

# Toward the Use of Evidence Based Practices with Sexual Offenders in Correctional Settings

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## Workshop Goals

- Attempt to unite the existing empirical literature with the everyday practice of treating sex offenders.
- Present a detailed description of the field of evidence based practices (EBP's).
- Discuss previous and current efforts to outline the use of EBP's in field of sex offender assessment and treatment.
- Provide a list of commonly used approaches with sex offenders and their ratings as a potential EBP.
- Discuss the role of an Integrated Model of Sex Offender Treatment (IMSOT) in the use of EBP's.

## What are you doing and why are you doing it?

- How do you decide what to assess and what assessment tools you use?
- How do you decide what to treat, what interventions you use, and at what intensity?
- Are the interventions you currently provide evidence based? If so, how do you know they're evidence based?

## Take Home Messages

- Relatively little has been determined to be evidenced-based in the field of SO Tx.
- Programs should continually review research findings and update accordingly
- Provide the right dosage of treatment
- Target dynamic risk factors in treatment
- Individualize treatment

## What are Therapists Currently Doing?

- McGrath, et. al. (2010), surveying US and Canadian treatment programs, found:
  - Top 3 Theories that describe program
    - More than 90% cognitive-behavioral
    - More than 60% relapse prevention
    - About 35% GLM
  - Core Treatment Targets
    - About 90% offender responsibility
    - About 90% social skills training
    - About 90% victim awareness/empathy

## Do you use best practices?



## “Best Practices”

- Not the same as Evidence-Based Practice
- Very Broadly Defined.
- Best Practices Usually Includes:
  - Static and dynamic risk assessment
  - A cognitive-behavioral treatment approach
  - Group therapy as the main modality
  - Relapse prevention as a core treatment component
  - GLM and/or Self-Regulation Model?
  - Responsibility taking as a core requirement?

A herd mentality in the S.O.  
field?





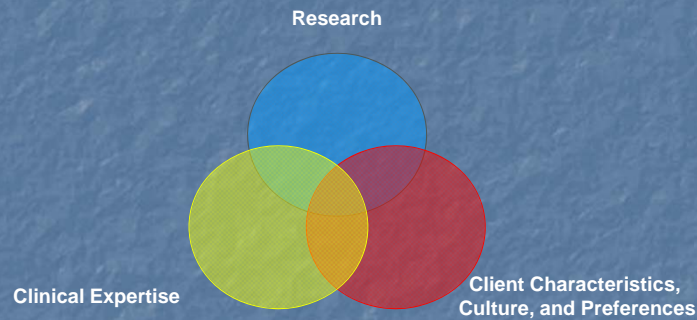
## A herd mentality in the S.O. field?



## Evidence Based Practices

- What are EBP's?
  - The Integration of the best available research with a clinician's clinical expertise, in the context of client characteristics, culture, and preferences.
    - American Psychological Association (2006).
  - Within the EBP trinity, research stands as the primary source of evidence.

# The EBP Trinity



## Best Available Research

- Can relate to prevalence, assessment, treatment, and client populations in the various settings
- Should be based on systematic reviews, reasonable effect sizes, statistical and clinical significance, and a body supporting evidence.

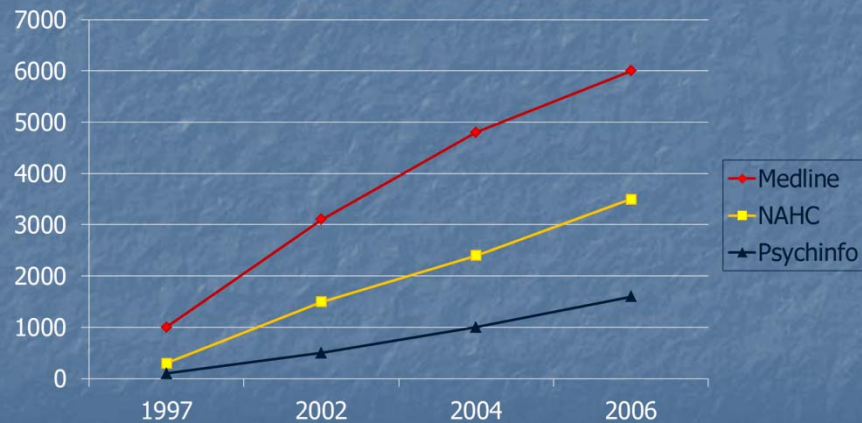
## Clinical Expertise

- Can include education, training, and professional experience relating to assessment and diagnosis, treatment, and monitoring progress.
- It is vital that the clinician have an awareness of the limits of one's skills and attention to the factors that can influence clinical judgment.
- Affiliation with an organization devoted to the treatment and research of sexual offenders.
- Annual (or regular) training and continuing education on sex offender assessment/treatment.

## Client Characteristics, Culture, and Preferences

- Personal strengths, sociocultural context, and client preferences must be integrated into clinical decisions to provide the best services.
- Clinical decisions should evolve in collaboration with the client and in consideration of possible costs/benefits not directly addressed by available research.
- Individualize treatment.

## Number of Articles Using "Evidence Based" as Keyword



## EBP Dilemma's

- What constitutes evidence of effective practice?
  - All three components of the EBP trinity can constitute as evidence of effective practice, but best available research will typically assume top priority



## EBP Dilemma's

- What qualifies as research for effective practice?
  - The "gold standard" in research is randomized clinical trials (RCT's).
  - Meta-analyses
  - Controlled studies with limited participants
  - Case studies?

## EBP Dilemma's

- What treatment outcomes should establish EBP's?
  - The field of medicine often has physical indices of treatment outcome.
  - Mental health outcomes are sometimes harder to measure.
  - Do client self-reports qualify
  - In the field of sex offender treatment, what outcomes should be established?

## EBP Dilemma's

- Does manualization improve treatment outcomes?
  - Outcome research requires that patients receive similar/identical interventions.
  - Manualization is often considered a prerequisite for inclusion as an EBP.
  - Yet, there is mixed opinion on their helpfulness and utility.

## EBP Dilemma's

- Do research patients and clinical trials accurately reflect real world practice?
  - Many research findings do not generalize well to the real world.
  - Translating science to client service can be difficult.

## EBP Dilemma's

- What should we seek to validate?
  - In medicine, or biomedical research, the agent of change is often obvious (medication, surgery, etc).
  - Mental health outcomes often include variables (therapist style, client motivation) that are not related to the treatment intervention itself.

## EBP Dilemma's

- What influences what is published as evidence?
  - Research results, and the publication of research results, are often influenced by theoretical allegiances, funding sources, human biases.

## EBP Dilemma's

- Do treatments designated as EBP's produce outcomes superior to non-EBP's?
  - EBP's are often only compared to no treatment conditions or placebo conditions.
  - True EBP's should also outperform other therapy approaches.

## EBP Dilemma's

- How well do EBP's address patient diversity?
  - In many studies, client diversity, such as race, ethnicity, gender, sexual orientation, socioeconomic level, and other factors that could impact treatment outcome, are not addressed or studied.
  - Are EBP's validated on "majority populations" valid for clients not represented in the research?



## Literature on Use of EBP's with Sexual Offenders

- Not much out there!
- Yates (2005) – A good review of the literature...but no clear indication of what is evidence-based.
- Ohio Department of Rehabilitation and Correction – “Best practices tool-kit: Sex offender assessment and treatment.”

## Literature on the Use of EBP's with Sexual Offenders

- A few articles discuss EBP's and public policy regarding sex offenders (Harris & Lurigio, 2010; Tewksbury & Levenson, 2007).
- Finally, several articles review the use of EBP's in correctional settings (Williams, 2008; Washington Institute for Public Policy, 2006; Serin, 2005).

## EBP's in Sex Offender Treatment?

- The American Psychological Association's Society of Clinical Psychology (Division 12)
  - Website on research-supported psychological treatments (PsychologicalTreatments.org):
    - No research supported treatments relating to sexual offending, sexually illegal, or sexually unhealthy behavior listed on website.

## EBP's in Sex Offender Treatment?

- The US Substance Abuse and Mental Health Services Administration (SAMHSA)
  - In 2007 launched the National Registry of Evidence-based Practices and Programs (NREPP): ([www.nrepp.samhsa.gov](http://www.nrepp.samhsa.gov))
    - Multi-systemic Therapy for Youth with Problem Sexual Behaviors
    - Moral Reconciliation Therapy (EBP for "criminal recidivism")
    - Relapse Prevention (not listed for use with sex offenders)
    - Social Skills Training (listed for persons with schizophrenia)

## EBP's in Sex Offender Treatment?

- Standards and Criteria Used to Determine EBP's:
  - Defining and quantifying research support as evidence based can be challenging.
  - One approach used in mental health research is that provided by Chambless et al (1998).
    - Strong – Well established, well designed studies converge to support efficacy
    - Modest – One well designed study

## EBP's in Sex Offender Treatment?

- Standards and Criteria Used to Determine EBP's:
  - Collaborative Outcome Data Committee (CODC)
  - Formed in 1997 to assess sex offender treatment outcome research.
  - Uses a four point scale to rate research:
    - Strong – Good – Weak - Rejected

## EBP's in Sex Offender Treatment?

- Collaborative Outcome Data Committee (CODC) – 7 criteria categories:
  - Administrative control of the I.V.
  - Experimenter expectancies
  - Sample size
  - Attrition
  - Equivalence of groups
  - Outcome variables
  - Correct comparison conducted

## The International Project for Evidence Based Practices with Sexual Abusers (IPEPSA)

- A comprehensive review of the sex offender research literature is currently underway.
- Four areas (domains) are under review:
  - Assessment
  - Treatment
  - Community Supervision
  - Public Policy



## IPEPSA

- Within each domain, separate categories (of “clinical practice”) are identified and given an EBP rating.
- **Category Examples:**
  - Assessment – Static-99
  - Treatment – Denial
  - Community Supervision – COSA
  - Public Policy – Registration laws

## IPEPSA

- Within the current review of research the following categories for Evidence Based Practices with sexual offenders are being considered:
  - Strong
  - Modest
  - Marginal
  - Unsupported
  - Ineffective

## Description of each EBP category rating based on available research

### ■ Strong

- Multiple (at least 3) very well designed studies, generally replicating outcomes between studies, and demonstrating consistently valid, hypothesized or “desired” outcome(s) on the same research topic or variables.

## Description of each EBP category rating based on available research

### ■ Modest

- One or two well-designed studies, demonstrating a valid, hypothesized or “desired” outcome(s) on the same research topic or variables.

## Description of each EBP category rating based on available research

### ■ Marginal

- One or more studies showing a trend toward the hypothesized or “desired” outcome, but with questionable validity or with mixed results within the study or between multiple studies, and/or only partially supporting the hypothesized or “desired” outcome(s) on the same research topic or variable(s).

## Description of each EBP category rating based on available research

### ■ Unsupported

- Primarily theoretical, or with no empirical support and/or no research conducted on the topic or variable(s) to date.

## Description of each EBP category rating based on available research

- Ineffective

- One or more very well designed studies on the same research topic or variable(s), generally replicating outcomes between studies, and demonstrating results that suggests the approach is ineffective in achieving hypothesized or "desired" outcome(s).

## Decision Making Regarding EBP Database

- How to rate research?
- Efforts are made to be objective.
- Commentaries or theoretical papers included in the EBP research database will be considered "non-empirical" .
- Only published research or research conducted by a public entity are included.



## IPEPSA

- All research articles reviewed are being cataloged in a "Sex Offender EBP Database" that will soon be available for public use and review.
- The database contains citations for all research reviewed, the "empirical strength" rating for each research article, and the overall category EBP rating.

## Future Directions for EBP Database

- Category just for dynamic risk factors?
- Category of sex offender characteristics?
- Category just for recidivism?
- Female sex offenders
- MR/DD sex offenders
- More on juveniles
- Civil commitment

## The Use of EBP's with Sexual Offenders

- The long term, multi-level use of EBP's within the field of sex offender treatment can be facilitated by the following:
  - An analysis of the system to determine where research is needed.
  - Seeking the participation and input of leaders in the field.
  - Collaboration with key stakeholders, such as clinicians, clients, family members, and victims groups.

## The Use of EBP's with Sexual Offenders

- Long term use of EBP's Continued:
  - Avoid single approach and time limited interventions
  - Training to clinicians focusing on the use of EBP's
  - Administrative support to programs using EBP's
  - Assess and track staff fidelity in using EBP's

## Implementing EBP's: Core Skills

- How should a clinician treat clients from and EBP perspective?
  - Ask a specific question
  - Access the best available research (e.g., Deming EBP database)
  - Appraise the research
  - Translate that research into practice
  - Integrate your clinical expertise and client characteristics with the research
  - Evaluate the effectiveness of your process

## An Integrated Model of Sex Offender Treatment (IMSOT)

- The goal of an IMSOT is to develop a semi-structured approach to the treatment of sexual offenders that is based on the best available research relating to the development and maintenance of sexually illegal/abusive behavior, its assessment and treatment.
- This model is necessarily dynamic, and must be able to respond to empirical research and implement new findings into practice on an ongoing basis.

## Integration: Why use it?

- The goal is to meaningfully combine and use those treatment approaches and interventions which are demonstrating the greatest effectiveness.
- Allows for the use of the best of two or more treatment approaches into one unified approach.
- Integration of treatment approaches has been an ongoing process in this field for years. However, it is often done somewhat haphazardly and without structure (e.g., "cognitive-behavioral" treatment of sexual offenders).

## Past and Present Sex Offender Integrated Models

- Schwartz (The Sexual Offender, 1995)
- Rich (2003) – (Sex Offender Treatment with Juveniles)
- Integrated Humanistic (Bauman & Kopp, 2004)
- Experiential (Juveniles) (Longo, 2004)
- Dialectical Behavior Therapy (Shingler 2004)
- Risk, Need, Responsivity (Andrews & Bonta, 2006)
- Bill Marshall et. al. (2006)
- Individual Psychology (Johnson & Lokey, 2007)
- Good Lives/Self Regulation (Yates & Ward, 2008)
- Acceptance and Commitment Therapy



## The INSOMM Program

- Indiana Sex Offender Management and Monitoring (INSOMM) Program
- Highly effective and efficient program
  - Phase I - Assessment
  - Phase II - Treatment
  - Phase III – Community Management
- Uses an integrated model with EBP's and BP's (examples to be provided below)

## IMSOT

- An Integrated Model of Sex Offender Treatment Should:
  - Be grounded in etiological theory relating to the development and maintenance of sexually illegal/unhealthy behavior.

## IMSOT

- An Integrated Model of Sex Offender Treatment Should:
  - Be capable of addressing and accommodating individualized needs, such as persons with widely varied sexual offense histories, cognitive abilities, and motivation for change.

## IMSOT

- An Integrated Model of Sex Offender Treatment Should:
  - Effectively utilize the “common factors” and therapist variables that are known to positively impact and facilitate personal change and treatment outcomes, as well as those “specific factors” that have been empirically validated as effective in treating sexual offenders.

# IMSOT

- An Integrated Model of Sex Offender Treatment Should:
  - Encompass the range of treatment needs commonly seen in sexual offenders, including both sex offender specific and sex offender related treatment targets. Treatment interventions, where possible, should be based on empirically validated effectiveness and an “evidence based practices” approach.

## Core Components of an EBP-IMSOT

- Actuarial and dynamic risk assessment.
- Treatment preparation and readiness.
- Risk based and individualized treatment.
- Interventions that focus on dynamic risk factors and sex offender specific treatment targets.
- Relapse prevention approaches:
  - are **secondary** to core treatment interventions.
  - are discussed **after** fundamental personal/behavioral **change has been established**.
  - are used to **maintain treatment gains**.

## The Role of Assessment in the IMSOT

- Assessment is ongoing:
  - Should inform treatment decisions
  - Should lead to more efficient use of resources
  - Should lead to better treatment outcomes
  - Should involve the client as an informed participant in the treatment process

## Risk Factors and Treatment Targets

- Mann et. al. (2010) looked at the strength of evidence regarding suspected risk factors.
- Meaningful risk factors are those where:
  - A plausible rationale exists that the factor is a cause for sexual offending.
  - There is strong evidence that the factor predicts sexual recidivism.



## Risk Factors and Treatment Targets

- Mann et. al. (2010) Continued:
  - Concept of *propensities* vs. static/dynamic risk.
  - Five categories based on empirical findings –
    - Empirically supported risk factors
    - Promising risk factors
    - Unsupported but interesting exceptions
    - Worth exploring
    - Little or no relationship to sexual recidivism

## Risk Factors and Treatment Targets

- Mann et. al. (2010) Continued:
- **Empirically Supported Risk Factors** -
  - Sexual preoccupation
  - Any deviant sexual interest (PPG, sexual viol., mult. paraphilias)
  - Offense supportive attitudes
  - Emotional congruence with children
  - Lack of emotionally intimate relationships with adults
  - Lifestyle impulsivity
  - General self-regulation problems (employment instb.)
  - Resistance to rules and supervision (viol. cond. rlse)
  - Grievance/hostility
  - Negative social influences

## Individualizing Treatment within a Group Modality

- Within the IMSOT, individualized treatment needs are targeted within the group therapy process (and/or in individual therapy).
- The sex offender therapist must remain cognizant of two ongoing layers of the treatment process:
  - Individual client needs and progress
  - Dynamics within the group therapy process that influence and facilitate the therapeutic impact upon each individual

## Therapeutic Interventions within the IMSOT

- Common Factors
  - Program philosophy, treatment preparation
  - Therapist factors
  - Group dynamics that facilitate change
- Specific Factors
  - The treatment core is not RP. Rather, treatment interventions address both sexual and global problems relating to skill deficits, cognitive dysfunction, and behavioral regulation.
  - RP techniques are introduced at the back end of treatment as a way of maintaining treatment gains.

## Therapeutic Interventions within the IMSOT

- Skill Development
- Cognitive Dysfunction
- Behavioral Excesses/Deficits
- Maintenance of Treatment Gains
- Enhancing Ego Strength/Healthy Behavior

## Therapeutic Interventions within the IMSOT

- Skill Development
  - Interventions: Psycho-educational
    - Social isolation and social relationships
    - Lack of emotionally intimate relationships with adults and general intimacy deficits
    - Dysfunctional coping and stress management
    - Axis I disorders

## Therapeutic Interventions within the IMSOT

- Cognitive Dysfunction
  - Interventions: Cognitive Restructuring
    - Offense supportive and criminogenic attitudes/beliefs
    - Hostility toward women
    - Emotional identification and congruence with children
    - Lack of concern for others and empathy development
    - Emotional management/anger management
    - Self-esteem and self concept
    - Axis II disorders

## Therapeutic Interventions within the IMSOT

- Behavioral Regulation
  - Interventions: Behavioral Therapies
    - Sexual regulation/arousal management
    - Deviant sexual interests
    - Sexual preoccupation
    - Impulse control and lifestyle impulsivity
    - Resistance to rules and supervision
    - Substance abuse/dependence

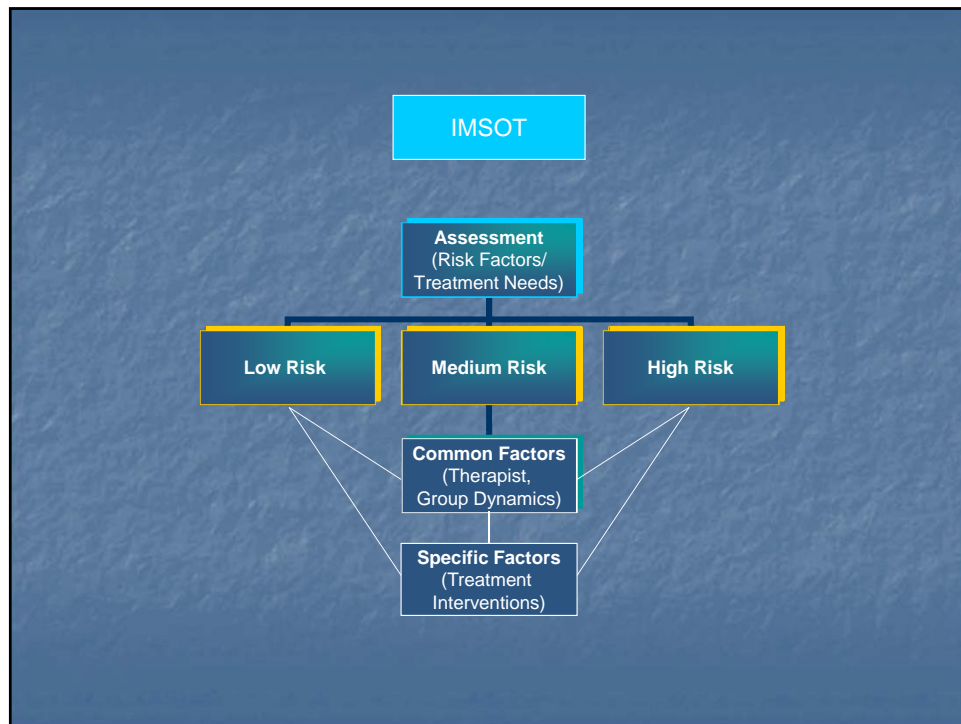


## Therapeutic Interventions within the IMSOT

- Maintenance of Treatment Gains
  - Intervention: Relapse Prevention
    - Cognitive-Behavioral Relapse Prevention Plans
    - Managing acute risk factors (used primarily with medium and high risk offenders)
      - Access to victims
      - Negative social influences

## Therapeutic Interventions within the IMSOT

- Enhancing Ego Strength/Healthy Behavior
  - Intervention: Supportive Therapy
    - Developing and maintaining meaningful, enjoyable, and healthy leisure activities
    - Developing relationships and identity through work and occupational fulfillment
    - Enhancing self esteem
    - Managing re-entry, social stigma, and identity issues (being ostracized by culture/friends)



## IMSOT Program Characteristics

- Program is structured in a manner that clients are encouraged and rewarded for taking responsibility for and being actively engaged in their treatment.
- Program is structured in a manner that clients are encouraged and rewarded for being informed consumers of research and information related to the perpetration of sexual violence and abuse, and its assessment and treatment.

## IMSOT Program Characteristics

- Value and importance of pre-treatment orientation and preparation (e.g., see Marshall et. al., 2008).
- Consistent and clear communication of program philosophy.
- Importance of communicating belief in the capacity for positive change and the value of every client as a person.

## Discussion/Q and A

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## References

- American Psychological Association Task Force of Evidence Based Practice (2006). Evidence based practice in psychology. American Psychologist, 61, 271-285.
- Andrews, D.A., & Bonta, J. (2006). The Psychology of Criminal Conduct (4<sup>th</sup> ed.). Newark, NJ: LexisNexis.
- Bauman, S. & Kopp, G. (2004). An integrated humanistic approach to outpatient groups for adult sex offenders. American Counseling Association, Vistas Online 2004.



## References

- Beach, A., Bourgon, G., Hanson, R.K., Harris, A.J.R., Langton, C., Marques, J., Miner, M., Murphy, W., Quinsey, V., Seto, M., Thornton, D., and Yates, P. (2007). Sexual Offender Treatment Outcome Research: CODC Guidelines and Overview. Public Safety Canada, 2007-02.

## References

- Chanbless, D.L., Baker, M.J., Baucom, D.H., Beutler, L.E., Calhoun, K.S., Christoph, P.C., Daiuto, A., DeRubeis, R., Detweiler, J., Haaga, D.A., Johnson, S.B., McCurry, S., Mueser, K.T., Pope, K.S., Sanderson, W.C., Shoham, V., Stickle, T., Williams, D.A., & Woody, S.R. (1998). Update on Empirically Validated Therapies, II. The Clinical Psychologist, 51, 3-16.

## References

- Hanson, R.K., & Thornton, D. (2003). Notes on the development of the Static 2002 (User Report No. 2003-01). Ottawa, ON: Solicitor General Canada.
- Harris, A.J., & Lurigio, A.J. (2010). Introduction special issue on sex offenses and offenders: Toward evidence-based public policy. *Criminal Justice and Behavior*, 37, 5, 477-481.

## References

- Johnson, D.A., & Lokey, J.P. (2007). Individual psychology approaches to group sex offender treatment. Professional Issues in Psychology, Summer 2007.
- Longo, R.E. (2004). An integrated experiential approach to treating young people who sexually abuse. Journal of Child Sexual Abuse, 13, 3-4, 193-213.

## References

- Mann, R.E., Hanson, R.K., & Thornton, D. (2010). Assessing risk for sexual recidivism: Some proposals on the nature of psychologically meaningful risk factors. Sexual Abuse: A Journal of Research and Treatment, 22, 191, 217.
- Marshall, W.L. (2005). Therapist style in sexual offender treatment: Influence on indices of change. Sexual Abuse: A Journal of Research and Treatment, 17, 109-116.

## References

- Marshall, W.L., Marshall, L.E., Fernandez, Y.M., Malcolm, P.B., and Moulden, H.M. (2008). The Rockwood preparatory program for sexual offenders: Description and preliminary appraisal. Sexual Abuse: A Journal of Research and Treatment, 20, 25-42.
- Marshall, W.L., Marshall, L.E., Serran, G.A., and Fernandez, Y.M. (2006). Treating sexual offenders: An integrated approach. New York: Routledge.
- McGrath, R.L. & Cumming, G.F. (2003). Sex offender treatment needs and progress scale manual. Silver Springs, MD: Center for Sex Offender Management, U.S. Department of Justice.

## References

- McGrath, R.J., Cumming, G.F., Burchard, B.L., Zeoli, S., & Ellerby, L. (2010). Current practices and trends in sexual abuser management: The Safer Society 2009 North American Survey. Brandon, VT: Safer Society Press.

## References

- Norcross, J.C., Hogan, T.P., and Koocher, G.P. (2008). Evidence-Based Practice in Psychology. The Register Report, 34, 10-15.
- Ohio Department of Correction (2007). Best practices tool-kit: Sex offender assessment and treatment. Institute for Excellence in Justice.
- Rich, P. (2003). Understanding, assessing, and rehabilitating juvenile sexual offenders. John Riley & Sons: Hoboken, New Jersey.



## References

- Schwartz, B.K. (1995). Introduction to the integrative approach. In Schwartz, B.K. and Cellini, H.R. (Eds.), The Sex Offender: Corrections, treatment, and legal practice (1995). Kingston, NJ: Civic Research Institute.
- Serin, R.C. (2005). Evidence-based practice: Principles for enhancing correctional results in prisons. National Institute of Corrections.

## References

- Shingler, J. (2004). A process of cross-fertilization: What sex offender treatment can learn from dialectical behaviour therapy. Journal of Sexual Aggression, 10, 171-180.

## References

- Stirpe, T., Wilson, R.J., & Long, C. (2001). Goal attainment scaling with sexual offenders: A measure of clinical impact at post treatment and at community follow-up. Sexual Abuse: A Journal of Research and Treatment, 13, 65-77.
- Tewksbury, R., & Levenson, J. (2007). When evidence is ignored: Residential restrictions for sex offenders. Corrections Today, 69, 6, 54-57.

## References

- Ward, T., & Beech, A. (2006). An integrated theory of sexual offending. Aggression and Violent Behavior, 11, 44-63.
- Aos, S., Miller, M., & Drake, E. (2006). Evidence-based adult corrections programs: What works and what does not. Olympia: Washington State Institute for Public Policy.

## References

- Williams, D.J. (2004). Sexual offenders' perceptions of correctional therapy: What can be learned? Sexual Addiction and Compulsivity, 11, 145-162.
- Williams, T.H. (2008). What works? Evidence-based practices in parole and probation. Interviews with Policy Makers.

## References

- Yalom, I.D. (1985). The Theory and Practice of Group Psychotherapy. New York: Basic Books.
- Yates, H.M. (2005). A review of assessment and treatment of sex offenders. Pennsylvania Department of Corrections Office of Planning, Research, Statistics, and Grants.

## References

- Yates, P.M. & Ward, T. (2008). Good lives, self-regulation, and risk management: An integrated model of sexual offender assessment and treatment. Sexual Abuse in Australia and New Zealand, 1(1), 3-20.