

Sex Offender Treatment: A Systematic Review of Outcome Evaluations

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Jerry Lee Symposium, February 23-24, 2004,
University of Maryland & Washington, DC

Summary (1)

- 80 comparisons between treated groups (TG) of sex offenders and control groups (CG)
- 9,512 offenders in TGs and 12,669 in CGs
- Overall: a positive effect of treatment (T) on sexual and other reoffending
- Mean odds ratio approx. 1.7; 6-14 percentage points less recidivism in TGs than in CGs
- Great variation between and within types of T
- Largest effects: Castration and hormonal T; however, confounded with other variables
- Cognitive/behavioral programs more effective than other psychosocial approaches

Summary (2)

- Large part of outcome variance due to methodological and other variables
- Relatively large effects in small samples, ambulatory T, and T with researchers involved
- Smaller effects in official recidivism
- Treatment dropouts: high risk of reoffending
- No consistent relationship between design quality and effect size
- However, only one-fifth of studies well controlled
- More high-quality studies strongly needed
- Data support systematic policymaking (e.g., program accreditation)

Background (1)

- Sex offending: a high profile topic in many countries
- Strong public concern due to media reports on extremely serious cases of child abuse
- Over-estimation of real crime figures
- Reforms of penal law
- Incapacitation and treatment as approaches to prevent recidivism
- Controversy about the effectiveness of treatment

Background (2)

Previous reviews vary in

- Types of programs included
- Methodological quality of studies
- Methods of analysis
- Results

This Review

- Psychosocial & biological treatment
- Not only studies in English language
- Analysis of methodological factors
- Inclusion of most recent research
- Authors not involved in specific programs

Questions

- General effects of sex offender treatment on (sexual) reoffending?
- Differential effects?
 - Treatment characteristics
 - Offender characteristics
 - General study characteristics
 - Methodological characteristics
- Knowledge gaps and research deficits?

Eligibility Criteria

- Convicted sexual offenders
- Intervention aimed at reducing reoffending
- Measure of recidivism as outcome
- Control or comparison group (untreated, other treatment, not only dropouts)
- Sample size ($n_{TG} + n_{CG} \approx 10$)
- Sufficient data for effect size computation
- Language: English, German, French, Dutch

Literature Search

- Electronic databases
(e.g., ERIC, PsycInfo, MedLine, C2-SPECTR, NCJRS)
- Previous reviews/meta-analyses
(e.g., Hall, 1995; Hanson et al., 2002; Lösel, 2000)
- Original articles (Snowball method)
- Handsearch of journals
- Internet
(e.g., Departments of Corrections, Conferences)
- Expert contacts

Selection of Studies

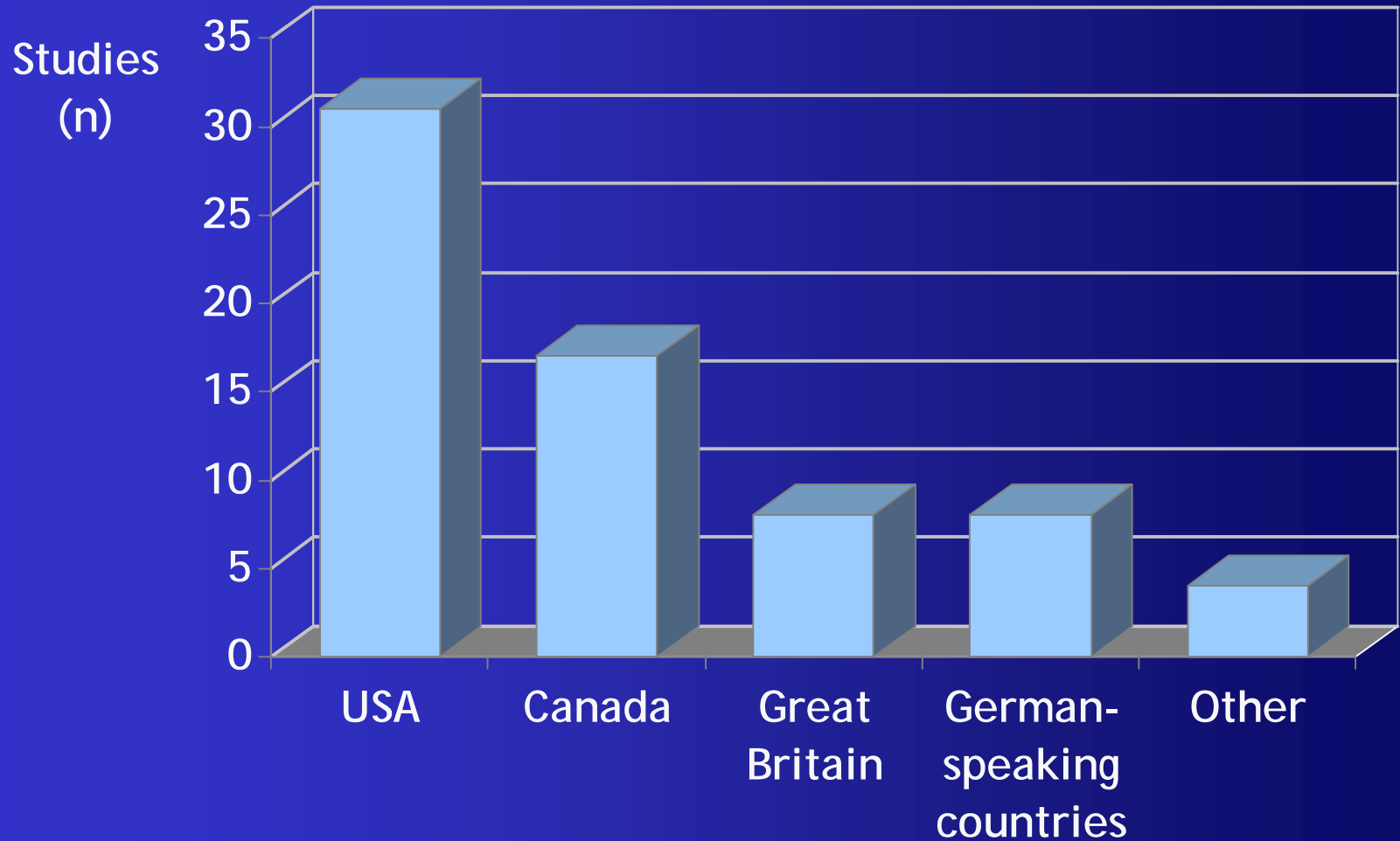
Reports identified (by mid-2003)	2,039
Obviously not adequate	586
Not specific for sexual offenders	242
No primary study / outcome evaluation	641
No recidivism measure	189
No adequate comparison group	236
Double/complementary publication	56
Insufficient data to compute ES	2
Unobtainable	21

Data Base

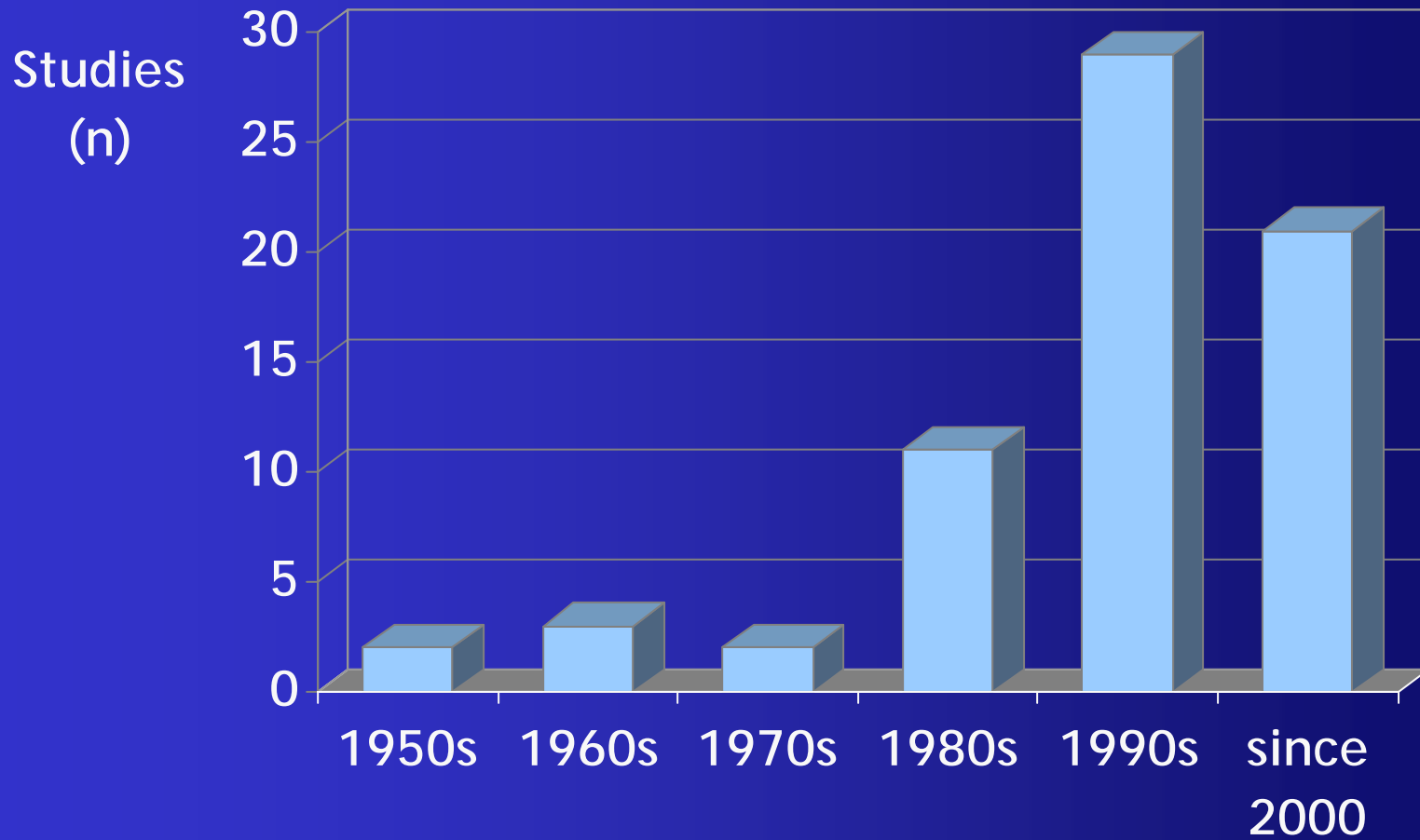
- 66 reports
- 69 studies
- 80 comparisons

- 22,181 sex offenders
 - Treatment $n = 9,512$
 - Control $n = 12,669$

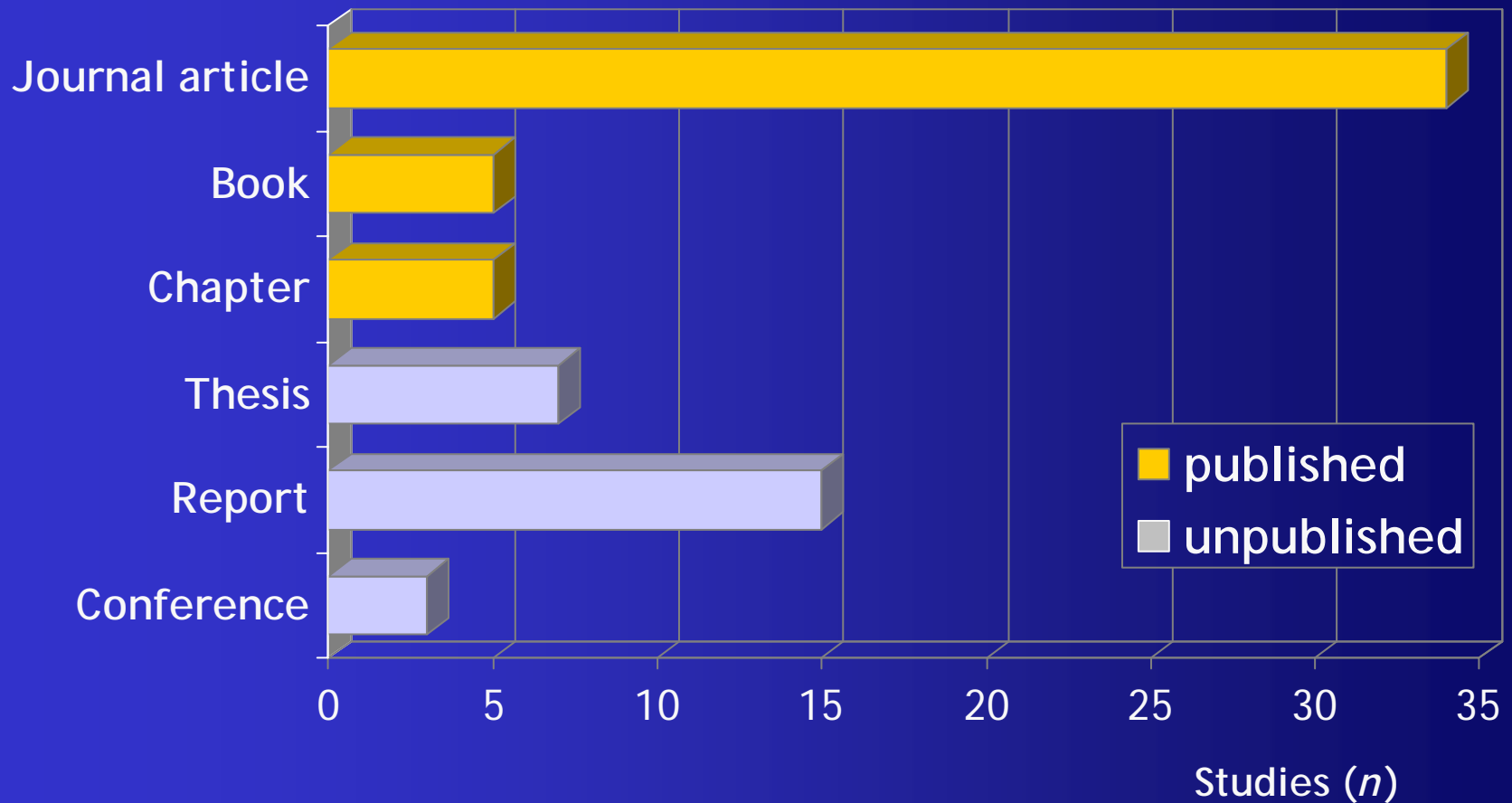
Countries of Origin



Year of Publication

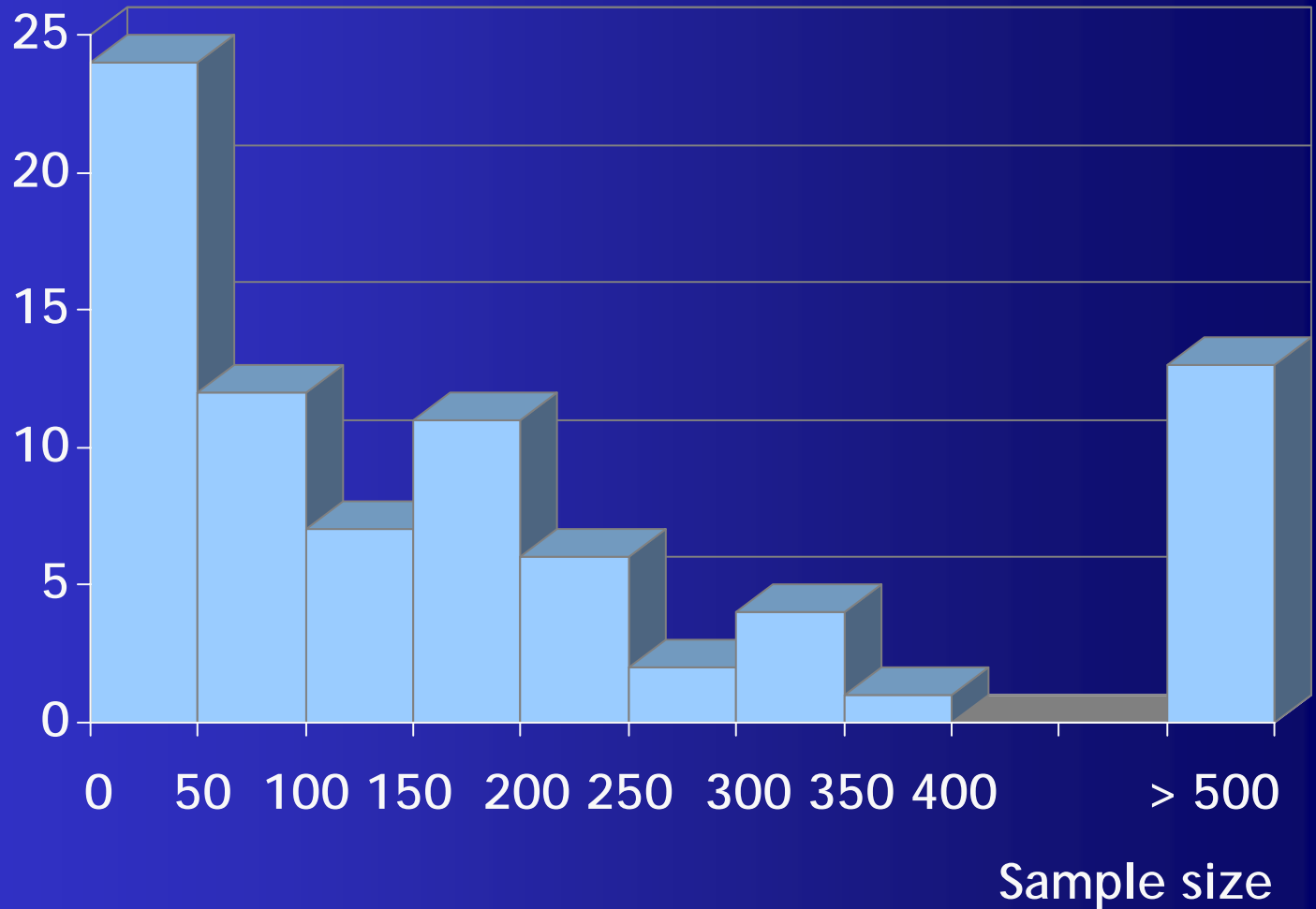


Source of Studies



Total Sample Sizes

Comparisons
(k)



Study Quality: Maryland Scale

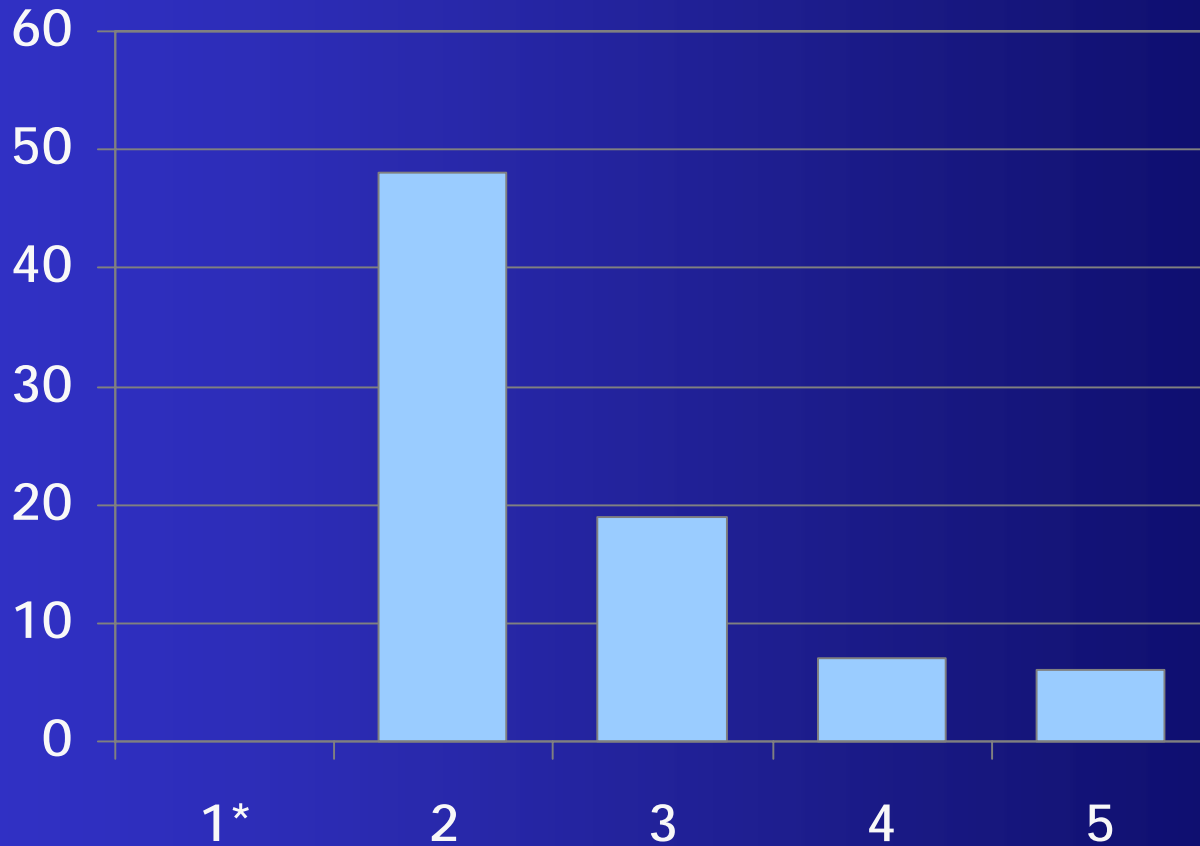
(Sherman et al., 1997, modified)

1. No control/comparison group (CG)
2. Nonequivalent CG (e.g., refusers)
3. CG judged to be equivalent (e.g., comparison of offender characteristics)
4. Systematic strategy applied to achieve equivalence (e.g., matching)
5. Randomized assignment (not impaired by attrition etc.)

Maryland Scale

Comparisons

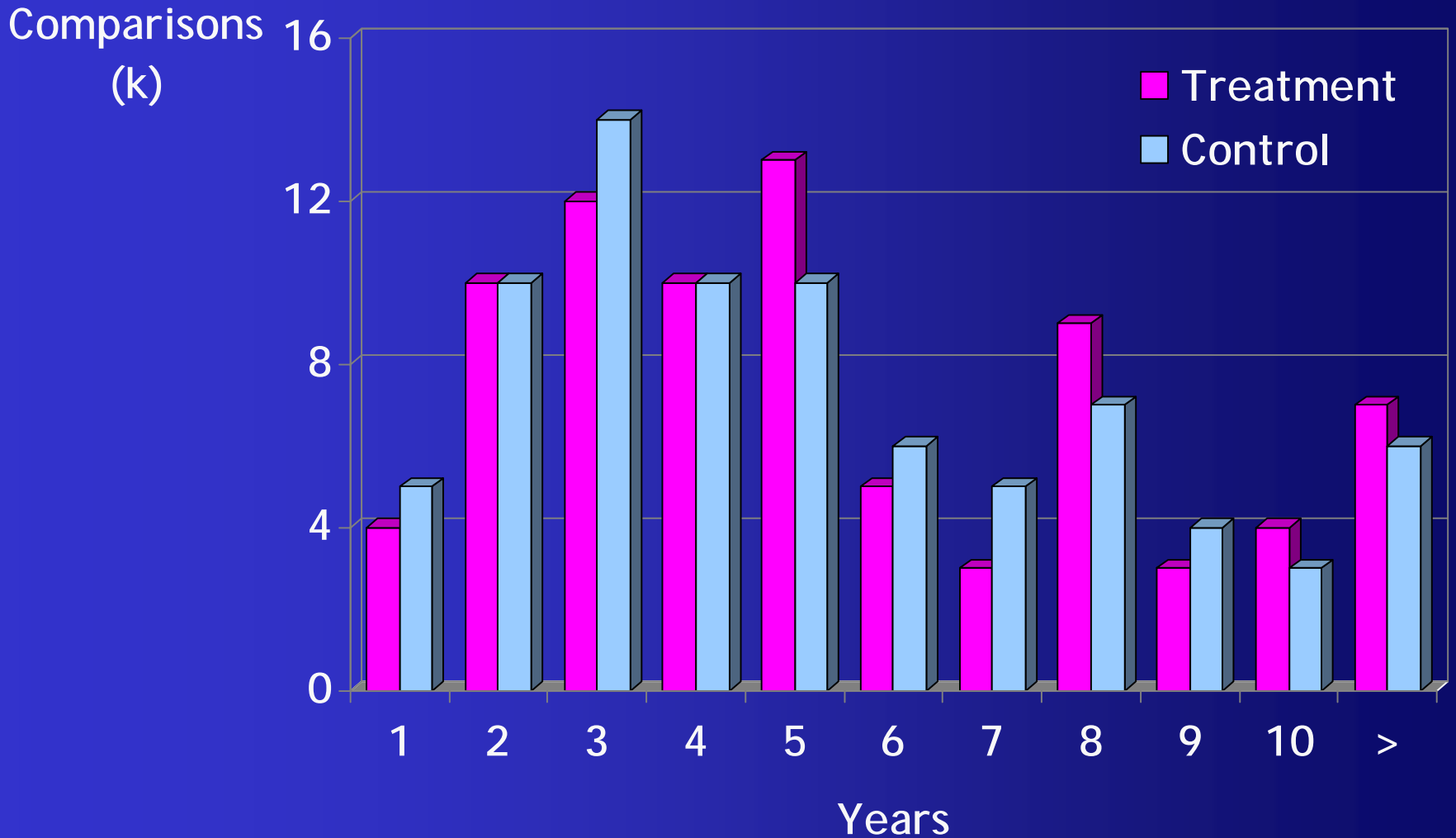
(k)



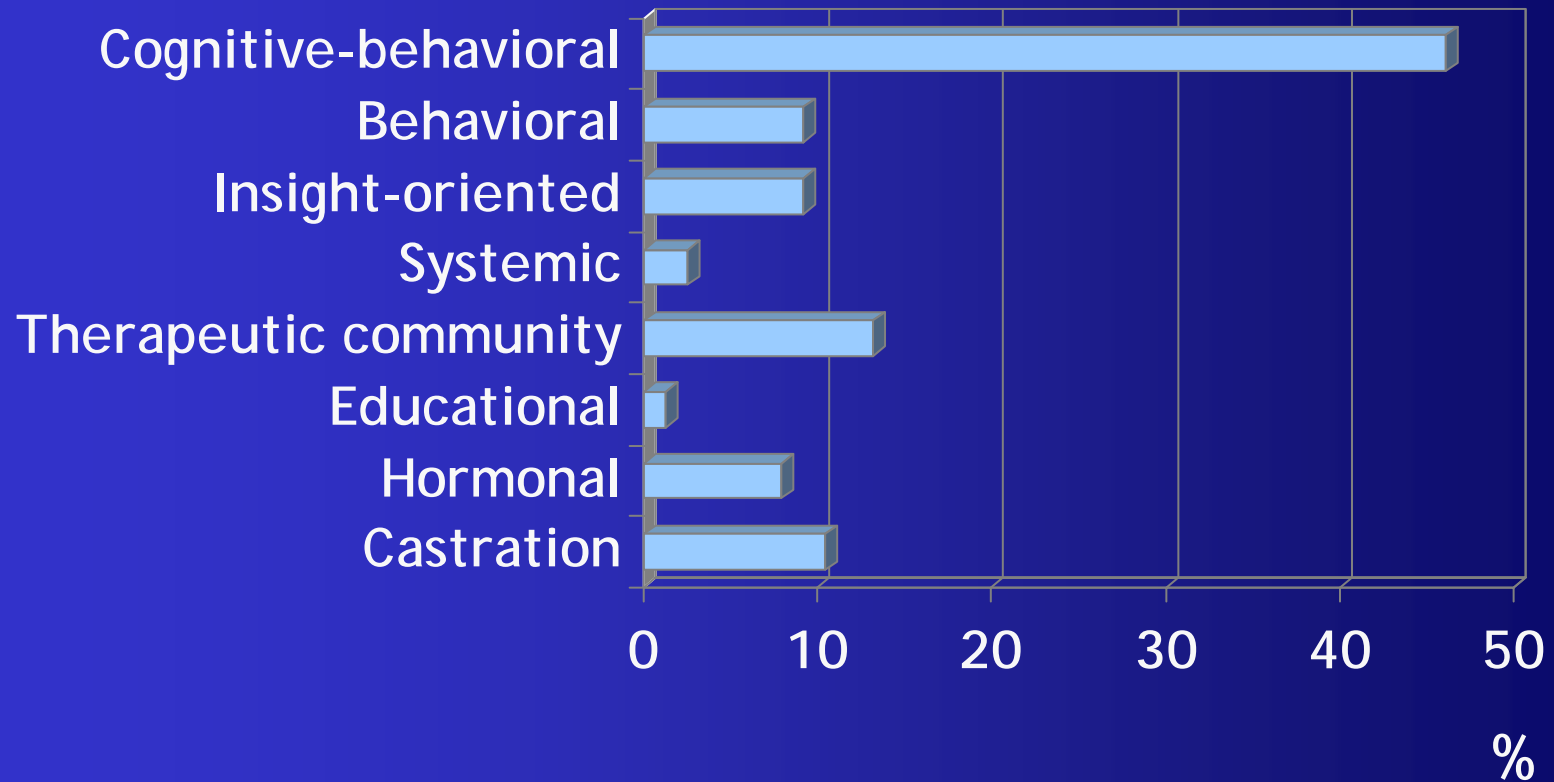
*Excluded

Maryland Scale Rating

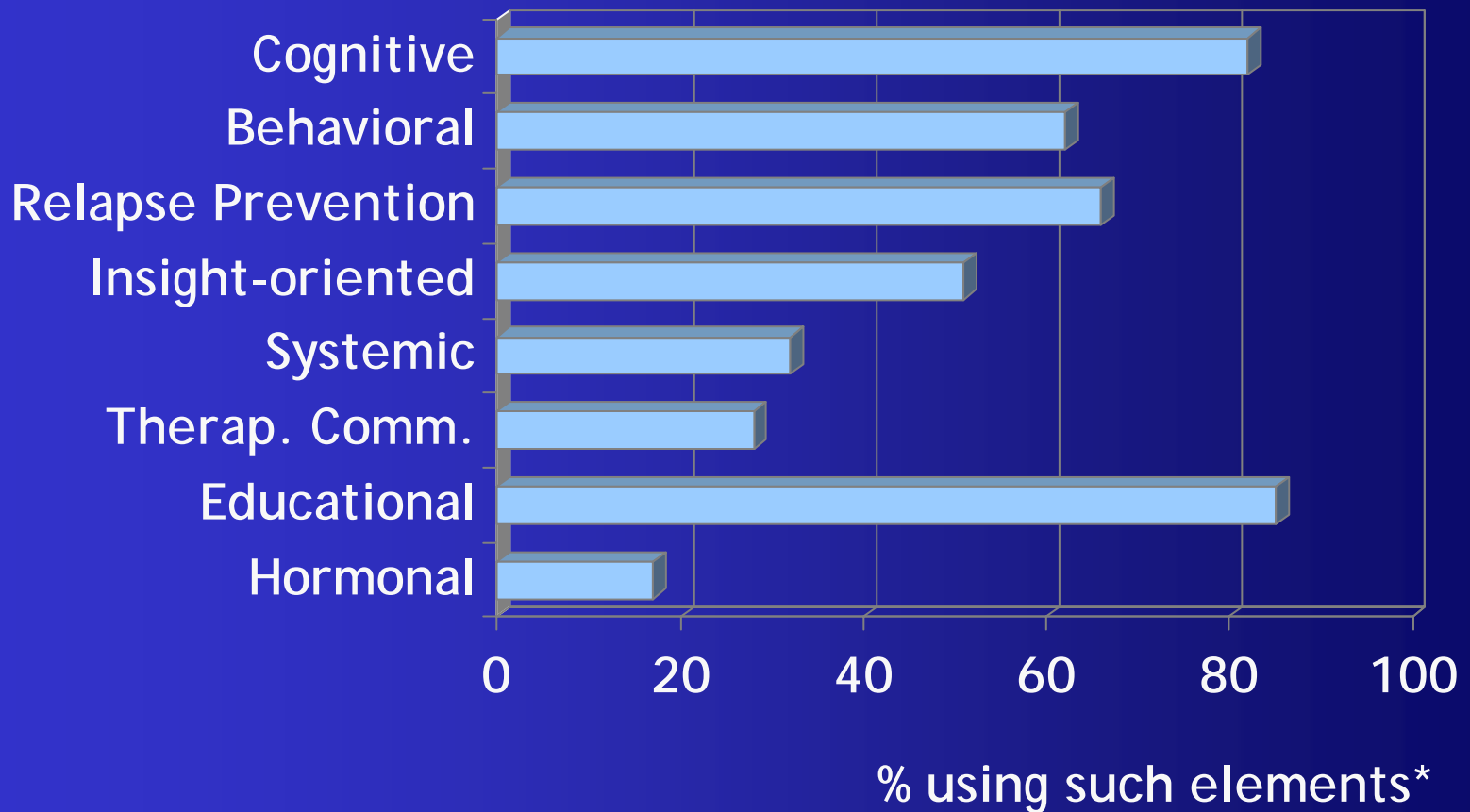
Follow-up Times



Primary Type of Treatment



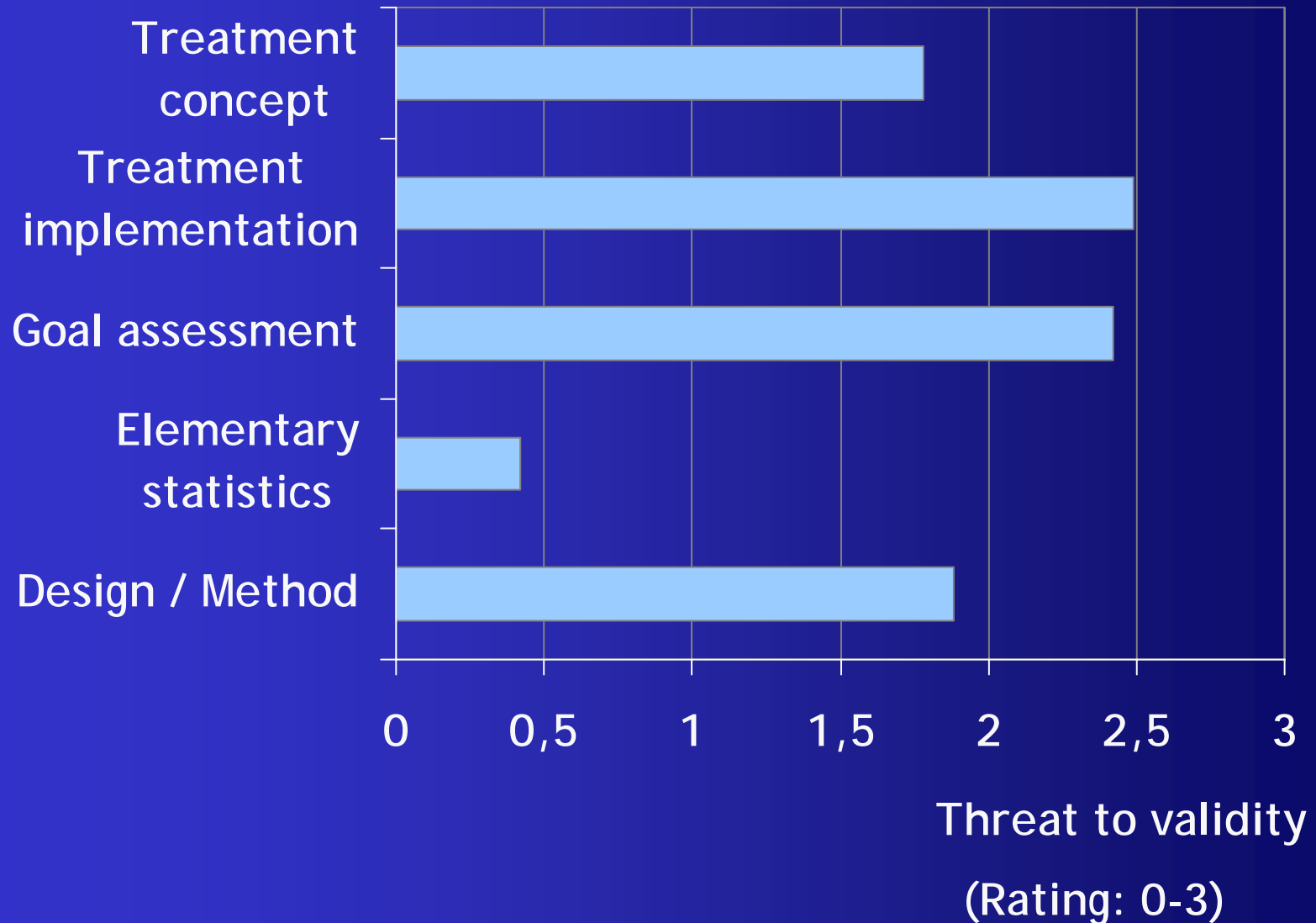
Treatment Elements



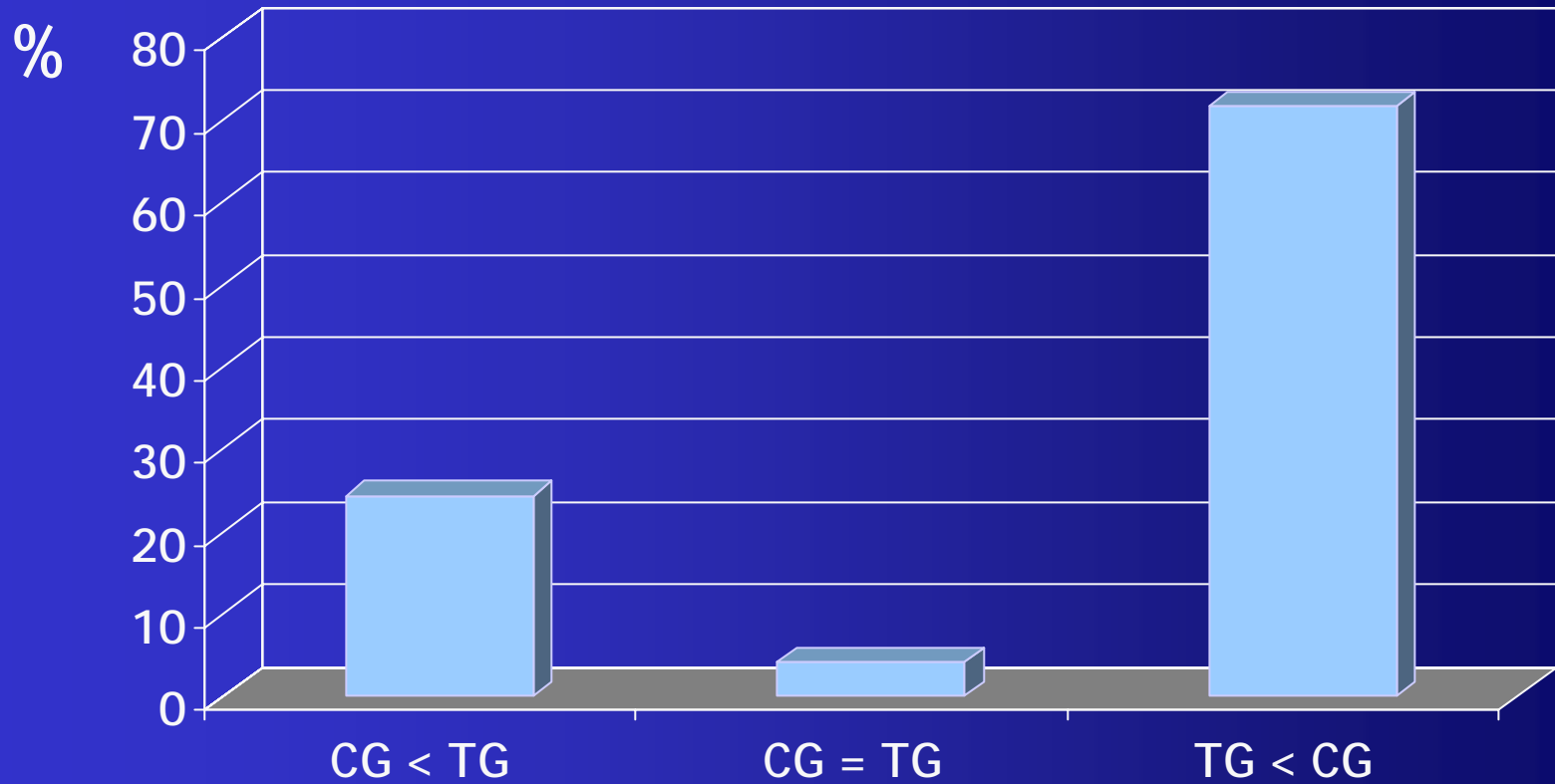
*Castration excluded

Descriptive Validity

(Lösel & Köferl, 1989)



Recidivism in TG and CG



Odds Ratio

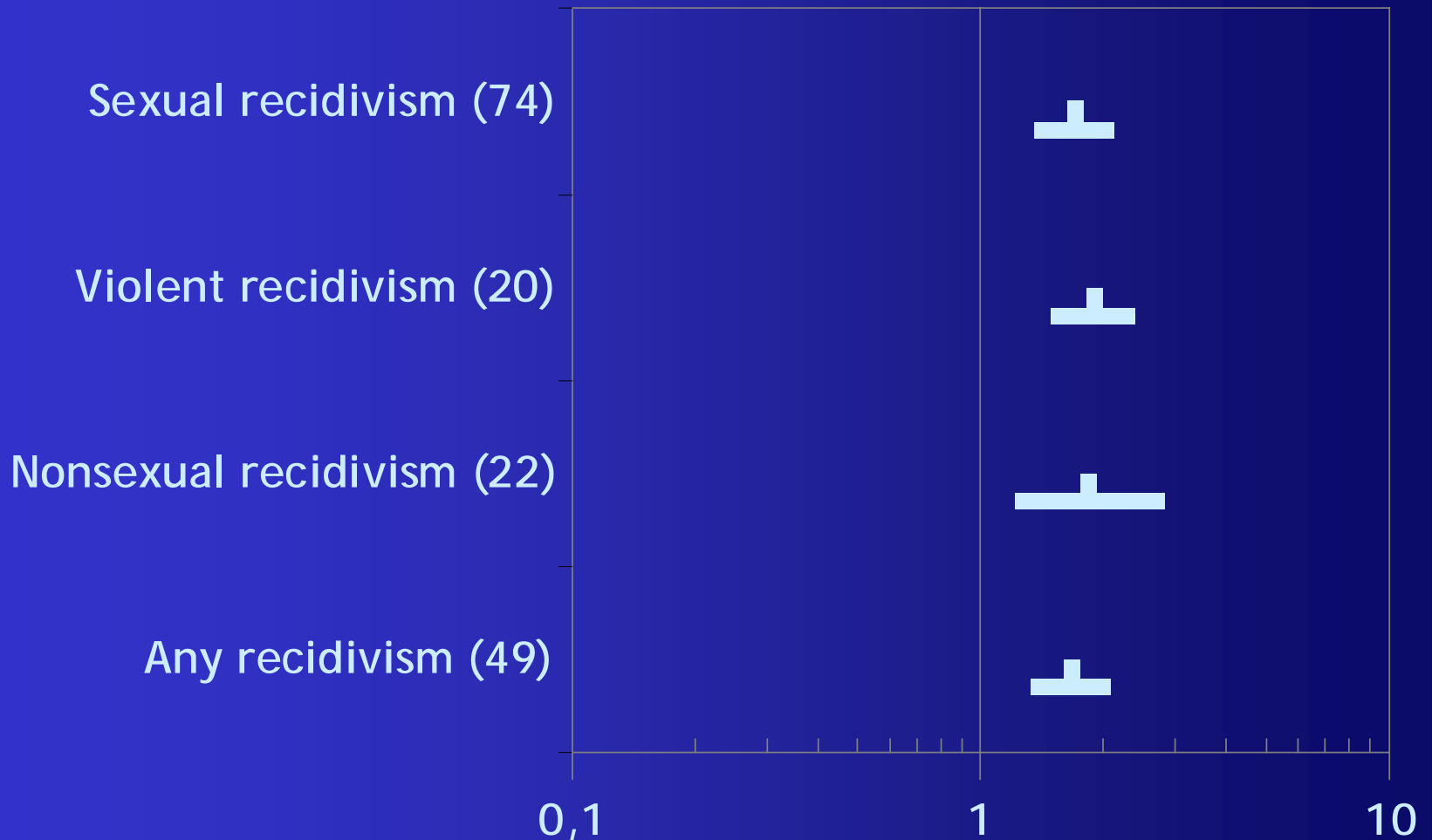
Odds Ratio = Odds CG / Odds TG

Odds = Recidivists / Nonrecidivists

OR < 1: Less recidivism in CG

OR > 1: Less recidivism in TG

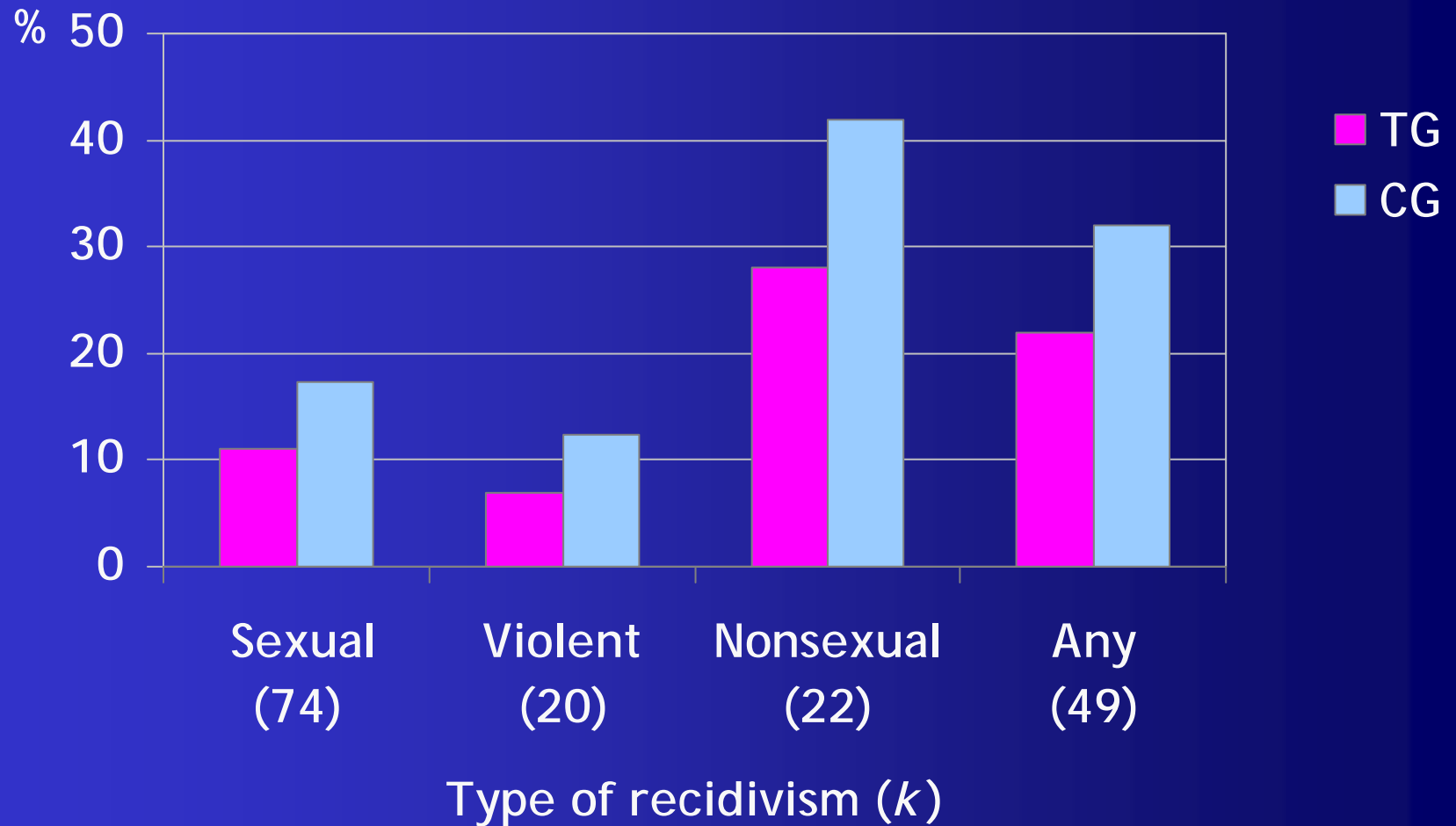
Total Effects



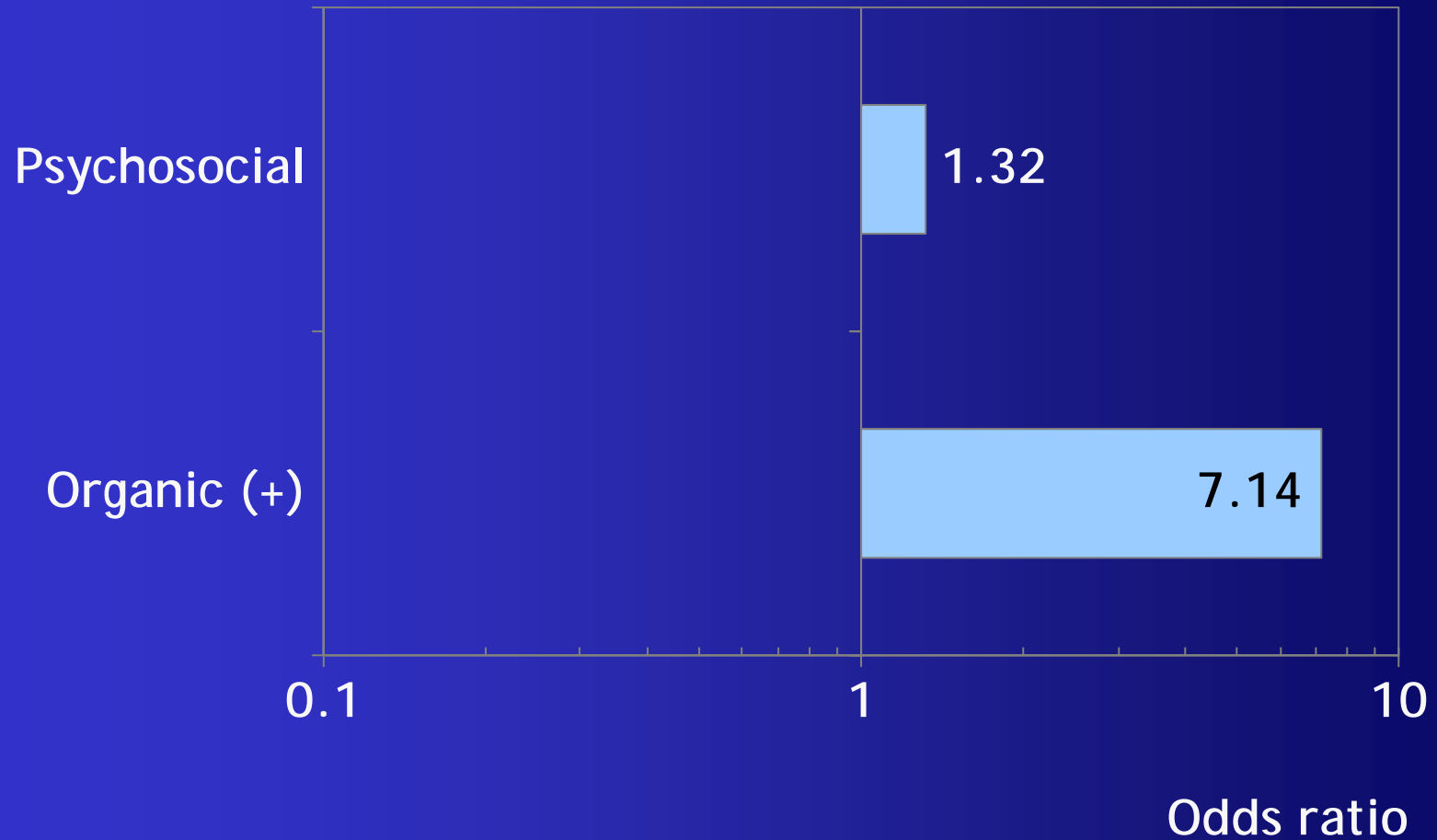
Mean and CL

Odds ratio

Estimated Recidivism Rates

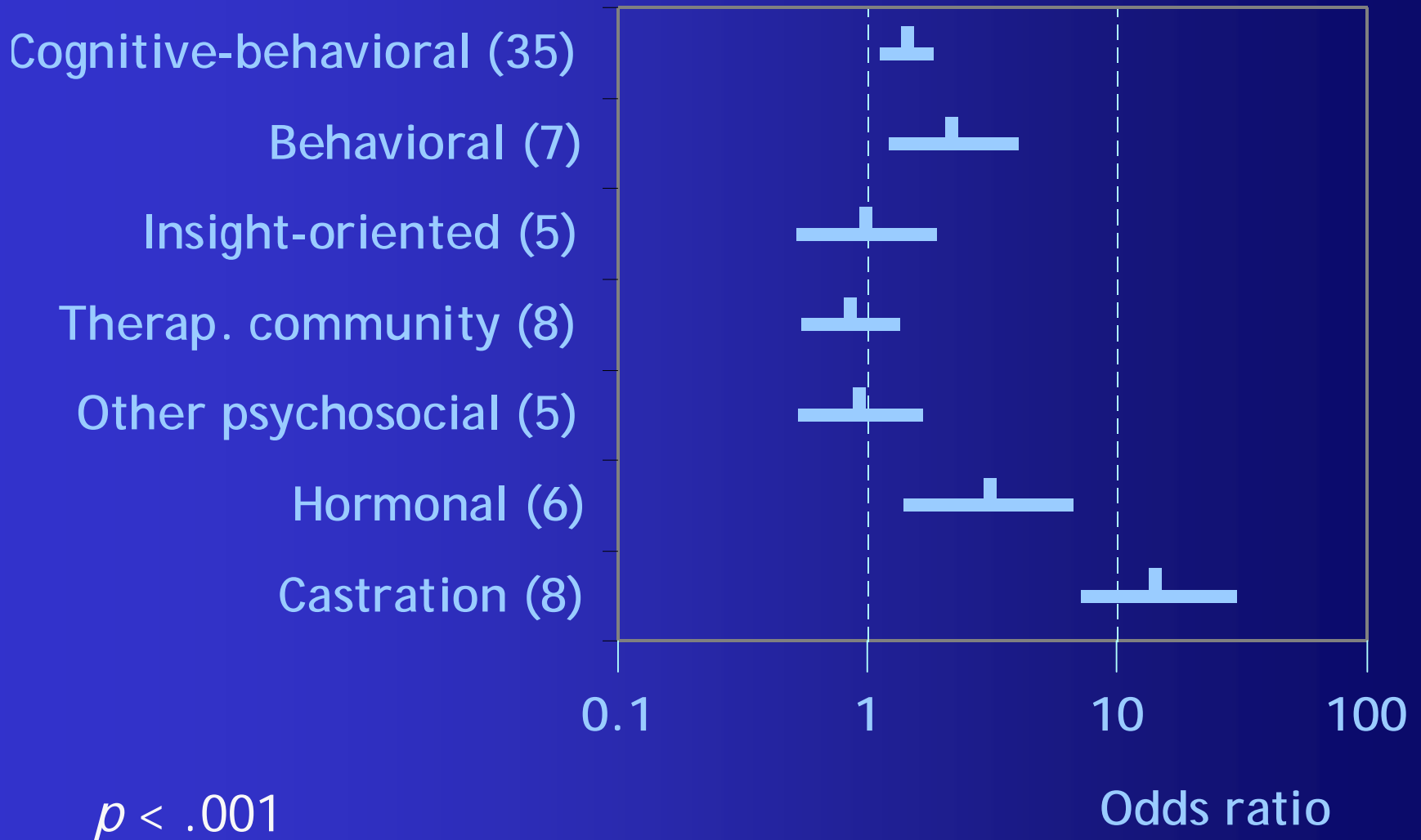


Treatment Type and ES

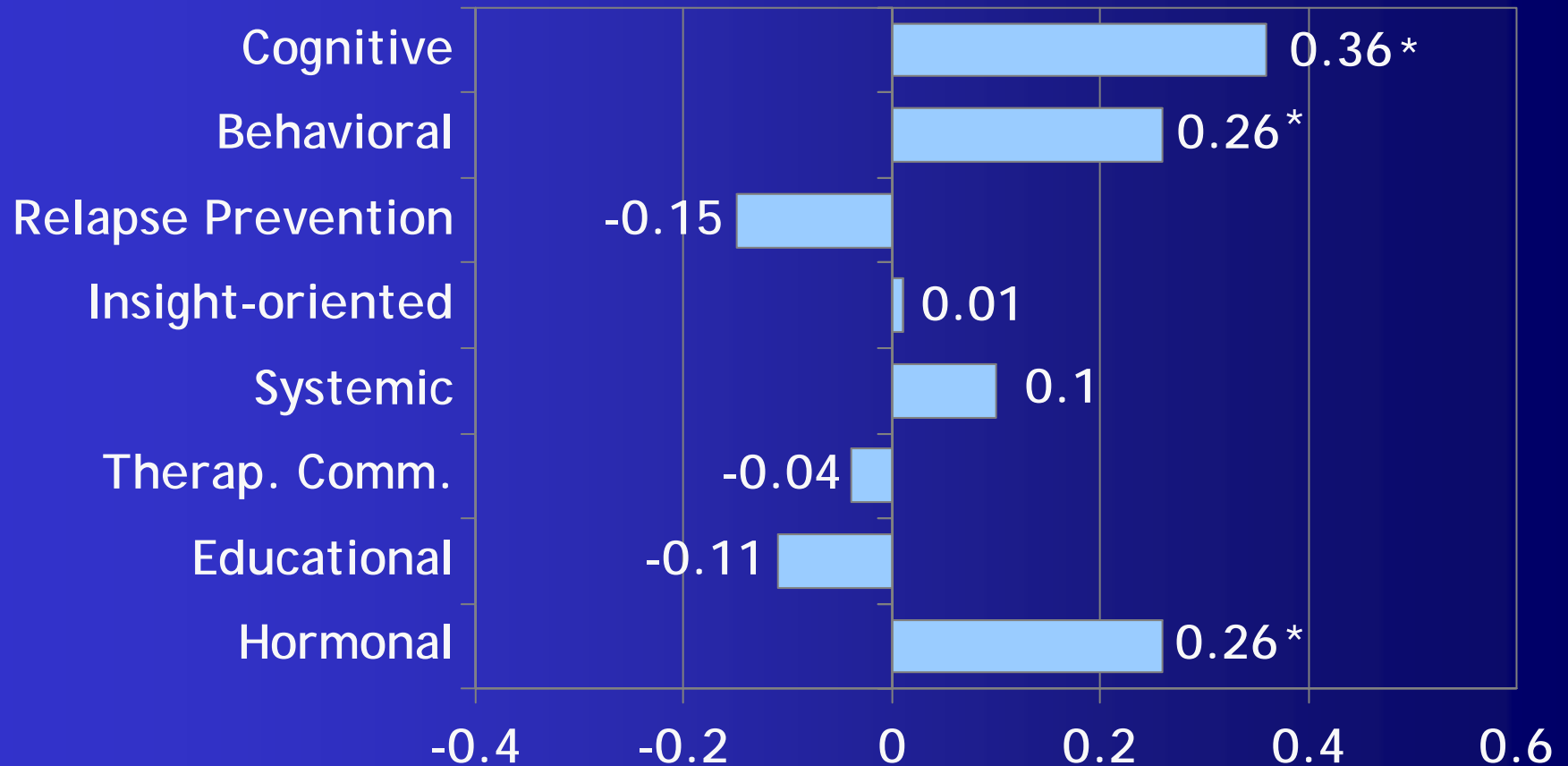


$p < .001$

Mode of Treatment and ES

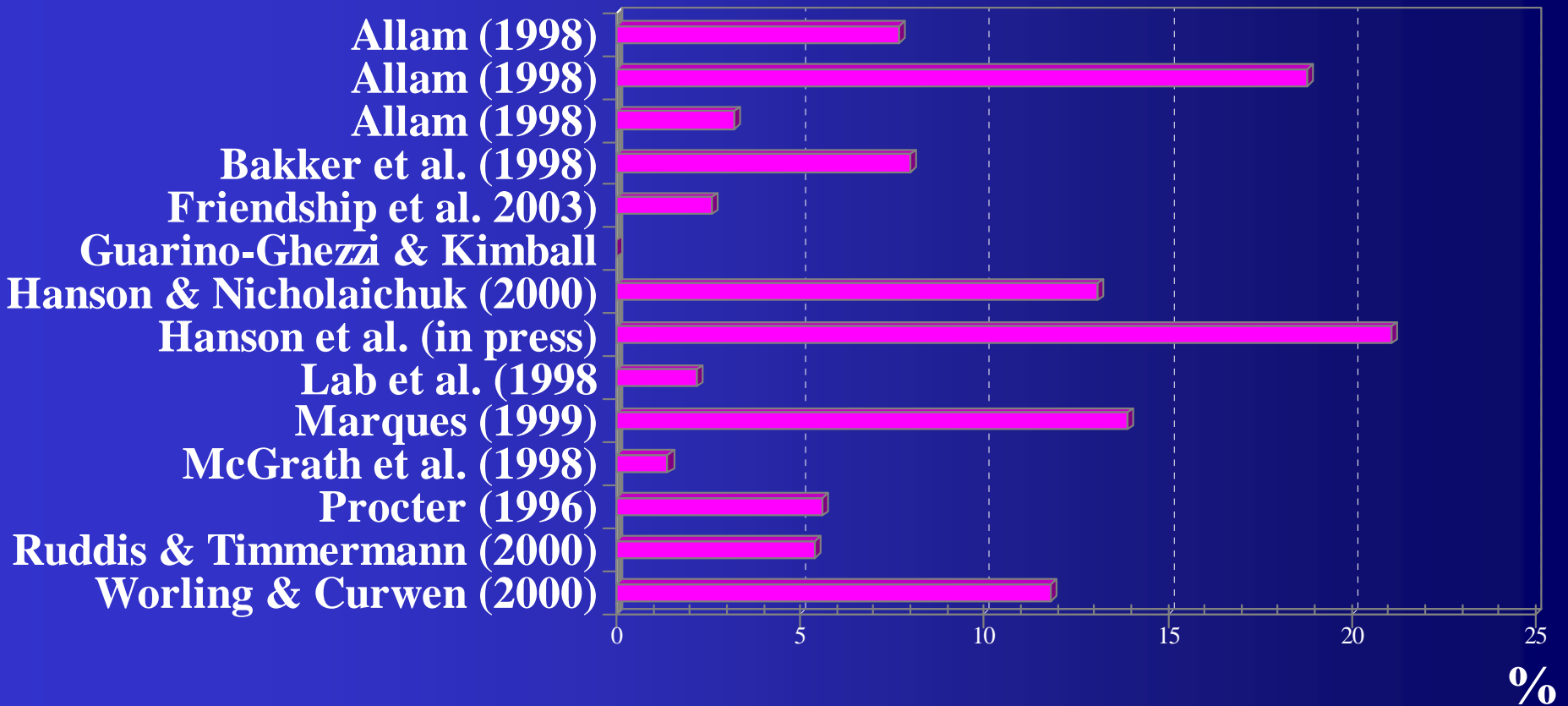


Impact of Treatment Elements on ES



Beta weight

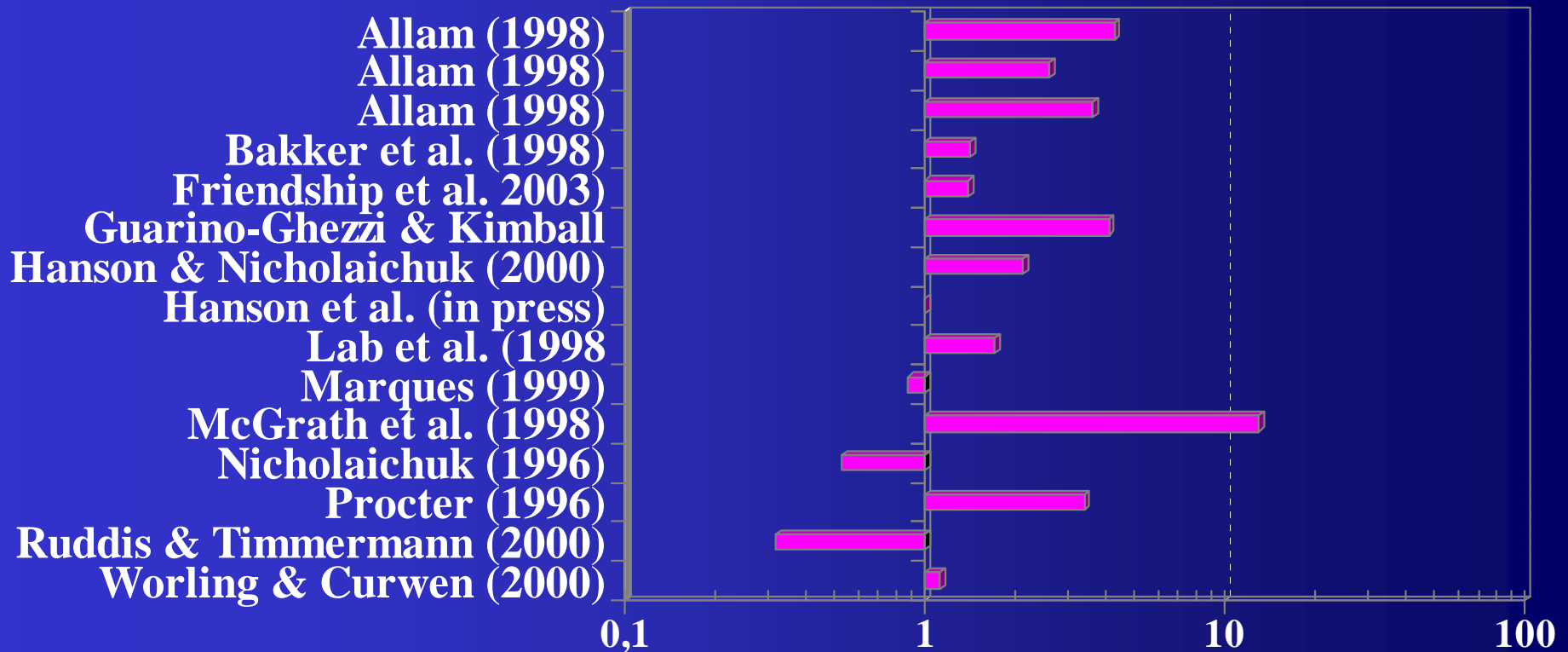
Outcome Variation Between Cognitive-Behavioral Programs *



*Maryland Scale ≥ 3

Recidivism

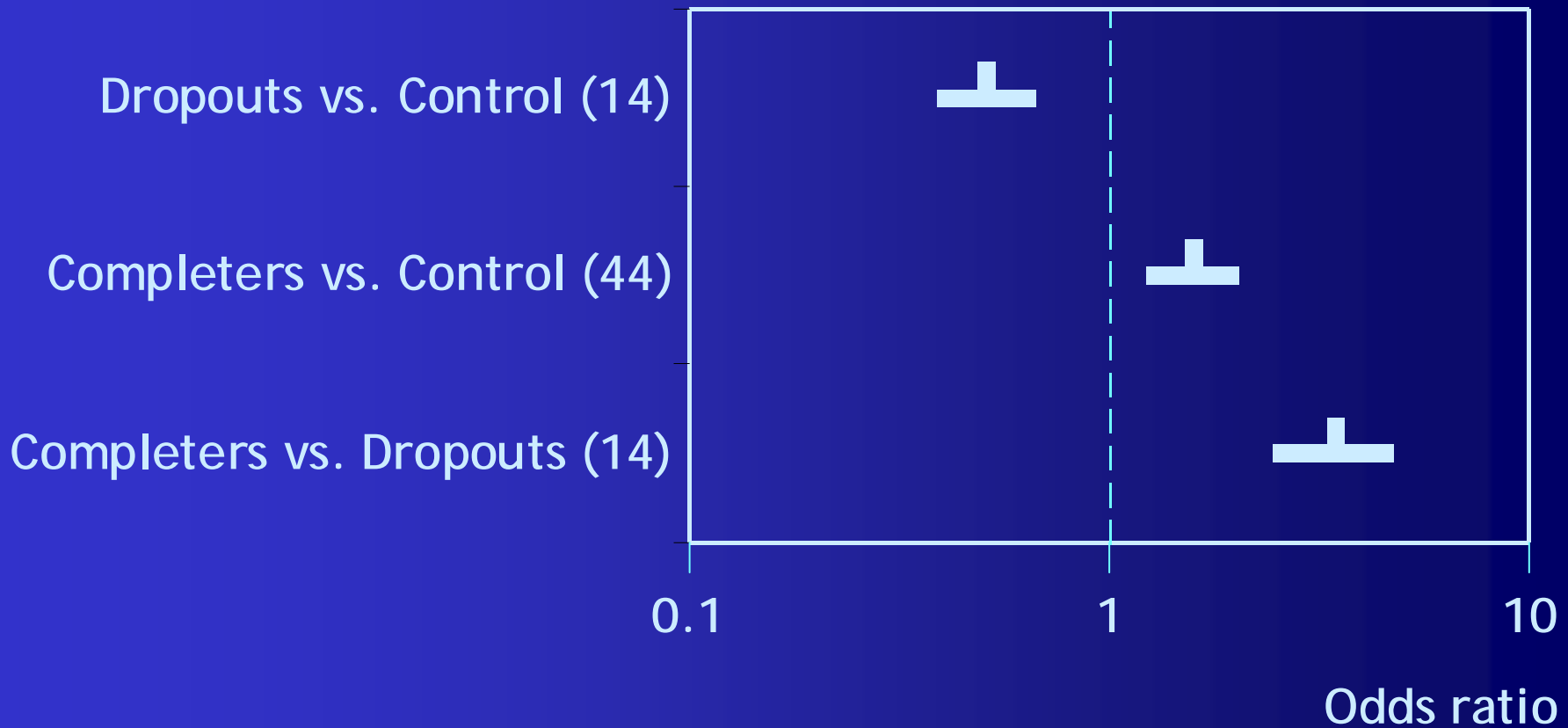
Variation of ES Between Cognitive-Behavioral Programs*



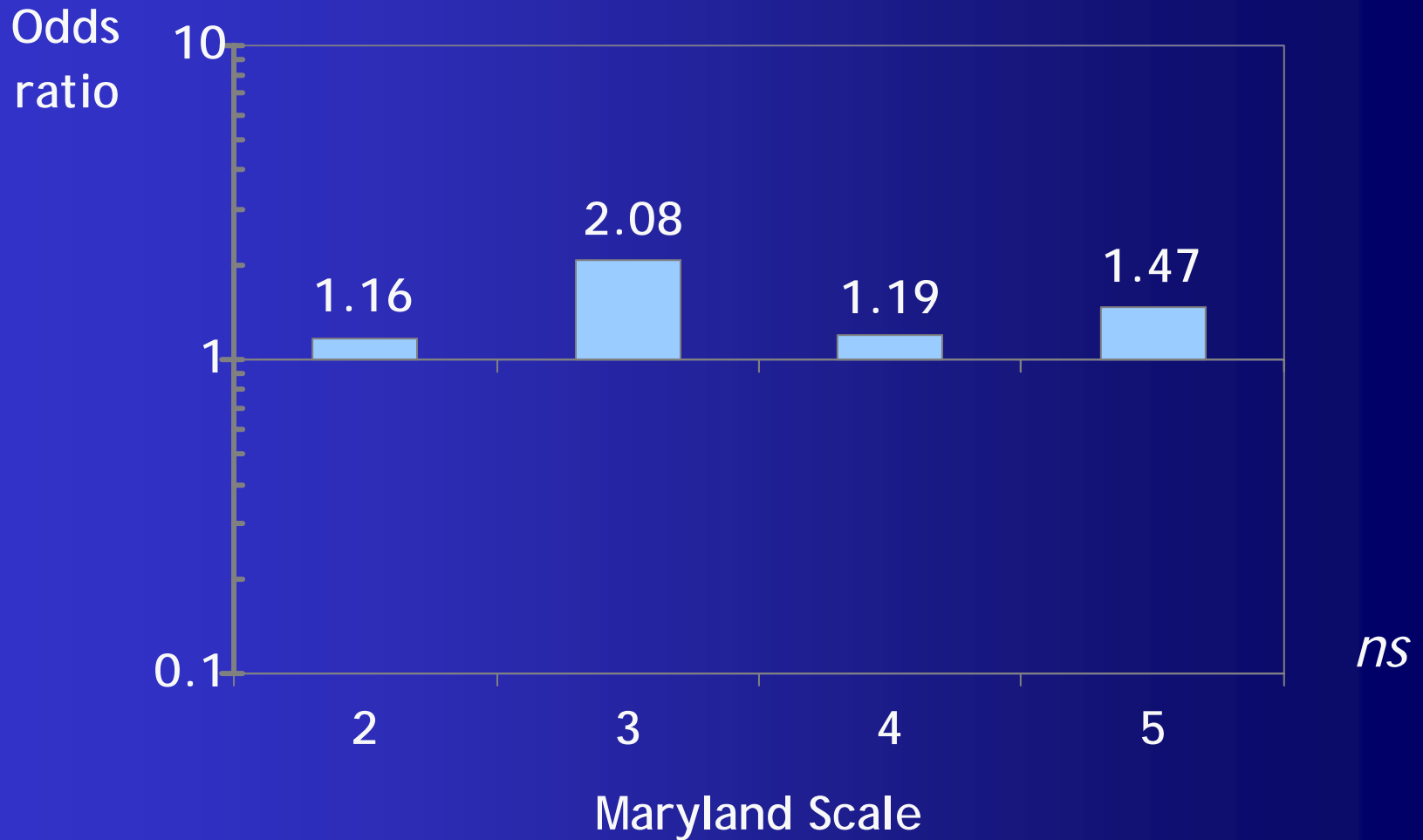
Odds ratio

*All Studies: Maryland Scale \approx 3

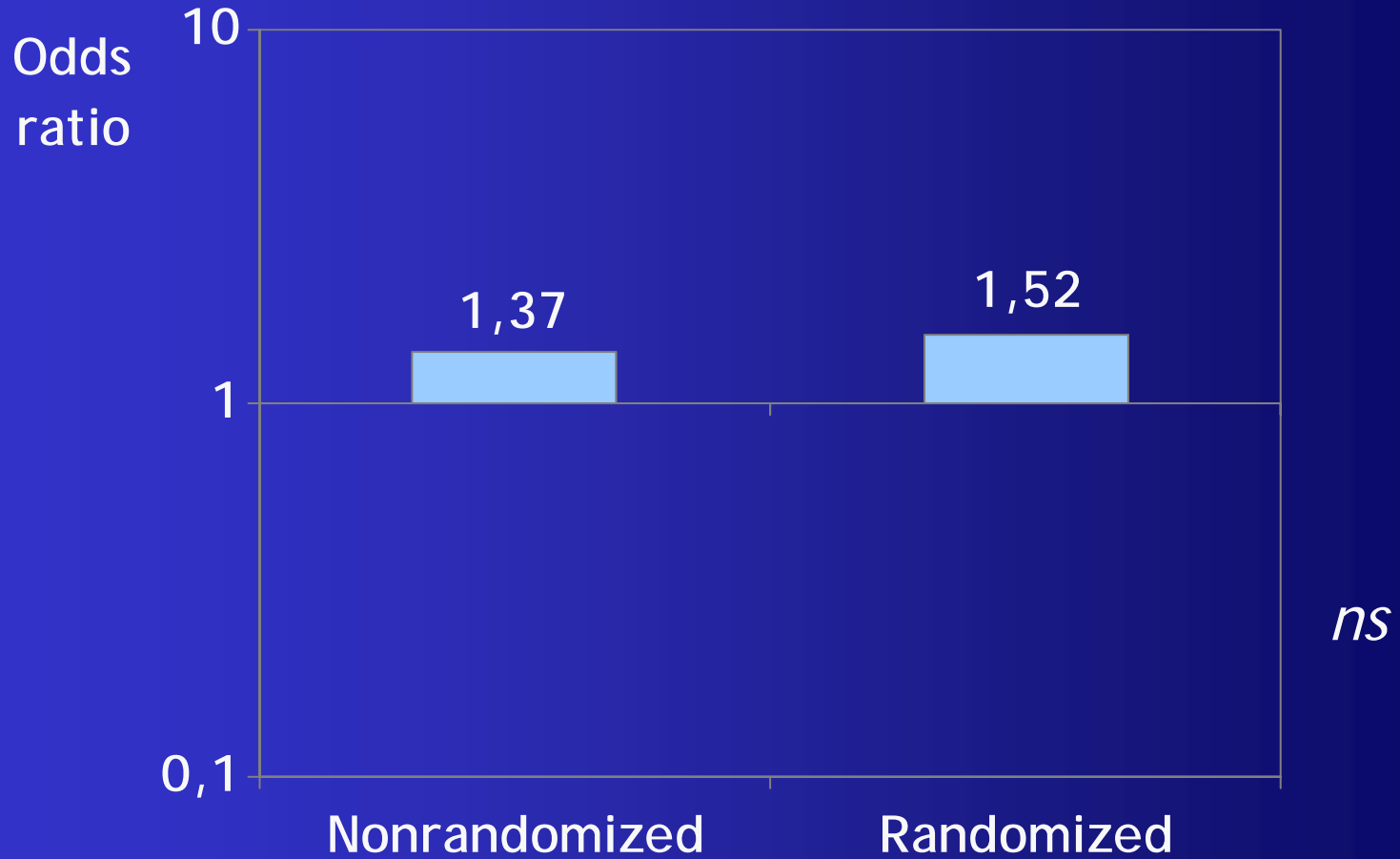
Treatment Dropout and ES



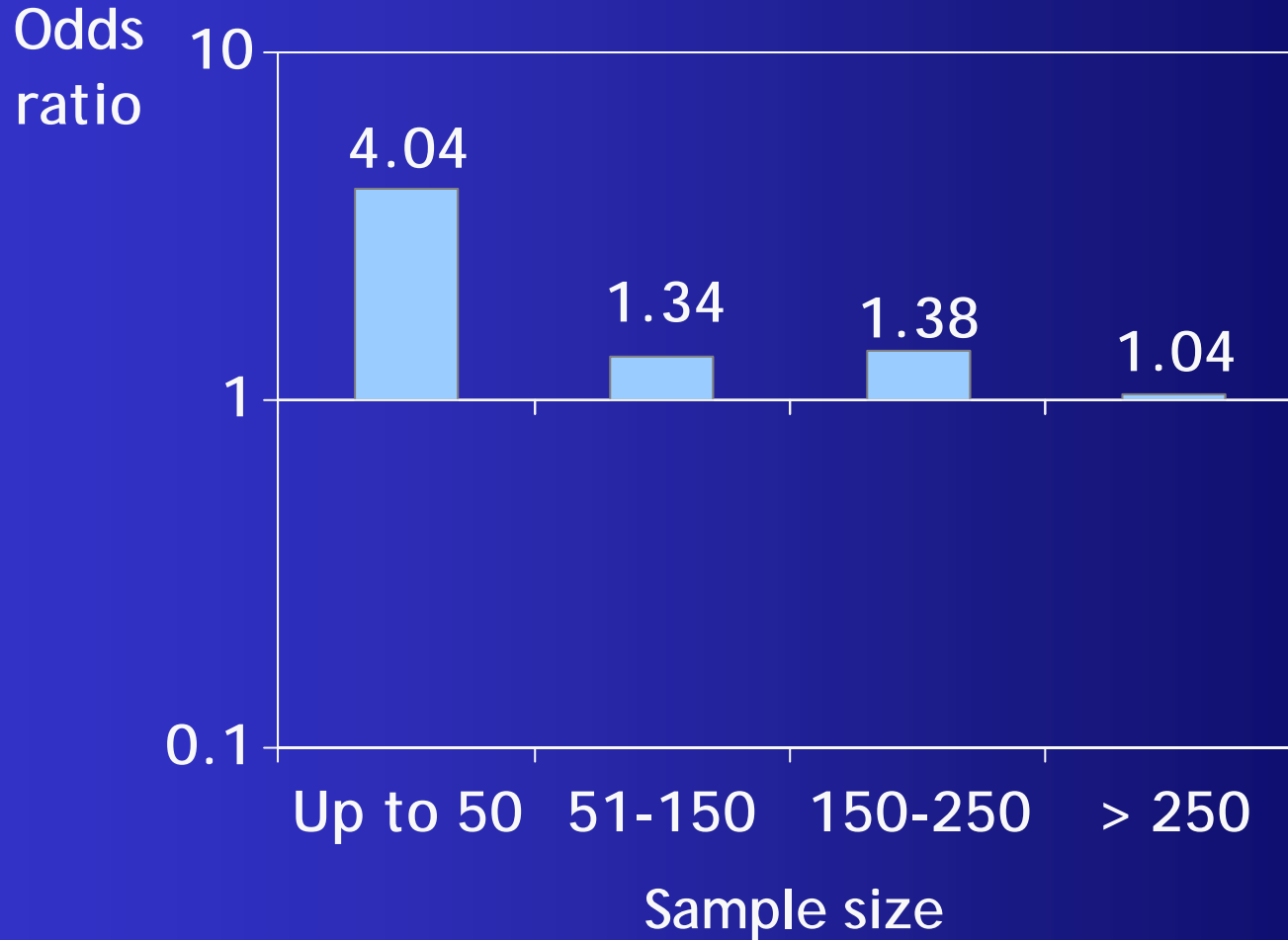
Methodological Quality and ES



Randomization and ES

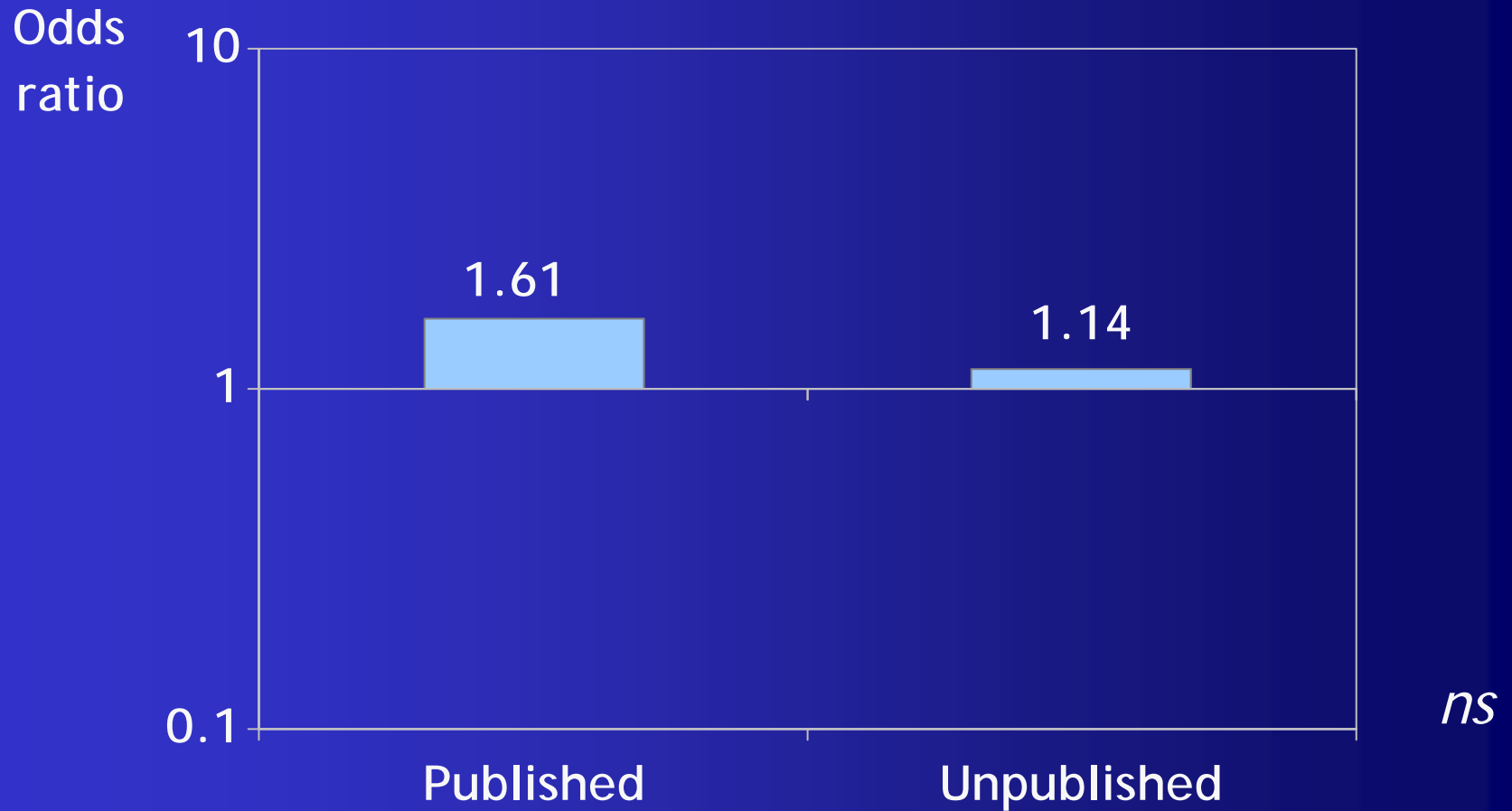


Sample Size and ES

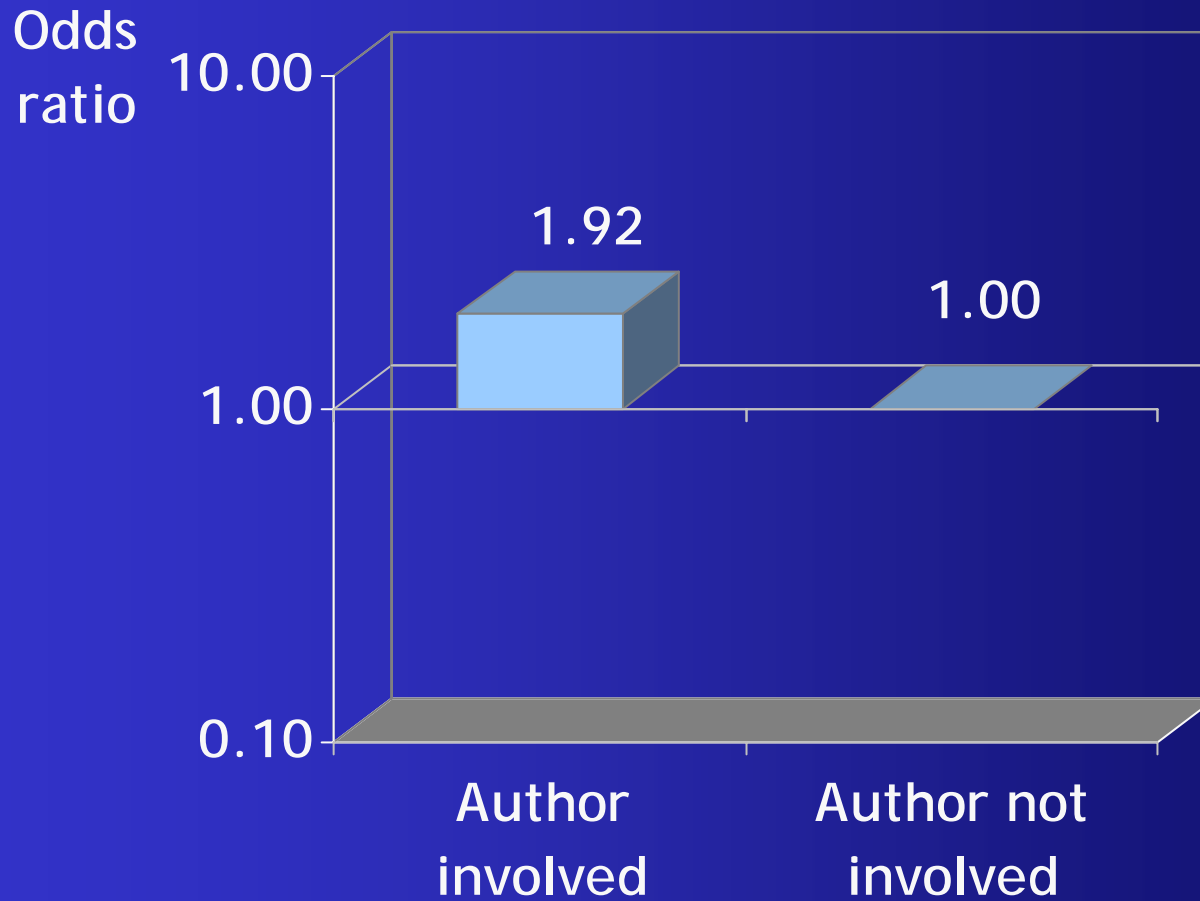


$p < .01$

Publication Bias?

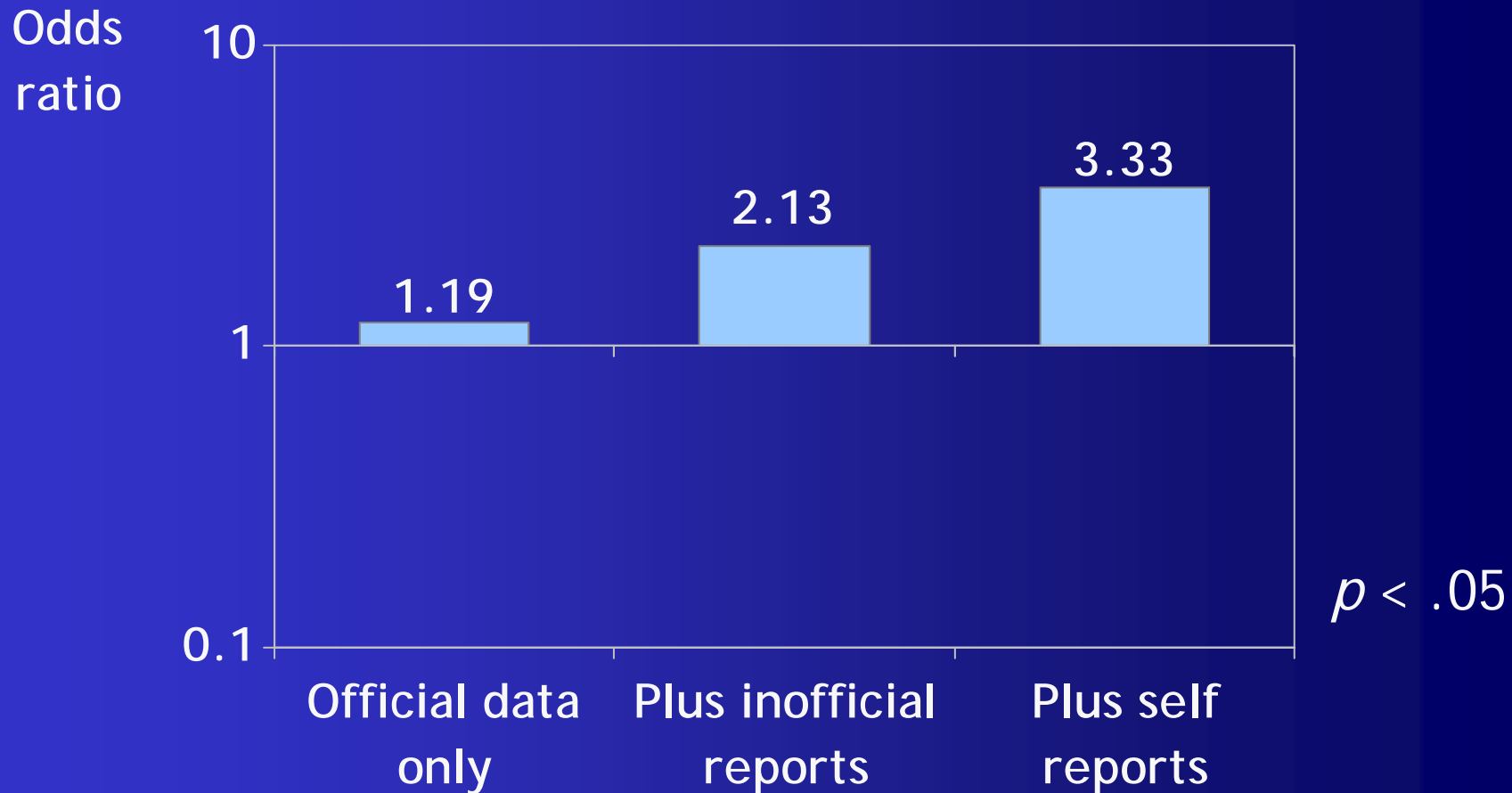


Authors' Program Involvement and ES

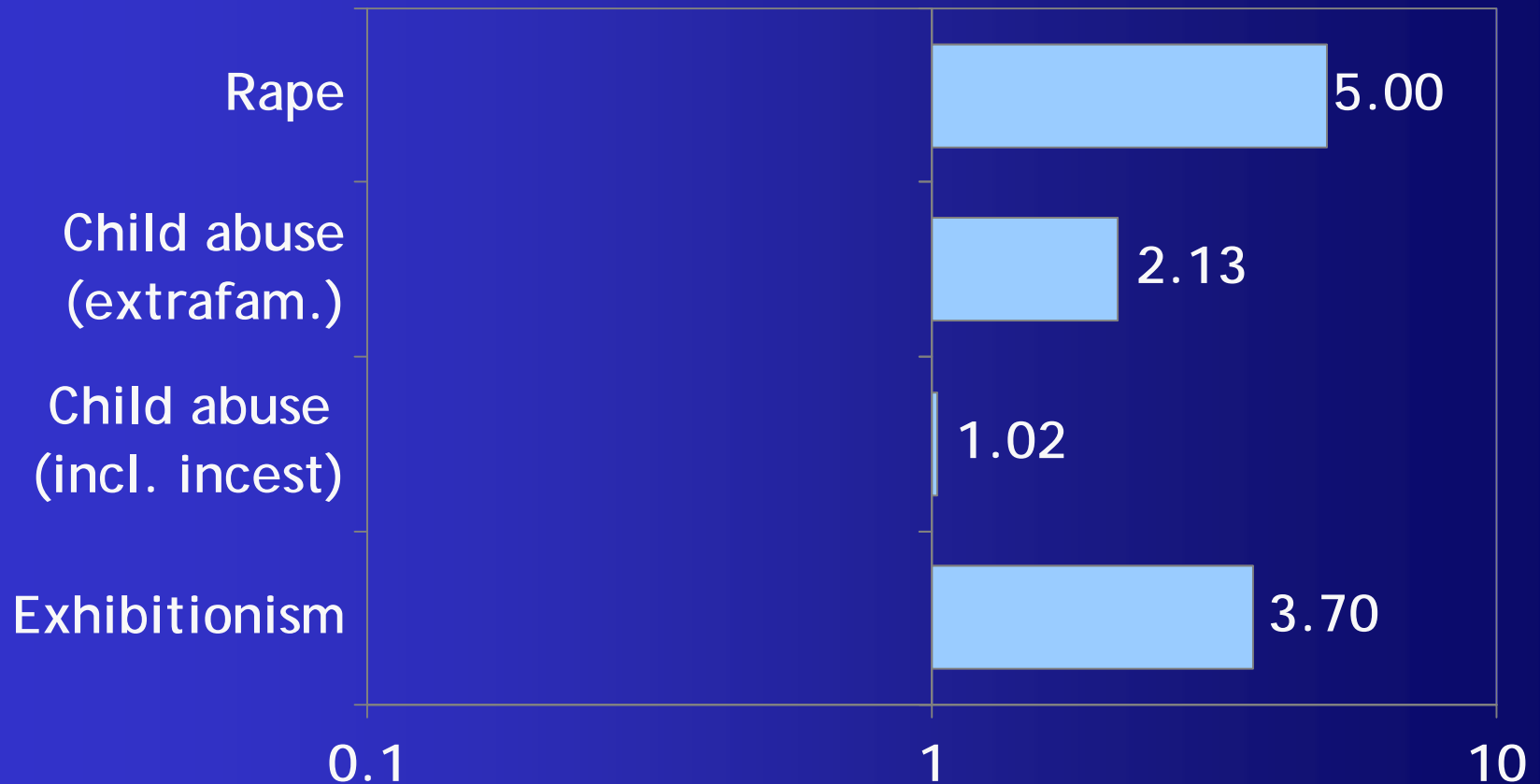


$p < .001$

Source of Recidivism Data and ES



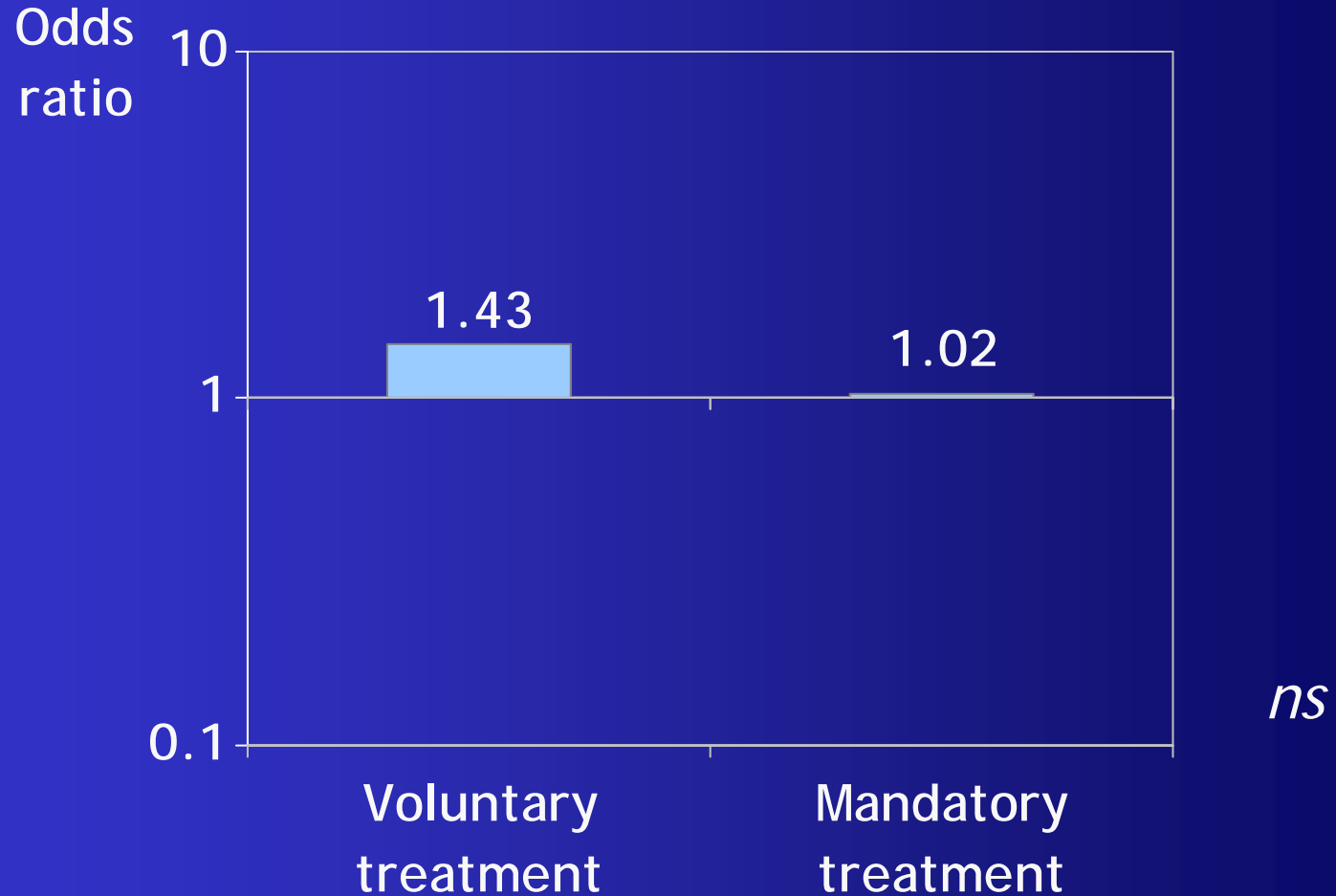
Type of Sex Offense and ES



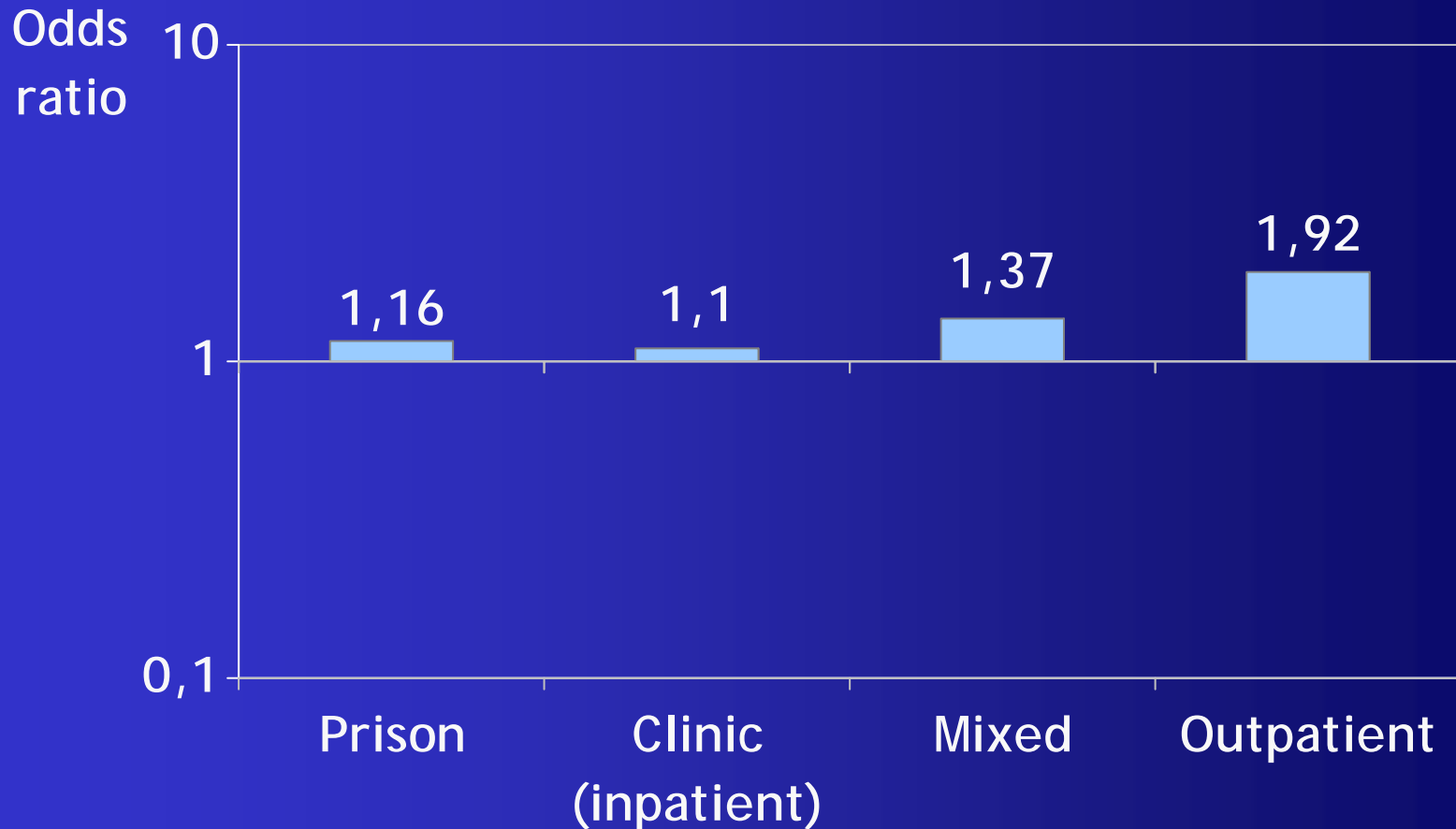
$p < .05$

Odds ratio

Voluntary/Mandatory Treatment and ES

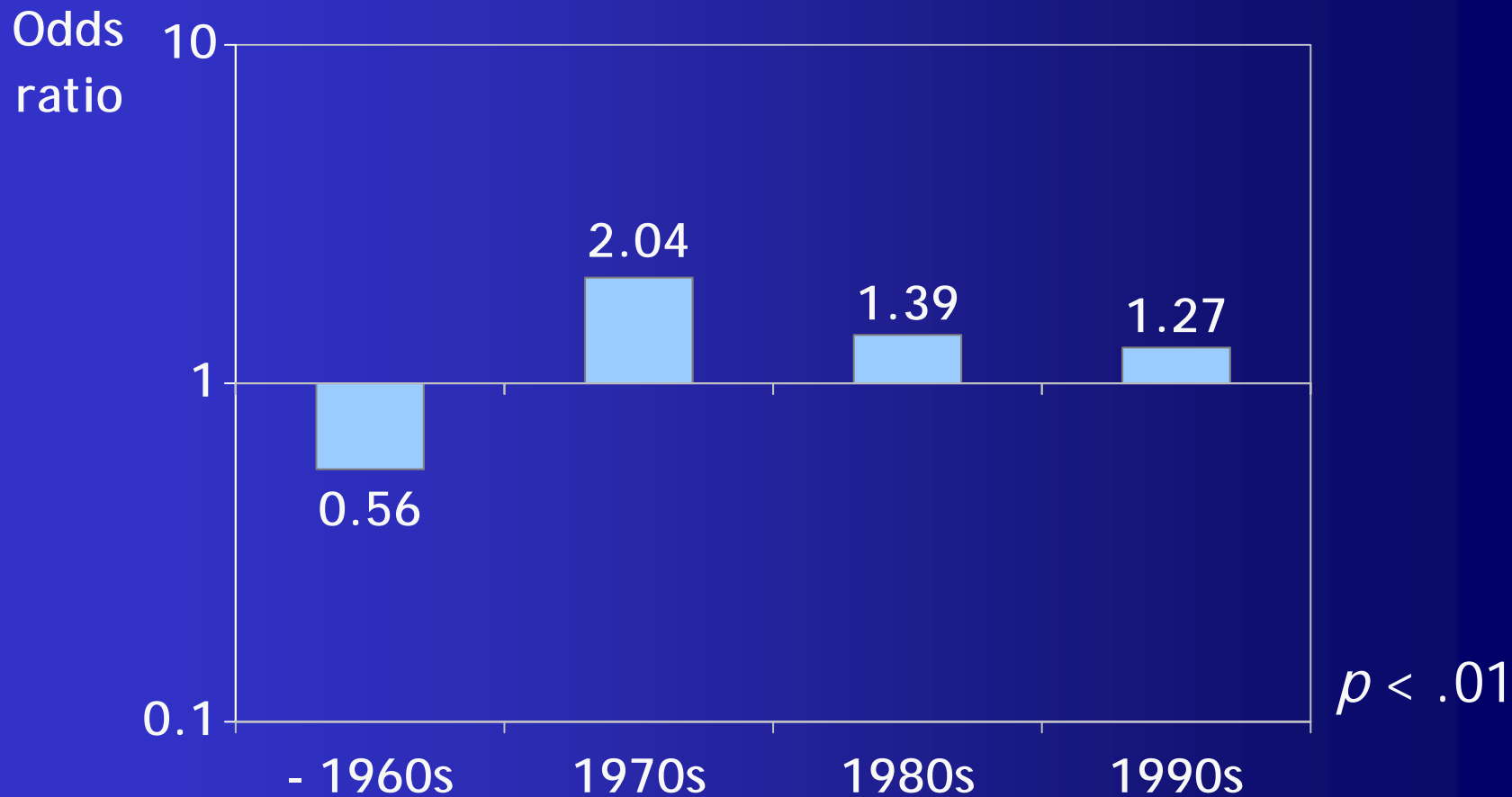


Treatment Setting and ES

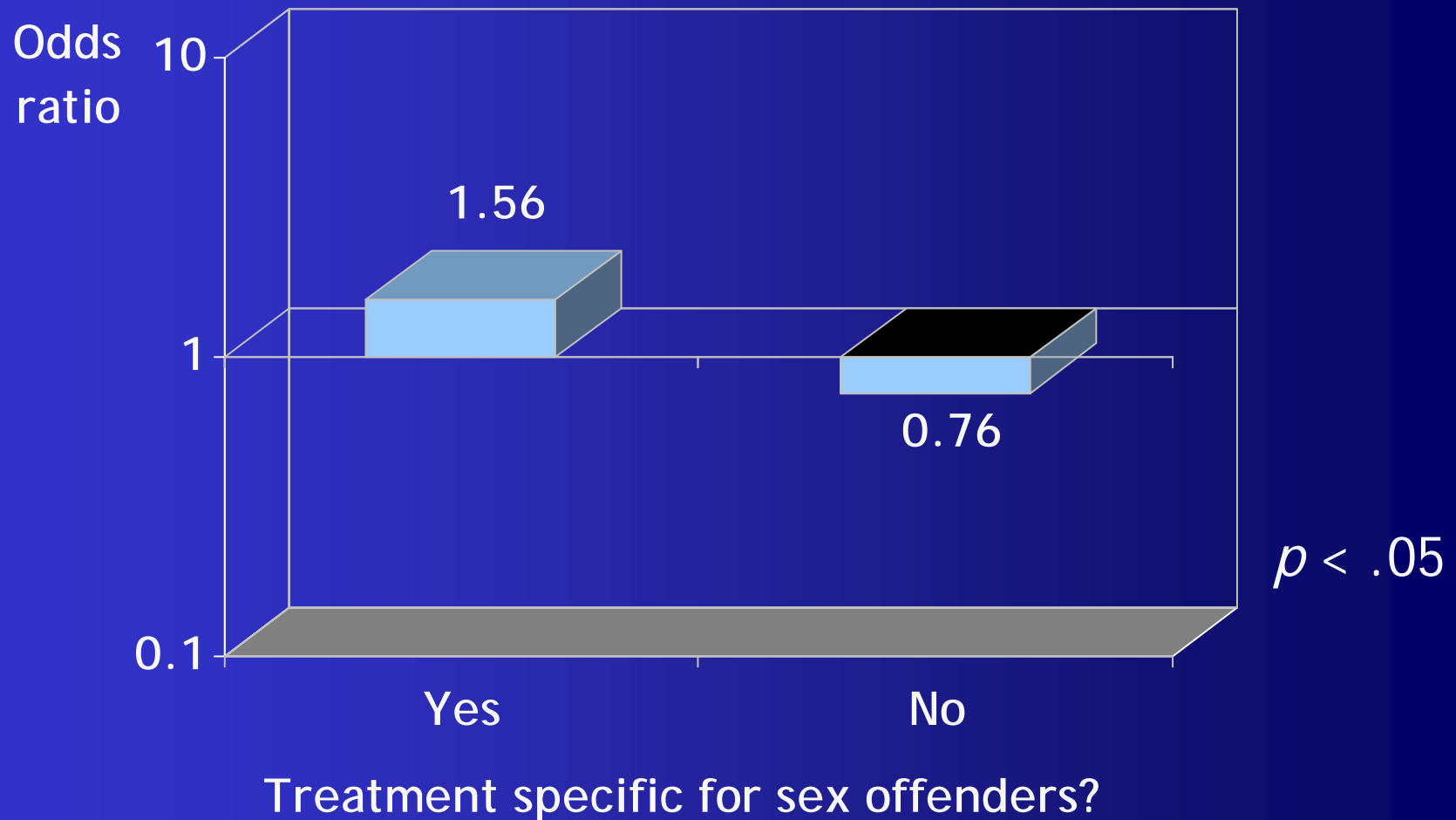


inst. vs. amb.: $r = .27, p < .05$

Decade of Treatment and ES



Treatment Specificity and ES



Explained Variance (Hierarchical Regression)

Variable Cluster	R^2
Methods/Unspecific <i>missing information</i> ***, <i>base rate of recidivism</i> **, <i>inclusion of dropouts</i> ***, <i>sensitivity of data source</i> **	.31***
Offenders <i>voluntary treatment</i> ***, <i>age homogeneity</i> *, <i>inclusion of incest offenders in TG</i> *	.08**
Setting/Context <i>involvement of authors</i> ***, <i>outpatient treatment</i> **, <i>group setting</i> *	.12**
Content of Treatment <i>cognitive orientation</i> **	.06**

* $p < .05$, ** $p < .01$, *** $p < .001$

Positive/negative beta weight

Conclusions (1)

- Overall, there is a positive effect of sex offender treatment.
- However, the outcome pattern is so complex that we should not yet generalize too far.
- Practice should concentrate on cognitive-behavioral and hormonal treatment programs.
- In addition, we should promote smaller units, treatment integrity, and ambulatory programs.
- The dropout problem should be reduced by improved assessment and program monitoring.

Conclusions (2)

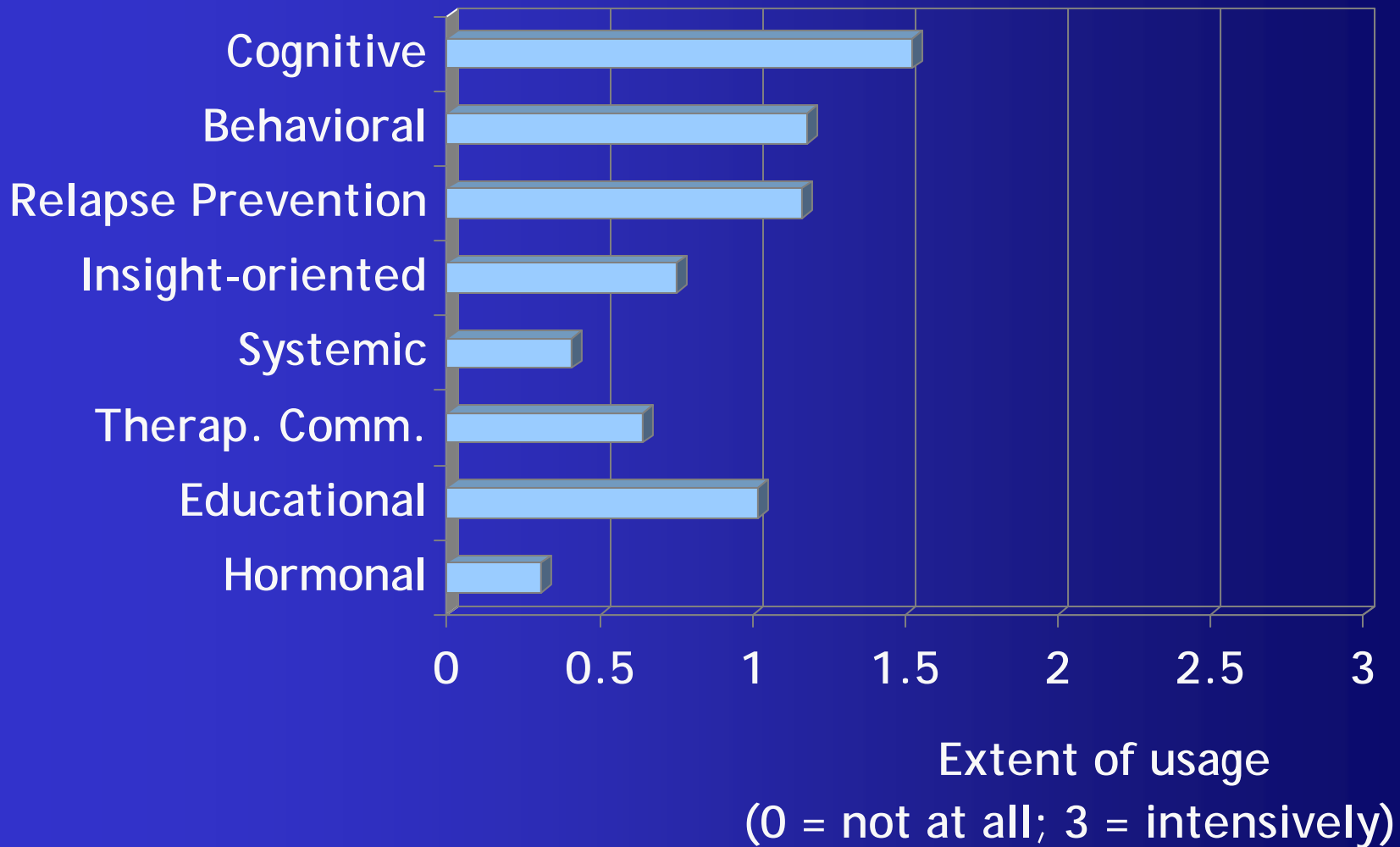
- We need more-well controlled replications and evaluations.
- In particular, more studies should address specific characteristics of treatment, offenders, and setting.
- Although further evidence is needed, the present data base can be used for program accreditation and other systematic strategies of policymaking.

ENDE

END

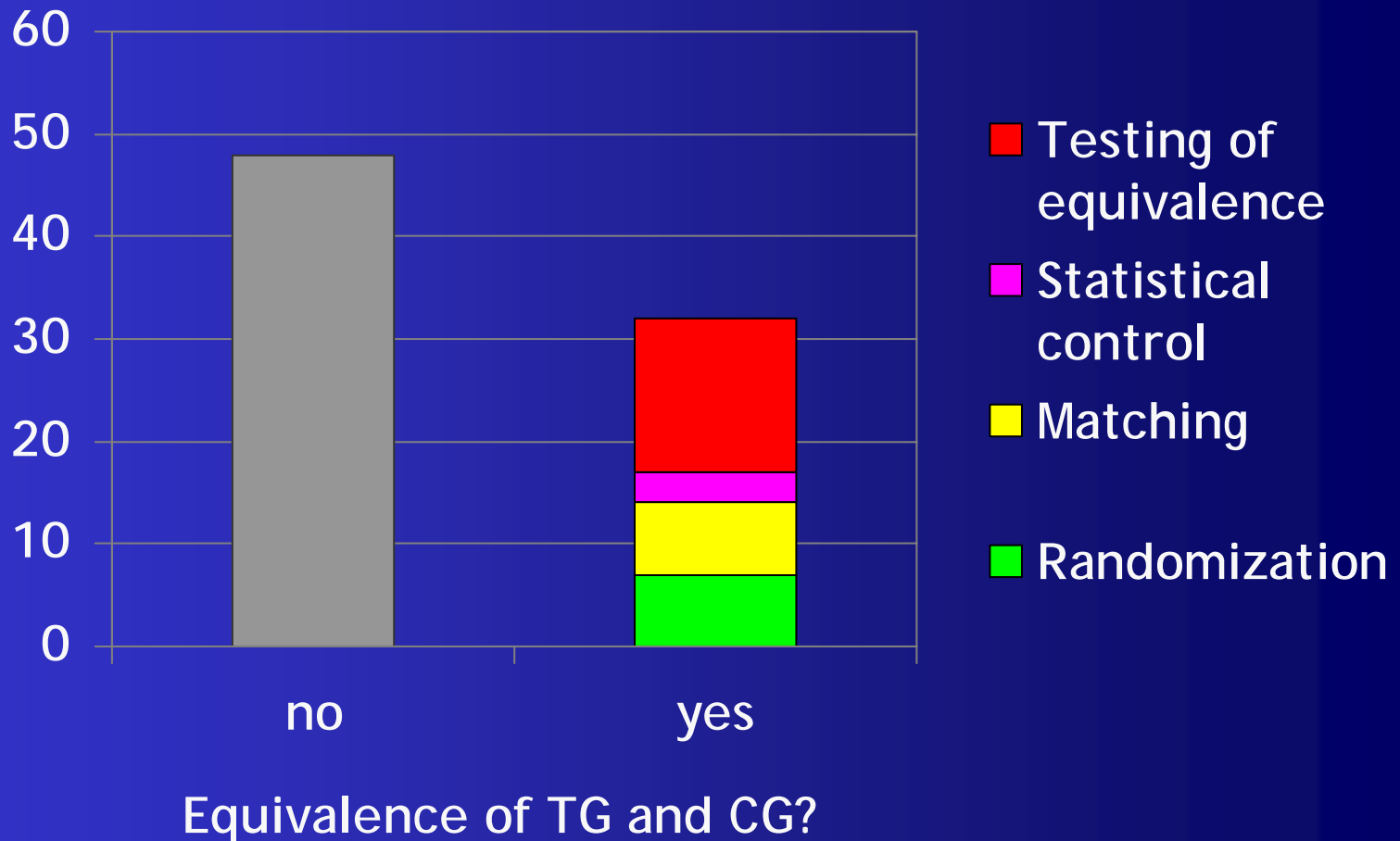
FIN

Treatment Strategies



Group Equivalence and Design

Comparisons
(k)



Methodological Quality and ES

- Overall similar results in high quality studies
- Tendency: Smaller ES
- Tendency: Less heterogeneity
- Lack of studies for differentiated analyses

Program Status and ES

