Tertiary prevention programme for convicted, adult male sex offenders in prison

REFERENCE

Core Sex Offender Treatment Programme

Target population

Men aged 18 and over with a conviction for a contact, or attempts at a contact, sexual offence who are medium, high or very high risk of reconviction according to RM2000/s and have an IQ over 80. Low risk sexual murderers are also placed into this programme.

Delivery organisation (e.g. LFF UK, Prison Service of England and Wales)

National Offender Management Service (England and wales).

Mode and context of delivery

The treatment method is broadly cognitive-behavioural. That is, methods aim to intervene in the pathway to offending by (1) restructuring attitudes that support or permit sexual offending, and (2) changing previous dysfunctional behaviours by building new skills and resources. This is a Group based treatment approach for 9 adult male sexual offenders in custody settings.

The Core Programme is an accredited treatment programme. As such, all providers of the Core programme are subject to audit procedures. The purpose of audit is to ensure that the programmes are being delivered as intended, both operationally and clinically. Operationally, audit ensures that programmes receive appropriate management support and attention, that delivery is not compromised by insufficient resources, that staff are supported and that assessments and other paperwork are completed in an appropriate and timely way. The clinical assurance process ensures that the quality of treatment delivery is in line with expectations. Each programme is rated against two criteria: (1) the quality of delivery of the programme, and (2) the quality of treatment management. The QA process involves examination of treatment documents such as "products" (work completed by participants) and logs and reports by programme staff; viewing at least three recordings of sessions, and examining the supervisor's records (such as observational notes and supervision records).

Level/Nature of staff expertise required (e.g. professional background)

The SOTPs are designed to be delivered by "para professional" staff; e.g., prison officers, education officers, assistand psychologists. Suitability for this work is competency based, not based on professional qualifications/ background. All staff working on sex offender programmes in custody undergo a nationally-prescribed comprehensive selection process followed by residential training during which their understanding, competencies and abilities will be assessed. Staff must first be assessed as suitable to become a facilitator. This will involve completion of various psychometric assessments and interviews with local managers. They then have to pass an assessment centre. Those who are successful will attend training in the fundamental skills associated with working with sexual offenders and then the Core

programme specific training. Those staff who pass the training will provide treatment under the supervision of a Treatment Manager or designated supervisor at all times.

Intensity/extent of engagement with target group(s)

The Core programme constitutes 84 sessions of treatment. Each session is approximately 2.5 hours in length. Treatment takes place up to 5 times per week.

Description of intervention (max. 600 words)

Core SOTP helps offenders develop understanding of how and why they have committed sexual offences. The treatment targets include both evidence-based dynamic risk factors for sexual recidivism, as set out by Mann, Hanson & Thornton (2010). The programme also increases awareness of victim harm. The main focus is to help the offender develop meaningful life goals and practice new thinking and behavioural skills that will lead him away from offending. The programme is broken down into 20 blocks.

Block One: The principal target of this block is to create a good basis for the establishment of group cohesion, pro-change norms and positive relationships between group members.
Block Two: The principal target of this session is to begin the process of identifying and challenging pro-offending thinking
Block Three: The principal target of this block is to teach positive coping strategies and start group members off on an action plan for practising positive coping that continues throughout the programme.
Block Four: The principal target of this block is for group members and therapists to identify etiological factors contributing to their sexual offending
Block Five: The principal target of this block is for each group member to verbalise an accurate account of his offending behaviour, identifying triggering events, relevant emotions, behaviours and cognitions present in the offence pathway.
Block Six: The principal target of this block is to increase awareness of the relevance of deviant sexual fantasy to offending, and to increase motivation to abandon deviant fantasy and develop non-deviant fantasy material.
Block Seven: The principal target of this block is for group members to identify patterns in their personality and personal functioning related to their offending behaviour and to begin to raise their awareness of need to change these areas.
Block Eight: The purpose of this block is to build on insights gathered in blocks 1-7 and to formally begin the process of change where targets for new behaviours and ways of thinking are first set.
Block Nine: The principal target of this block is to enhance motivation to change.
Blocks Ten, Eleven, Twelve and Thirteen: The principal target of these blocks is to undermine any beliefs that the experience of being abused was harmless or positive for group members' victims.
Block Fourteen: The principal target of this block is to establish each individual's risk factors for future offending.
Block Fifteen: The principal target of this block is to set inspiring goals for change that are incompatible with future offending.
Block Sixteen: The principal target of this block is to improve coping behaviours for risk factors.
Block Seventeen: The principal target of this block is to teach the skill of goal laddering.
Block Eighteen: The principal target of this block is to prepare group members for lapses.

Block Nineteen: The principal target of this block is to improve coping behaviours for risk factors.
Block Twenty: The principal target of this block is to enhance motivation for continued behaviour change.

Evaluation

Large-scale research indicates that sex offenders who receive treatment, in both prison and community settings, have a lower sexual reconviction rate than those who do not receive treatment. Cognitive-behavioural treatment is the most effective, especially if paired with pharmacological treatment (e.g. hormonal drugs that reduce sexual drive). Other approaches (psychotherapy, counselling and non-behavioural treatment) generally do not reduce reconviction.

Hanson, Bourgon, Helmus, & Hodgson (2009) examined 23 studies that met minimum standards for methodological quality and found an eight percentage point difference (10.9% and 19.2%, respectively, or a relative 43% reduction) between treated offenders and untreated controls in sexual reconviction. Sex offender programmes which follow the risk, need and responsivity principles lead to the largest reductions in reconviction. Medium and high risk sexual offenders benefit most from treatment.

Schmucker & Losel (2009) combined 26 high-quality research studies of sex offender treatment. The sexual offending reconviction rate for treated offenders was on average 3.4 percentage points lower than that for untreated offenders (this can also be phrased as a 27% reduction in sexual offending). The general reoffending rate was also reduced by treatment. Mandatory treatment had as much impact as voluntary treatment. The treatment effect was better for juveniles and for high risk offenders, and was better in well-documented programmes and programmes that were delivered through individual sessions as well as groupwork.

The impact of cognitive behavioural interventions with sexual offenders is as good as, and in some cases better than, the impact of many well accepted medical and psychological treatments (Marshall & McGuire, 2003). There is an empirical literature into risk factors for sexual recidivism (e.g., Hanson & Morton-Bourgon, 2004), which provides useful guidance on the essential targets for treating those who have engaged in sexually abusive behaviour (Mann, Hanson, & Thornton, 2010). The established risk factors are often viewed as clustering into four domains (Craissati & Beech, 2003; Hanson, 2000): sexual arousal factors; attitudes tolerant of sexual deviance; interpersonal deficits; and self-regulation deficits.

Beech, Beckett and Fisher (1998) found that the Core SOTP led to improvements in nearly all of the dynamic risk factors targeted during treatment as measured by psychometric tests. Over two-thirds of offenders changed in terms of their attitudes supporting offending, and one-third of the sample changed in all the areas targeted by treatment.

Friendship, Mann, & Beech (2003) compared the 2-year reconviction rates of 647 adult male offenders who had taken part in the Core SOTP between 1992 and 1994, with 1910 adult male offenders who had not taken part in the Core SOTP. The two samples were matched on year of discharge and shared the same broad characteristics. The treated offenders had significantly lower sexual and/or violent reconviction rates at 2 years than the untreated offenders (4.6% compared to 8.1%). The biggest impact on reconviction occurred with medium risk offenders. Low risk offenders were very unlikely to be reconvicted, whether treated or not, and the Core SOTP did not seem to be sufficient treatment for high risk sex offenders.

Wakeling, Webster, & Mann (2005) surveyed men who attended Core SOTP. 39 out of 46 felt that doing the Core programme had been a positive, worthwhile experience. Offenders felt they improved in understanding their offences, understanding the effects on the victims, and learning how to cope differently in the future.

References

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Cost per head of intervention (£££; ££; £; or $$$, $$, $ etc)

Approximate cost £5,477*

* Please note that the cost per head of intervention is approximate and should be interpreted with caution. These costings were calculated in 2009 and since then NOMS has undergone a number of organizational changes which will have impacted on the reliability of the costs quoted. Work is currently underway to determine the cost of treatment.