MHM Sex Offender Treatment Program Massachusetts Treatment Center

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Overview

- Massachusetts Treatment Center & SOTP Overview
- Overview of Best Practices for Treatment
- MTC SOTP Assessment & Treatment Services
- Preliminary Results: Risk frequency data at MTC

MTC & SOTP Overview

Massachusetts Treatment Center

- **Population Demographics**

  Total Population: 550

  State Inmate Pop: 310

  Total Civil: 207

  Total Temp. Comm: 31

MHM Sex Offender Treatment Program (SOTP)

- Populations Served
  - State inmates convicted of a sexual offense
  - Temporarily committed offenders
  - Civil residents committed as Sexually Dangerous Persons (SDPs)

- Multiple Facilities
  - State inmates

    -Massachusetts Treatment Center (MTC)

    -North Central Correctional Institution- Gardner

    -Massachusetts Correctional Institution-Norfolk

    -Old Colony Correctional Center

    -Massachusetts Correctional Institution- Framingham
  - Civil residents

    -MTC (with exceptions)

State Inmates

- Eligibility
  - Generally within 6 years of earliest possible release
  - Need ~18 months on sentence for transfer to MTC
  - Referred by Correctional Programming Officer

- Treatment Phases
  - Assessment & Treatment Introduction (off site only)
  - Assessment & Treatment Preparation (MTC)
    ~6 months
  - Nonresidential Treatment (MTC) OR Residential Treatment (MTC)

Nonresidential Treatment (MTC)	OR	Residential Treatment (MTC)
Moderate intensity treatment		High intensity treatment
12-18 months		24-36 months

  - Maintenance Treatment (MTC, NCCI Gardner, & MCI Norfolk)

SDPs

- Eligibility
  - Temporarily Committed to MTC
  - Civilly Committed as SDP

- Treatment Phases
  - Assessment & Treatment Preparation
    ~6 months
  - Therapeutic Community Treatment
    High Intensity Treatment
  - Community Transition House
  - Community Access Program

Overview of Best Practices for Treatment of Adult Sexual Offenders

Best Practices: Treatment

- Best Practices in SO Treatment
  - Cognitive Behavioral Therapy (CBT) model
  - Include aspects of Social Learning Theory
  - Include components of Relapse Prevention (RP)
  - Focus on dynamic risk factors
  - Focus on risk, needs, responsivity principles
  - Incorporate aspects of positive psychology (strengths-based treatment)
  - Individualized treatment services
  - Objective measures of treatment progress
  - Focus on risk management AND rehabilitation
  - No more one size fits all treatment

(Ward & Fisher, 2006; McGrath et al., 2010; Olver et al., 2012)

Treatment Effectiveness

- Treatment Works! (when using best practices)

- Sexual recidivism
  - 13.4% (Hanson & Bussiere, 1996, 1998)
  - 17.4% untreated vs. 9.9 % treated (Hanson et al., 2002)
  - 17.5% untreated vs. 11.1% treated; a relative 37% reduction (Losel & Shumaker, 2005)
  - 19.2% untreated vs. 10.9% treated; a relative 43% reduction (Hanson et al., 2009)
  - 20.2% untreated vs. 10.7% treated (Olver et al., 2012)

- General recidivism
  - 12.2% (Hanson & Bussiere, 1996, 1998)
  - 51% untreated, 32% treated (Hanson et al., 2002)
  - 32.5% untreated, 22.4% treated (Losel & Shumaker, 2005)

Shift in Treatment Models

- Classic Relapse Prevention model is most widely used
  - Use is declining significantly (McGrath et al., 2010)
- Criticisms:
  - ‘One size fits all’ treatment
  - Includes only one offense pathway
  - Focus on avoidance goals only
  - Minimal support in treatment outcome literature
- Move toward a more comprehensive RP model
  - Differences related to offense pathway(s)
  - Approach and avoidance goals
  - Emotional states and regulation
  - Differences in planning
  - Less emphasis on revealing detailed accounts of offending in order to move forward in treatment

(Laws & Ward, 2006)

Treatment Models

- Risk Need Responsivity (RNR)
  - Risk: who?
  - Need: what?
  - Responsivity: how?
- Self-Regulation Model
  - Modified RP
  - Multiple pathways to offending (approach and avoidant)
  - Based on regulation and goal theories
- Good Lives Model
  - Strengths-based approach
  - Approach is goal oriented (vs. avoidant)

(Laws & Ward, 2006)

RNR

- Risk: Who needs treatment?
  - Match risk level and amount of treatment
  - High risk for recidivism should receive the most treatment
- Need: What treatment is needed?
  - Focus on criminogenic needs /dynamic risk factors
- Responsivity: How is treatment delivered?
  - Style and mode of treatment appropriate for population
  - Account for learning style, motivation, cognitive ability, culture, personality characteristics, etc.

(Andrews & Bonta, 2010; Marshall & Moulden, 2006, McGrath et al. 2010; Andrews et al., 2011)

- SO treatment programs that adhere to all three RNR principles have greater reductions in sexual recidivism (10.9% treated vs. 19.2% untreated)

(Hanson et al., 2009)

SO Risk Assessment

- Static & Dynamic Risk
  - Static Risk Factors
    -Historical, fixed and unchanging factors that contribute to risk of reoffense
    -Not treatment targets- cannot change
    -Level/amount of risk
  - Dynamic Risk Factors
    -Psychological or behavioral factors that can change and contribute to risk of reoffense
    - Stable (relatively enduring)
    - Acute (rapidly changing)

    -Identify treatment targets
    -Level/amount of risk
    -Change in risk/ability to manage risk (increase or decrease)

(Mann et al., 2010)

Influential Research

- Hanson & Bussiere (1996, 1998)
  - Looked at 61 studies with a total of 28,972 sex offenders
  - Identified factors related and unrelated to sexual recidivism

- Mann, Hanson, & Thornton (2010)
  - Empirically supported risk factors (stand alone)
  - Promising risk factors (need supportive evidence)
  - Unsupported risk factors, with interesting exceptions
  - Risk factors worth exploring (inconclusive or no studies)
  - Risk factors with little or no relationship to sexual recidivism

Static Risk Factors

- Prior sexual offenses
- Diverse sexual offenses
  - Contact and noncontact offenses, adult and child victims
- Non sexual violence
  - Separate from sex offense and/or at time of sex offense
- Victim characteristics
  - Unrelated victim
  - Stranger victim
  - Male victim
- History of criminal behaviors
- Having never been married/lived with partner
- Younger age (at time of assessment)
- Having dropped out of SO treatment

(Hanson & Bussiere, 1998)

Risk Factors for Sexual Recidivism

- Sexual preoccupation
- Sexual preference for prepubescent or pubescent children
- Sexualized violence
- Multiple paraphilias
- Offense-supportive attitudes
- Emotional congruence with children
- Lack of emotionally intimate relationships with adults
- Lifestyle impulsiveness
- Poor problem solving
- Resistance to rules and supervision
- Grievance/hostility
- Negative social influences (Mann et al. 2010)

“Promising” Risk Factors

- Hostile beliefs about women
- Machiavellianism
- Lack of concern for others
- Dysfunctional coping
  - Sexualized coping
  - Externalized coping

Factors <u>Unrelated</u> to SO Risk

- Denial*
- Low self-esteem*
- Major mental illness*
- Loneliness*
- Depression
- Social skills deficits
- Poor victim empathy
- Lack of motivation for treatment (assessed pretreatment)

* Some exceptions noted (Mann et al., 2010)

Implications

- Assessment and treatment should target empirically supported risk factors
- No one factor alone is strongly related to recidivism -> do not be over influenced by one factor, assess for a range of risk factors in a comprehensive manner
- Some factors can be changed through treatment, some cannot
- All factors can be managed

Common Assessment Tools

- Static:
  - Static 99-R
  - Static 2002-R

- Dynamic:
  - Stable 2007 & Acute 2007
  - Structured Risk Assessment (SRA)-Forensic Version
  - Sex Offender Treatment Progress Scale (SOTPS)
  - Multidimensional Inventory of Development Sex and Aggression (MIDSA)

Static 99-R

- Revised in 2003 by Harris, Phenix, Hanson, and Thornton
- Actuarial measure of static risk for sexual violence
- 10 items:
  - Age
  - Ever lived with
  - Index non sexual violence
  - Prior non sexual violence
  - Prior sex offenses
  - Prior sentencing dates
  - Convictions for non contact offenses
  - Unrelated victims
  - Stranger victims
  - Male victims

Stable-2007

- Developed by Hanson & Harris
- Most widely used measures of dynamic risk for sexual offenders in United States and Canada (McGrath et al., 2009)
- Designed for community offenders; more recently recommended for use with incarcerated offenders (DPP & DSP; Hanson & Harris 2000 and Hanson & Harris 2004)
- More predictive when looking at average over last 6-12 months…changes the way we look at acute factors, more than imminent risk
- Should be used in combination with Static 99R/2002R to estimate recidivism rates for sexual, violent, and general recidivism with SO

(Fernandez, Harris, Hanson, & Sparks, 2012)

Stable 2007

- Significant Social Influences
- Capacity for Relationship Stability
- Emotional Identification with Children
- Hostility toward Women
- General Social Rejection/Loneliness
- Lack of Concern for Others
- Impulsive Acts
- Poor Problem Solving Skills
- Negative Emotionality
- Sex Drive/Sex Preoccupation
- Sex as Coping
- Deviant Sexual Interests/Preference
- Cooperation with Supervision

Treatment Planning

- Stable dynamic risk factors
  - Can change over time or through learning and using new skills

- Evidenced-based treatment plan
  - Developed based on risk assessment (risk assessment is a checklist for treatment plan)
  - Individualized
    - Treatment recommendations based on factors identified as contributing to risk
    - Specific to the offender- not one size fits all
  - Collaborative
  - Update annually (or more frequently)
    - Evaluate stable dynamic risk factors
    - Measure treatment progress

(Harris & Hanson, 2010; Fernandez et al., 2012;)

Need to Individualize Treatment

- Difference between Child Molester and Pedophile
  - Molesting children is a behavior
  - Pedohilia is a sexual interest/urge
  - Not all child molesters are sexually attracted to children and not all pedophiles molest children

- Types of Offenders Based on Motivation
  - Paraphilic Offenders
    - Paraphilic/deviant sexual interests motivate offending
    - Some offenders are otherwise relatively pro-social
  - Antisocial/Opportunistic Offenders
    - No specific sexual interest in a victim type or sexual behavior
    - Antisocial values/behaviors motivate offending

(Wilson et al., 2012)

Common Language & Key Terms

- Risk Need Responsivity (RNR)
- Static Risk Factors
- Dynamic Risk Factors
- Assessment-based treatment
- Individualized treatment
- Objective measures of treatment progress

MTC SOTP Assessment & Treatment Services

Treatment Model Summary

- RNR is the umbrella
  - Assessment based treatment
  - Match risk level and treatment intensity
  - Target dynamic risk factors in treatment
  - Consider individual factors related to responsivity to treatment

- S-R and GLM models used to engage offenders in treatment, understand offending, and move toward successful treatment and reintegration

SOTP Assessment Services

- Assessment as intervention
  - Occurs early in treatment
  - Required for all state inmates and civil residents who participate in treatment

- Goals/Utility:
  - Motivate and engage offenders in treatment
  - Identify risk and level of service needed
  - Identify treatment targets
  - Facilitate development of individualized treatment plan
  - Measure treatment progress
  - Communication of risk/Continuity of care upon release

SOTP Assessment Services

- Comprehensive Evaluation
  - Includes Clinical Interview, Risk Assessment, Personality Assessment, and Cognitive Screen (additional measures if necessary)
  - Risk measures: Static 99-R and Stable 2007
- Penile Plethysmograph (PPG)
- Polygraph (in development)
- Annual updated Stable-2007

SOTP Treatment Services

- Group therapy (1- 2x/week)
- Psychoeducational classes (based on dynamic risk factors)
- Community meetings, activities & privileges
- Peer support meetings
- Self-help meetings
- Rehabilitation programs
- Reentry services
- DOC services (education, vocation, religious, rehabilitation, reentry)

Treatment Progress

- Objective
  - Initial and annual Stable 2007 scores
  - PPG data
  - Institutional conduct
- Subjective/Clinical Impression
  - Clinical narratives about progress made
  - Course evaluations
- Documentation
  - Updated treatment plans
  - Parole status reports
  - Annual Treatment Review (SDPs)

SOTP Reentry Services

- SOTP close to release (state inmates)
- Focus on reintegration begins upon entry to SOTP, increased focus prior to release
- Updated assessments throughout treatment and prior to release
- Collaboration with DOC, related agencies, and community agencies when possible
  - Use of best practice allows for common language between systems and improved continuity of care upon release

Challenges to Reentry

- Catch 22
  - Often need housing and services in place for release/parole, need to be released/paroled to obtain housing and services
- Housing/Homelessness
  - Limited housing resources available: finances, risk, stigma, policy restrictions
- Community contacts
  - Difficult to make contacts: either no resources available or no resources willing
  - Community treatment providers generally do not set initial appointment/intake until offender is released

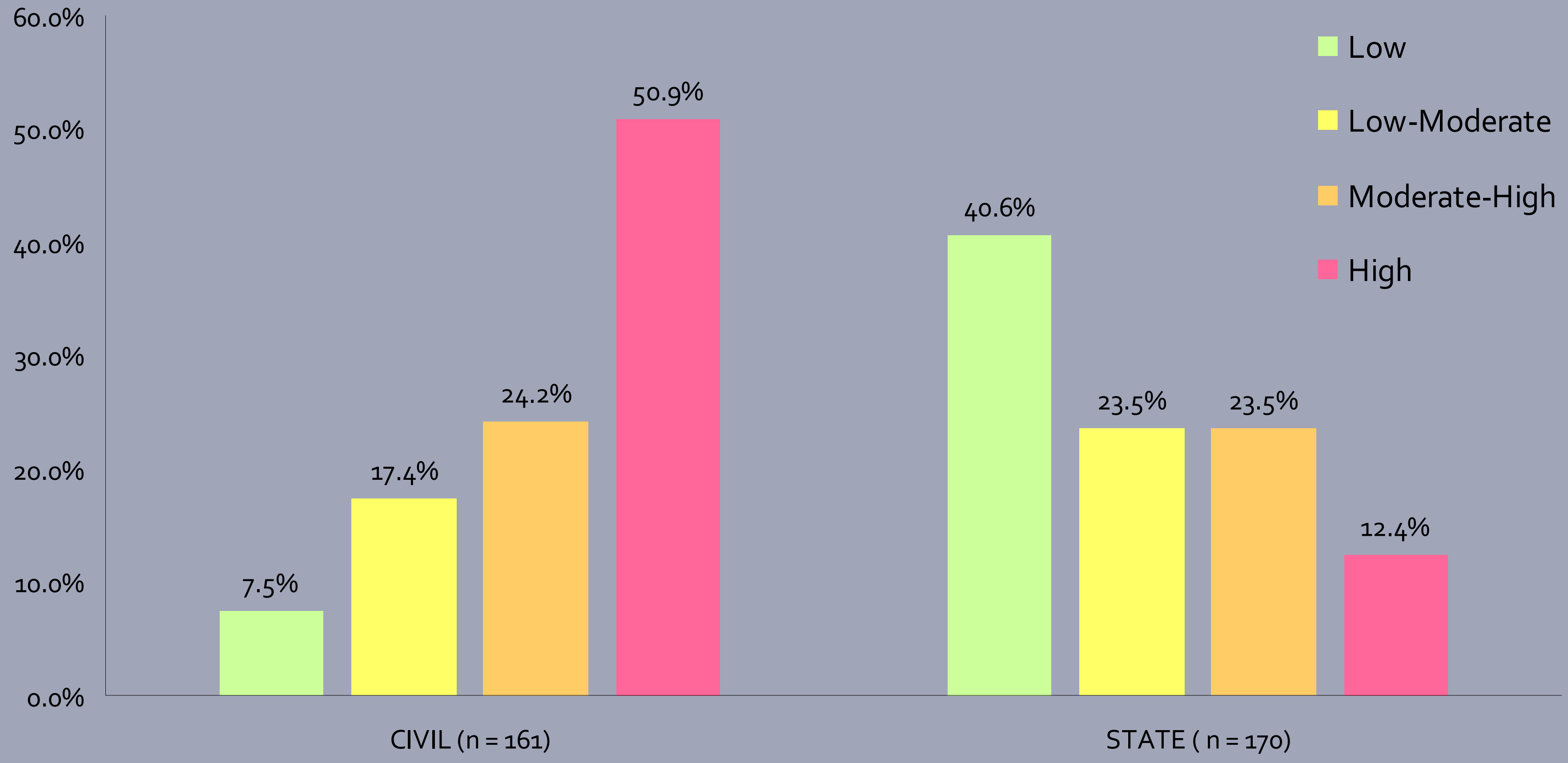
Preliminary Results: Risk Frequency Data at MTC

MTC Program Evaluation Research

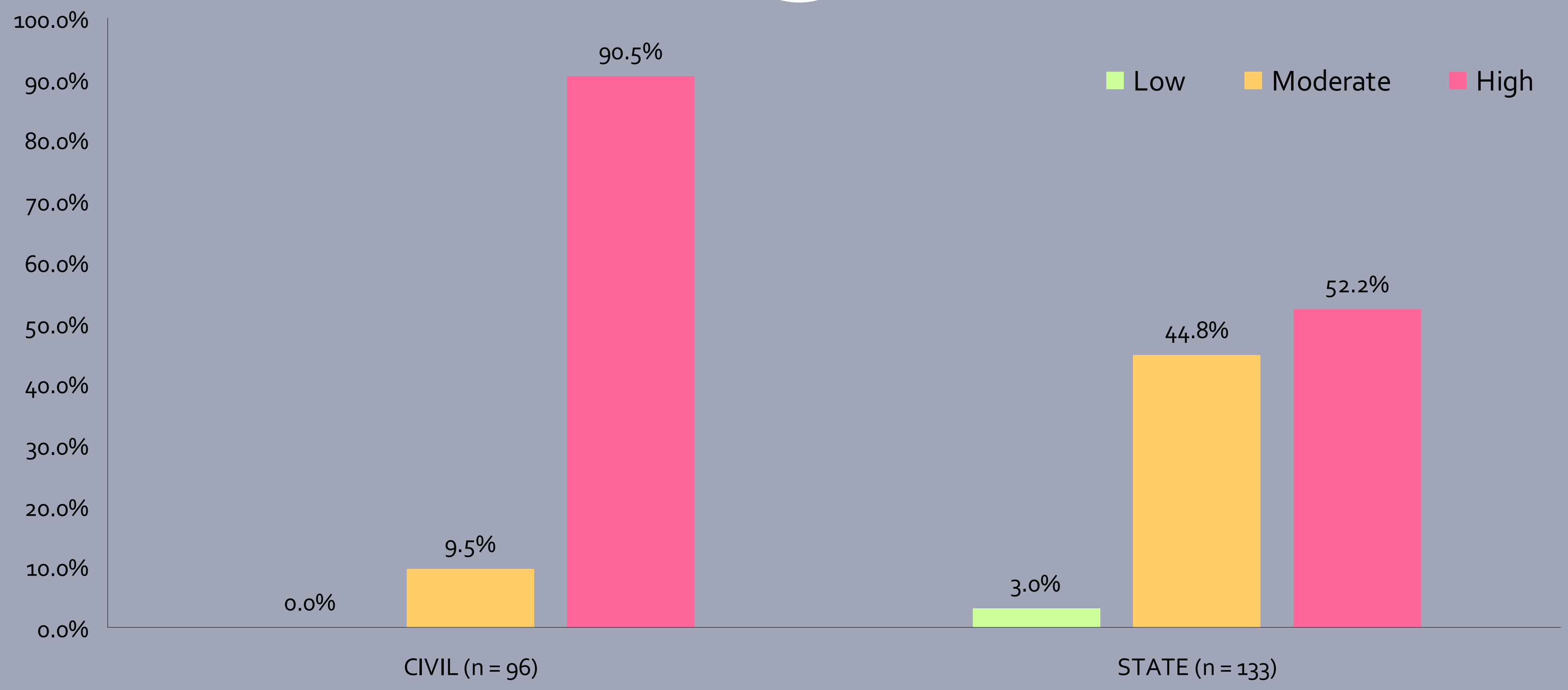
- Research approved by DOC Office of Planning & Research
  - SOTP Director of Research Shanon Maney, Psy.D.

- Goals:
  - Evaluate effectiveness of MHM SOTP
  - Improve the accuracy of identification of risk level/characteristics and improve treatment effectiveness

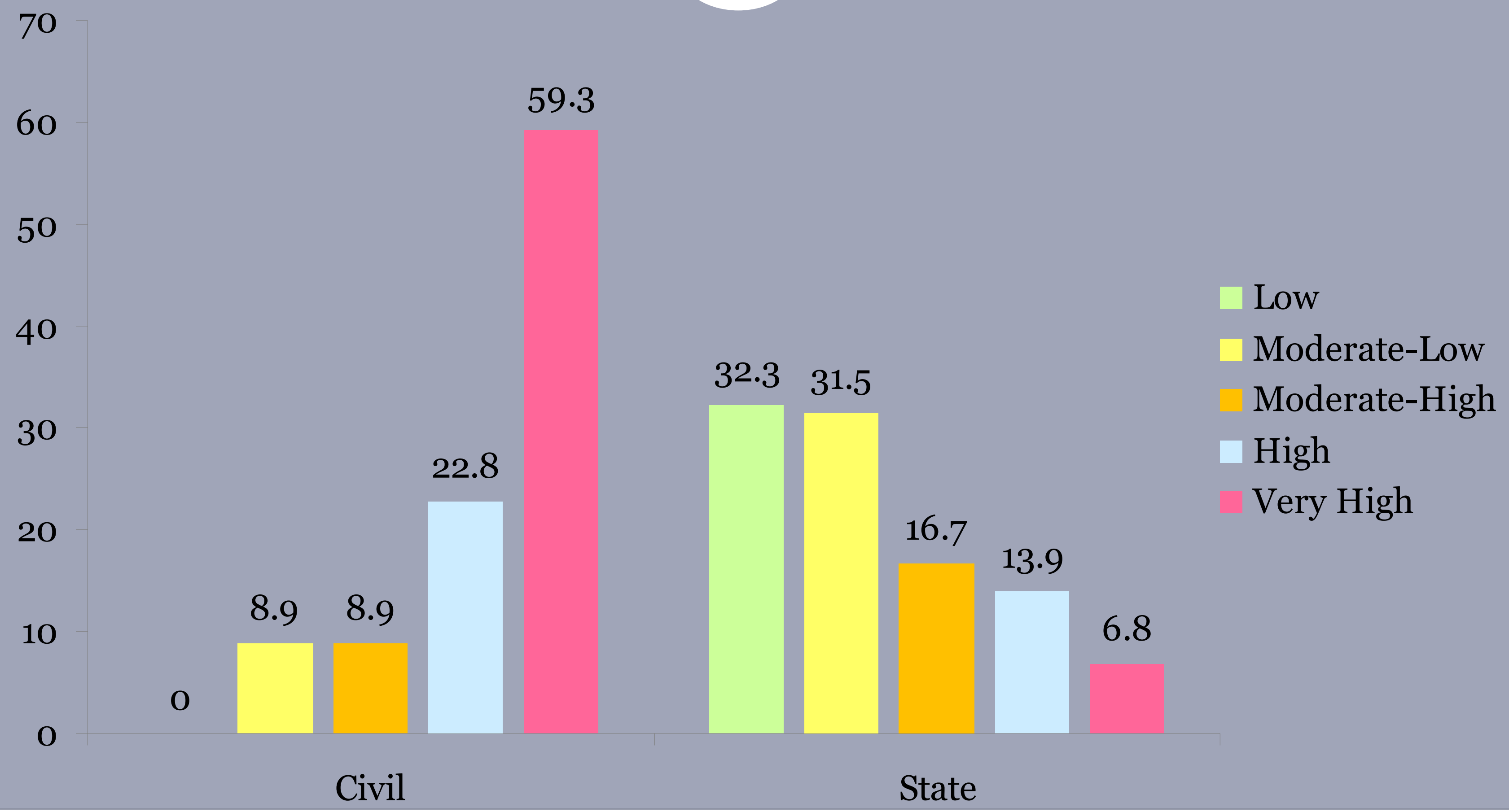
Static-99R Total Scores



Stable 2007 Total Score Comparisons



Static-99R & Stable-2007 Combined



Distribution of Stable-2007 Risk Categories

DSP (Hanson et al., 2007) (n=790)			Massachusetts Civil (n=96)			Massachusetts State (n=133)		
Low	Mod	High	Low	Mod	High	Low	Mod	High
23.3	56.6	20.1	0	9.5	90.5	3	44.8	52.2

Percentages Rounded; Risk Category Percentages for Stable-2007 Scores at First Assessment

Summary & Implications

- State Inmates
  - ~ 60% are in low or low-moderate risk category (combined Static 99R/Stable 2007)
  - ~ 3% are in low risk category on Stable 2007 only
- SDPs
  - No low risk (combined)
  - Majority are in very high risk category (combined)
  - ~50% are in high risk on Static 99R
  - ~90% are in high risk on Stable 2007
- Implications
  - Treatment intensity & resource allocation (differences within state and between state/civil)
  - Improved understanding of risk
  - Reentry planning
  - Importance of developing local norms
  - Communication of risk and treatment needs

Challenges

Challenges: An MHM SOTP Perspective

- Reentry
  - Release Decisions
    - At times inconsistent with treatment recommendations and evaluations
    - Importance placed on acceptance of responsibility
    - Ideally guided by assessments
  - Housing
    - Limited housing available for sex offenders, especially level 3
    - No transitional housing for SDPs
  - Supervision
    - Most SDPs are released with no supervision
    - Often one size fits all supervision for sex offenders (legal restrictions)
    - Ideally conditions are guided by assessments; RNR principles apply
  - Treatment
    - No system to facilitate continuity of care/communication
    - Inconsistency in sex offender treatment offered in community
  - Research
    - No follow up post release = no information on program effectiveness/recidivism
    - Note: research evolves
- Underutilization of MTC Resources?

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Questions

Thank you for your time

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