

The Effectiveness of Treatment for Adult Sex Offenders

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Introduction

Evaluating the effectiveness of treatment for adult sex offenders is a difficult task. Designing research studies with adequate control groups is challenging and executing them is even more so. The fact that sex crimes are grossly under-reported lowers the (apparent) base rate of sex offending and limits conclusions that can be drawn about the significance of treatment effects. In addition, individual research studies require years to complete and so data about treatment effectiveness are very slow in coming. Meta-analyses of studies already completed are complicated by difficult decisions that must be made about what studies to include and how to compare treatment effectiveness among the disparate individual studies.

Because of these difficulties, conclusions about the effectiveness of treatment for adult sex offenders are difficult to reach. Yet it is important to know what the research tells us.

We examined 27 research studies concerning treatment outcome (21 individual studies and six meta-analyses) published since 1984. Our survey is not intended to be a review of all studies ever completed on the effectiveness of treatment for adult sex offenders but we believe we have included the most recent and commonly referenced studies. The form of treatment most commonly offered sex offenders in these studies is cognitive/behavioral or relapse prevention therapy although other forms of treatment are addressed as well. The duration of treatment in the studies surveyed varies from just a few weeks to four years although 1-2 years was more common. The amount of time an offender is at risk following treatment ranged from 2 years to 28 years although most follow-up periods were less than 7 years. (In some studies, the duration of treatment and amount of time at risk were difficult to determine.)

No definitive conclusions can be drawn from individual studies about the effectiveness of treatment. About half suggest treatment may be effective in reducing recidivism and about half, including arguably the best-designed of the studies, suggest that treatment is statistically ineffective in reducing recidivism.

Of the 21 individual studies surveyed, nine (43%) concluded that some form of treatment significantly reduces recidivism (Aytes, Olsen, Zakrajsek, Murray, and Ireson, 2001; Hildebrand, deRuitter, and deVogel, 2004; Looman, Abracen, and Nicholaichuk, 2000; Maletzky, Tolan, and McFarland, 2006; McGrath, Cumming, Livingston, and Hoke, 2003; Minnesota Department of Corrections, 2007; Marshall and Barbaree, 1988; Nicholaichuk, Gordon, Gu, and Wong, 2000; and West, Hromas, Wengler, and Suthers, 2000 - data from "Alaska"). Another nine of the 21 studies (43%) concluded that treatment did not statistically reduce recidivism (Davidson, 1984; Friendship, Mann, and Beech, 2003; Hanson, Broom, and Stephenson, 2004; Hanson, Steffy, and Gauthier, 1993; Lowden, Hetz, Harrison, Patrick, English, and Pasini-Hill, 2003; Marques, Wiederanders, Day, Nelson, and van Ommeren, 2005; Quinsey, Khanna, and Malcolm, 1998; Rice, Quinsey, and Harris, 1991; and Schweitzer and Dwyer, 2003). Three studies (14%) did not offer statistical analyses of their findings (West, et al., 2000 - data from "Kentucky", "New Hampshire", and "Vermont").

Notably, findings from what is widely regarded as the best designed study of the efficacy of sex offender treatment, the Sex Offender Treatment and Evaluation Project in California, revealed no statistically

significant differences in recidivism among offenders treated for 1-2 years and then released from treatment (with one year of parole supervision following treatment) and untreated sex offenders (Marques, et al., 2005).

The methodologies of many of the studies have been questioned making it even more difficult to reach definitive conclusions.

Many of the nine individual studies which concluded that treatment had a significant positive effect in lowering recidivism are qualified by (sometimes unavoidable) design flaws. For example, two studies (Looman, et al., 2000; Nicholaichuk, et al., 2000) were criticized for having inadequate control groups (Hanson and Nicholaichuk, 2000; Rice and Harris, 2003). Two other studies (Aytes, et al., 2001; Hildebrand, et al., 2004) included as control groups sex offenders who had failed to complete treatment when it might have been equally appropriate to consider the failure of those offenders to be a poor outcome of a treatment endeavor rather than consider them as similar to offenders who never received treatment.

Another study showed a robust treatment effect (Maletzky, et al., 2006) but it should be noted that the treatment employed was hormonal/pharmacological, not the standard cognitive behavioral treatment employed by most sex offender treatment programs.

It should also be noted that one study which found no significant effect of treatment on sexual recidivism did find a significant positive effect of treatment on violent recidivism and overall recidivism (Lowden, et al., 2003). The authors concluded, in part, that sex crimes were the least commonly reported offenses making it difficult to compare groups using measures of sexual recidivism. .

Qualified conclusions can be drawn from meta-analyses about the effectiveness of treatment. Most conclude that there is a small but significant effect of treatment on recidivism but all the analyses are subject to criticism.

We surveyed six meta-analyses. Four concluded that treatment had a small but significant positive effect on lowering recidivism (Gallagher, Wilson, Hirschfield, Coggeshall, and MacKenzie, 1999; Hall, 1995; Hanson, Gordon, Harris, Marques, Murphy, Quinsey, and Seto, 2002; Losel and Schmucker, 2005) while one concluded that there was no such effect (Furby, Weinrott, and Blackshaw, 1989). One (Alexander, 1999) provided no statistical analysis.

Two meta-analyses (Gallagher, et al., 1999; Hall, 1995) have been critiqued about the particular studies which were chosen for inclusion. The Gallagher et al. meta-analysis has been criticized for including studies with “significant threats to validity” including early reports of studies which were contradicted by later versions of the same studies (Hanson, et al., 2004). The Hall meta-analysis has been criticized for including studies in which comparison groups were shown not to be equivalent; when these studies were removed from the analyses, the effect of treatment was no longer found to be significant (Hanson, Morton, and Harris, 2003; Harris, Rice, and Quinsey, 1998).

The authors of another meta-analysis (Losel and Schmucker, 2005) concluded that there is a significant effect of treatment on recidivism and that cognitive-behavioral treatments considered separately had a small but significant effect but much of the overall treatment effect appears to have come from studies in which treatment consisted of surgical castration.

Alexander’s meta-analysis (1999) is sometimes cited as concluding that treatment is effective, probably because recidivism percentages derived from the analysis for treatment groups are somewhat lower than recidivism percentages for control groups, but Alexander offered no statistical analysis of these findings.

The meta-analysis in which it was reported that no significant treatment effect could be demonstrated (Furby, et al., 1989) has often been criticized as well. These criticisms tend to focus on the fact that many of the studies included in the analysis focused on outdated treatment modalities.

Perhaps the most frequently cited recent meta-analysis is the ATSA Collaborative Outcome Data Project (Hanson, et al., 2002). The authors concluded that there was a small but statistically significant effect of treatment on sexual recidivism. It should be noted, however, that the decision rules employed about study inclusion have been questioned and it has been suggested that the conclusions reached by the authors are not supported because many of the studies included in the meta-analysis had serious design flaws (Rice and Harris, 2003). Rice and Harris concluded that there is “no convincing evidence” that treatment is effective in reducing recidivism.

It should also be noted that some other reviewers, while not conducting a formal meta-analysis, have concluded that treatment is effective. For example, a review of studies conducted in 1991 by Marshall and colleagues concluded that there is “an unequivocally positive answer” to the question of whether sex offender treatment reduces recidivism (Marshall, Jones, Ward, Johnston, and Barbaree, 1991). However, others criticized this review saying that the authors’ conclusion was not warranted because the review included too many studies that contained no adequate control groups and because the studies reviewed often could not ensure that comparison groups were equivalent (Quinsey, Harris, Rice, and Lalumiere, 1993).

In summary, research has not consistently demonstrated that time-limited treatment lowers the re-offense rates of adult sex offenders once they leave treatment and supervision programs.

Some individual research studies suggest that treatment lowers recidivism but others, including recent well-designed studies (and the only study to date employing randomized subject assignment), do not find such an effect. The findings of meta-analyses are encouraging but confusing and contested. Considered as a whole, we do not believe that research can be said to demonstrate that time-limited treatment lowers sexual recidivism rates.

Nevertheless, some treatment and supervision approaches show promise. Some research suggests that re-offense rates may be lower for particular groups of offenders and for offenders who remain in treatment and supervision programs longer.

Some intervention or set of interventions may eventually be shown to lower recidivism in some offenders. For example, Marques et al. (2005) indicated that a combination of treatment response measures was found to be a significant predictor of sexual re-offense in high risk offenders suggesting that some form of treatment might eventually be effective with these offenders.

Prolonged treatment, containment and supervision also appear to be important in lowering recidivism. The study of the Sex Offender Treatment Program at the Department of Corrections in Colorado revealed that re-arrest rates for all violent and sexual crimes (although, again, not specifically sexual crimes) were lower for offenders who remained in the DOC treatment program longer and who were subsequently placed on parole supervision when released (Lowden, et al., 2003).

The study of the prison-based treatment program in Vermont revealed that both the length of time in treatment and the degree to which offenders received aftercare and correctional supervision following treatment contributed to lower recidivism (McGrath, et al., 2003).

The study of the community-based treatment program in Oregon indicated that the effect of treatment in lowering recidivism was particularly strong for offenders who remained in the treatment program for longer than a year (Aytes, et al, 2001).

Finally, a study conducted by the Colorado Department of Public Safety Division of Criminal Justice (2004) showed that high risk adult sex offenders living in a quasi-milieu setting which typically provides increased supervision and monitoring (“shared living arrangement”) had significantly fewer violations of probation than adult offenders with other living arrangements.

Footnotes

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