more than one victim. Therefore, the assessing clinician would be justified in inquiring further about offending against other victims.

The scale developed in this study appears to show promise as a risk assessment instrument in circumstances such as those described in this article where corroborative information about offending behaviour is limited. However, results from this development sample are based on relatively small numbers of offenders, particularly the group of voluntarily-referred offenders. Further investigation of the scale with a validation sample is needed.

Acknowledgements

The database from which the data in this study were drawn was supported by a grant from the Criminology Research Council. The views expressed are the responsibility of the author and are not necessarily those of the Council.

References

Boer, D.P., Hart, S.D., Kropp, P.R., & Webster, C.D. (1998). *Manual for the Sexual Violence Risk-20: Professional guidelines for assessing risk of sexual violence.* Vancouver: British Columbia Institute Against Family Violence.

De Vogel, V., de Ruiter, C., van Beek, D., & Mead, G. (2004). Predictive validity of the SVR-20 and Static-99 in a Dutch sample of treated sex offenders. *Law and Human Behavior, 28*, 235-252.

Doren, D.M. (2002). *Evaluating sex offenders: A manual for civil commitments and beyond.* Thousand Oaks, CA: Sage.

Hanson, R.K. (1997). *The development of a brief actuarial scale for sexual offense recidivism.* Ottawa: Department of the Solicitor General of Canada.

Hanson, R. K., & Bussiére, M. T. (1998). Predicting relapse: A meta-analysis of sexual offender recidivism studies. *Journal of Consulting and Clinical Psychology, 66*, 348-362.

Hanson, R.K., & Harris, A. (2001). A structured approach to evaluating change among sexual offenders. *Sexual Abuse: A Journal of Research and Treatment, 13*, 105-122.

Hanson, R.K., & Thornton, D. (1999). *Improving actuarial risk assessments for sex offenders.* Ottawa: Department of the Solicitor General of Canada.

Heil, P., Ahlmeyer, & Simons, D. (2003). Crossover sexual offenses. *Sexual abuse: A Journal of Research and Treatment, 15,* 221–236.

Proeve, M., Day, A., Mohr, P., & Hawkins, K. (2006). Specific risk assessment based on victim type in child sexual offenders. *Psychiatry, Psychology, and Law, 13*, 28-40.