www.psicologia.pt
ISSN 1646-6977
Documento publicado em 15.05.2016

SEX OFFENDERS TREATMENT PROGRAMME – ASSESSMENT, INTERVENTIONS AND OUTCOME MEASURES FOR SERVICE EVALUATION

2016

Cláudio Vieira
Mestrado Integrado em Psicologia (Universidade de Coimbra)
Mestrando em Psiquiatria Forense (King's College of London)
Coordenador e Supervisor de Terapias Psicológicas
Serviços Forenses para Perturbações da Personalidade
Sistema Nacional de Saúde Britânico & Ministério da Justiça

E-mail de contato:
claudio.vieira@kcl.ac.uk

RESUMO

Sex offending can be comprehended as a constellation of acts of a sexual nature against an individual without that individual's consent (Hale et al., 2005) and can take many forms, from offensive exposure to the possession of illegal material (Thomas, 2001). It is thus an interpersonal crime, whereby the relationship between the perpetrator and the victim is the key to fully understand the crime.

The aim of this article is to gather the evidence-based studies in the field and consequently to propose an inpatient sex offender treatment programme, with particular focus on the assessment tools and treatment approach to be implemented. Lastly, a service evaluation protocol using appropriate clinical and service outcome measures will be established.

Palavras-chave: sex offenders, treatment, risk assessments, forensic, mental health

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INTRODUCTION

Sex offending can be comprehended as a constellation of acts of a sexual nature against an individual without that individual's consent (Hale et al., 2005) and can take many forms, from offensive exposure to the possession of illegal material (Thomas, 2001). It is thus an interpersonal crime, whereby the relationship between the perpetrator and the victim is the key to fully understand the crime. For the offender, this bond may represent a shift of difficult emotional states such as fear of rejection, rage and humiliation that have their onset in early experiences in early life or in failed adult romantic relationships. Moreover, the offending behaviour may also constitute an effort by the offender to re-claim control and self-esteem by reversing and re-enacting such experiences. Thus, despite the aetiology of the sexual offending, the offence embodies a failure of the offender to attain intimacy – integrating both emotional and sexual needs – in pro-social ways, which should be one of the core treatment targets of the main treatment programmes for sex offenders.

Over the last three decades, sexual offending has been placed in the core of rigorous and empirical research which has led to an increase of treatment programmes and rigorous evaluation of services. As a result, effective interventions have started to arise (Ward & Gannon, 2006).

The treatment for this heterogeneous class is still regarded as controversial, and clinicians are frequently asked to assess the risk they display and to deliver an evidence-based and effective pack of interventions.

This article will thus gather some of the evidence-based studies in the field and consequently propose an inpatient sex offender treatment programme, with particular focus on the assessment tools and treatment approach to be implemented. Lastly, a service evaluation protocol using appropriate clinical and service outcome measures will be established.

ASSESSMENT OF SEX OFFENDERS

A comprehensive assessment of sex offenders always involves an understanding of both the triggers of the crime and positive ways of tackling recidivism. The accuracy of the assessment is the ground for a good prediction of future risks and it also fuels future management and intervention plans. Furthermore, an accurate assessment also allows the access to a full-bodied service evaluation and effective measure outcomes (Ward & Beech, 2004).

Despite the ongoing debate over the employment of static and dynamic risk factors in the

recognition and management of risk (Quinsey et al., 2006) it is the consensus among clinicians that actuarial tools have shown a statistically significant level of predictive accuracy regarding the risk of recidivism, (Hanson & Thornton, 2000) whereas structured professional judgment (SPJ) play a significant role in the management of future plans and in clinical formulation of maladaptive behaviours.

The evidence-based and empirical studies in the field suggest the use of the following tools in the risk assessment of sex offenders:

1. *Static-2002 (Hanson & Thornton, 2003).*

Static-*2002* is an actuarial tool comprising 13 different items which cover age of release, number of sentences associated to sex offences and the risk of sexual offending. It emerged to increase the predictive validity of static-99 and thus expand its reliability. Based on the scores, the subjects can be classified from low (0-2) to high-risk (9+). Hanson & Thornton (2003) demonstrated robust support for the predictive validity of this tool in a sample of 3034 of convicted adult males whereas Langton et al. (2007) found an overall AUC value of .71 for their sample of 464 treated sexual offenders.

2. *Risk for Sexual Violence Protocol (RSVP - Hart, et al. 2003)*

The RSVP is SPJ tool developed from the Sexual Violence Risk-20 and from the broadly used Historical Clinical Risk-20 (Douglas et al., 2014). It is a 22-item tool which compiles items into five domains: sexual violence history, psychological adjustment, mental disorder, social adjustment and manageability. These measures also allow further attention of an individual's likely risk through the development of risk scenarios which are hypotheses about what type of offence the individual under assessment may be likely to commit. The authors describe this as 'scenario-based risk assessment' which aims to enlighten decision-making in the development of risk management plans. Despite the lack of studies on its validity, Hart and Boer (2010) have shown good to excellent inter-rater reability rates (ICC1.5 and ICC1 > .75). The RSVP is regarded as a useful clinical tool in terms of informing risk management and formulation, leading to a comprehensive understanding of the offender and its applicability for treatment programmes.

3. *Violence Risk Scale-Sex Offenders Version (VRS-SO; Wong et al., 2003)*

Composed of 7 static and 17 dynamic predictor factors, VRS-SO can be used for the identification and assessment of high-risk factors related to violence. These factors are rated both pre and post-treatment in order to highlight high-risk areas and to assess changes in risk of recidivism as a result of treatment interventions. Post-treatment ratings are then acquired by

regulating the pre-treatment scores on the dynamic factors taking into account the progression through the stage of changes (Prochaska et al., 1994). Olver et al. (2007) found a strong inter-rater reability (rage of .74 to .79) and recidivism predictive rates were .72 for pre-treatment and .72 for post-treatment.

THE TREATMENT APPROACH

The cognitive-behavioural approach is intrinsically well-established in the scientific community currently accessible for sex offenders. The Relapse Prevention is one of the models commonly used with sex offenders (Pithers, 1990) with strong emphases on the management of dynamic risk factors and their role when predicting reoffending. Its key-concept is the understanding of the offending behaviour and the development of coping mechanisms which contribute to the prevention of further offences (Ward & Hudson, 2000). The Relapse Prevention approach emerged from the broader Risk-Need rehabilitation model which highlights the targeting and the eradication of dynamic risk factors in order to reduce recidivism rates.

In the risk-need model an effective treatment is reliant on upon three main principles – Risk (the balance between level of risk and the intensity of treatment received); Need (the criminogenic needs are targeted in treatment) and Responsivity (expand the offender's skills to learn from a rehabilitative intervention).

Although this model is well-recognized for its effectiveness, a wide range of limitations have been addressed by Ward & Stewart (2003). The authors highlighted that despite the focus on risk factors and relapse prevention plans constituting an important component of the intervention, they are not sufficient treatment aim. That is, treatment should focus on the protective factors and goals of the offenders in order to meet their needs in more adaptive ways which will make them less likely to offend or harm themselves.

In order to overcome these weaknesses, a humanistic approach to the understanding of human behaviour emerged – The Good Lives Model (GLM) – with emphasis on the promotion of mental well-being whilst empowering individuals with their own strengths rather than simply highlighting psychological deficits (Ward & Stewart, 2003; Ward & Marshall, 2004).

GLM underlines the development of offender's own resources to attain primary human goods, and as a result, to reduce their likelihood of committing further offenses. Primary human goods can be understood as states of mind, individual characteristics, activities, or experiences which are pursued for their own sake and are liable to enhance psychological well-being (Ward & Stewart, 2003; Ward & Marshall, 2004). Consequently, treatment should empower the offenders with the knowledge and the skills required to accomplish these needs within an adaptive and

prosocial way. The effort is thus to put on the opportunity for the offenders to live a distinctive type of life, i.e., one that is likely to offer a feasible alternative to an antisocial lifestyle and so to reduce the likelihood of committing further crimes (Ward & Stewart, 2003). Furthermore, to also empower offenders with the essential skills to live more rewarding lives rather as opposite to merely seek the decrease of risk factors or focus on the enhancement of psychological deficits (Seligman & Peterson, 2003).

Treatment for Sex Offenders - Controversies

Whilst having support by the medical and mental health community, treatment for sex offenders has long been fairly controversial, in accordance to early researches suggesting that treatment for this class demonstrates no impact on tackling recidivism (Martinson 1974). Likewise, more recent research has also contributed to this debate. For instance, Schweitzer and Dwyer (2003) reported no statistically significant differences in recidivism between groups when evaluating a Sexual Offenders Treatment Program (SOTP) in Australia whereas Quinsey et al. (1998) reported that participation in treatment had opposite the anticipated effect in a sample of 483 offenders.

Yet, more recent researches argue that sex offender treatment rooted in a CBT framework instils moderate role in the reduction of recidivism. These findings were supported by Nicholaichuk and colleagues (2000) who evaluated an inpatient sex offender treatment program in a high secure unit in Canada and found that sex offenders who engaged in treatment shown a 15% rate of sex re-offending as opposite to the control group (33%).

A number of meta-analyses also encourage the CBT model as the core treatment to reduce recidivism among sex offenders. For instance, a study conducted by Hanson and Bussiere (1998) concluded that the reoffending rates of sex offenders exposed to treatment were lower than the reoffending values of untreated sex offenders. In line with this, Losel and Schmucker (2005) shown in a meta-analysis of different 69 sex offender treatment studies that CBT and classic behaviour therapy unveiled a significant impact on reducing sexual recidivism.

Although meta-analyses often reveal a small to moderate treatment impact on recidivism, most of them lack scientific rigor (Deanna & Wesley, 2012). That is, they indeed tend to rely on weak comparison groups such as program dropouts which may noticeably fluctuate from those who persist in treatment. In those cases, it becomes difficult and challenging to understand the treatment effect from that of pre-existing variances between individuals on recidivism (Deanna & Wesley, 2012).

Notwithstanding, Donato & Shanahan (2001) highlighted significant socio-economic benefits to be taken into account despite minimal reductions in reoffending. The authors stressed areas of savings associated with reduced recidivism, such as financial costs to the community

subsequent from court and incarceration expenses alongside a reduction in the impact of sexual offences such as physical injuries and psychological distress.

Overall, the SOTP, guided by a relapse prevention framework, aims to provide a comprehensive assessment and treatment services for sex offenders whilst comprising a well-coordinated community transition with competent monitoring plans. While there is no ultimate 'cure' for sex offenders, the core goal of clinical intervention is to empower sex offenders with the therapeutic skills to gain control over their sexual inadequacies in an effort to prevent re-offending.

The format of the SOTP is largely led by the Responsive principle and regards the group therapy as more advantageous when compared to individual work (Spencer, 1998). That is, group settings instil the development of interpersonal skills whilst allowing group members to offer constructive feedback and manage challenges in a prosocial way.

The content of the programme is largely embedded within the Need principle which concerns treatment as a vehicle to target offenders' dynamic factors. Those include cognitive distortions (e.g. rationalization and justifications) and intimacy deficits, largely recognized by Hanson & Morton-Bourgon (2005) as a strong predictor of sexual reoffending.

A PROPOSED TREATMENT PROGRAMME

The proposed treatment programme in this article is mostly guided by the Risk-Need-Responsiveness approach and followed by the Good Lives Model.

It comprises three main phases which are broadly described next.

1. Phase I: Looking in the Mirror

The first phase aims to introduce the participants to the purpose and goals of the course and is approximately 3 months in duration with two group sessions per week (2h with 15 minutes break). In the first session the offender is assigned a primary therapist who will work close with on a weekly 1:1 basis. Additionally, an individualized treatment plan is developed including a description of program objectives, the expectations of the offender, and available services (e.g., self-help materials, recreational games, and audiotapes for relaxation). Offenders are expected to reflect on what their risk factors are and what changes they might need to make. They are introduced to risk assessment and the VRS–SO is presented. Group members score themselves on the Static and Dynamic Risk Factors on the VRS and give feedback to the group with potential scores of 0,1,2,3 on all items depending on how related that factor is to their risk. Their stage of

change is also scored and subject to change through treatment. Also, in early stage of this phase, the offenders are expected to disclose their index offence. Initially a short narrative about the offence including a summary of their circumstances around the time of the offence, details of what happened, and their current understanding of what led to it. Group members finish the phase by presenting a detailed autobiographical account of their live, when possible reflecting on how events may have influenced their risk and their decisions.

2. Phase II: Breaking the Cycle

In this phase, group members are asked to produce an offence cycle, identifying the thoughts, feelings, behaviours and external risk factors that have led to violence. Group members are then introduced to key concepts in behaviour cycles: Perceptions/Schemas, Cognitive Distortions, Feelings, External Risk Factors. This will fuel a wide-range of CBT-orientated groups in order to achieve a better understanding of their offending behaviour and cognitions, to challenge discrepancies between thoughts, feelings, and actions. This phase will specifically cover topics such as 'Attitudes towards sex' and 'Risk Factors and Warning Signs'. These therapeutic interventions are framed around the relapse prevention (RP) model. The core target of RP is to allow sex offenders to recognize the high-risk factors and circumstances which are more likely to put them at risk to reoffend. Also it will assist them in developing coping mechanisms to control their sexually deviant behaviour.

3. Phase III: Relapse Prevention Plan

Group members are supported to develop internal and interpersonal skills, and to consider how they might use external supports; to address risk factors identified in previous phases. These are incorporated into their relapse prevention plans. Group members identify key High-risk situations, and are then introduced to three categories or relapse prevention skills and strategies: Internal strategies (perception checking, identifying emotional triggers, detaching past from present, cost-benefit analysis), interpersonal skills (assertiveness, communication skills, giving and receiving criticism) and external supports (professional support, personal support, accommodation, vocational / educational opportunities) which are incorporated into a final relapse prevention plan.

ISSN 1646-6977
Documento publicado em 15.05.2016

ADDITIONAL STRUCTURED INTERVENTIONS

Monitoring

Monitoring comprises an evaluation of risk and protective factors which may involve talking to the individual, use of breathalyser and urine drug testing, monitor the offender's use of internet and media and monitor his interaction with other offenders (Russel & Darkee, 2013).

Occupational Therapy

Provide fulfilling OT activities in order to develop interpersonal and vocational skills, enhancing protective factors and the own offenders' strengths. This may include gardening, cooking skills, ward jobs, art group and woodwork. Additionally, Occupational Therapists can also assist the individuals with in managing to community expectations, planning an accommodation and assisting in finding an employment (Lloyod, 1987).

Psychological Therapies

For those individuals with high-levels of psychopathy and/or personality dysfunctions, further psychological input may include a stronger focus on motivation and engagement in activities, increase flexibility, incorporate further therapy to target specific elements of personality (e.g. schema therapy, mentalized-based therapy and dialectical-behavioural therapy) and a comprehensive and structured assessment of personality using the International Personality Disorder Examination (IPDE; Loranger, 1999). If a history of non-sexual violence and other offences not sexual-related are present, the Historical, Clinical, Risk Managmenet-20 assessment (HCR-20; Douglas et al., 2014) may also be used.

Medication

Anti-libidinals and SSRIs may be prescribed in conjunction of psychological therapy to treat offenders who may have difficulties with sexual regulation which are not effectively focused by other interventions (Grubin, 2008)

PERFORMANCE INDICATORS AND OUTCOME MEASURES

The purpose of a sex offender treatment programme is to reduce recidivism whilst providing support and framework for rehabilitation, as opposed to simply punishing the offender. Hence, programme and service evaluation constitutes an importance piece of evidence which can guide further research and advances in the field. The following outcome measures are suggested to gather information regarding the evaluation of the service and treatment interventions to thus inform about its efficacy:

CORE Outcome Measure (CORE-OM)

CORE-OM is a self-report assessment intended to be administered before and after therapy. It comprises 34 questions about their mental state over the previous week, using a 5-point scale. The items comprise four factors, including subjective well-being, problems/symptoms, life functioning and risk/harm and has been reported as a useful instrument to assess treatment outcomes (Barkham et al., 2005).

Violence Risk Scale - Sex Offender Version (VRS-SO; Wong et al., 2003)

The VRS-SO is an assessment tool of treatment variation which adjusts pre-treatment rates on dynamic factors based on the progress through the stages of change. This SPJ tool has shown a strong predictive validity alongside sustenance for the link concerning changes in therapy on dynamic factors and reductions in reoffending (Olver et al., 2007). The purpose of this instrument as outcome measure is thus to observe changes in the ratings after therapy and whether the individual was able move through the stages of changes (e.g. from Preparation to Action Stage).

Sex Offender Treatment Intervention and Progress Scale (SOTIPS; McGrath et al., 2012)

SOTIPS is a 16-item dynamic tool developed to assist clinicians in evaluating risk, interventions and supervision requirements, and also changes observed in the sex offenders. This tool aims to rate offenders at the beginning of treatment and subsequently every six months. McGrath et al. (2012) has suggested that SOTIPS when associated with Static-99 rates shows a good predicted sexual recidivism rate.

Actuarially-based Evaluations (ABE)

ABE occurs when the clinician or researcher compare the recidivism rates of treated sex offenders with their anticipated recidivism scores based on the results from actuarial risk assessment tools (Marshall et al. 2006). The recidivism scored obtained in the study of Marques et al. (2005) was around 20% which is in line with what would be estimated from actuarial risk measures based on the risk categories. Hence, these results provide empirical and robust evidence support for utilising such estimates in order to evaluate a treatment programme and consequently its effectiveness.

Structured Assessment of Protective Factors (SAPROF; Vivienne, 2001)

SAPROF is a solution-focused tool which aims to support the risk assessment instruments by taking into consideration individual's protective factors whilst aiming to control the effects of risk factors as well as moderate the likelihood of recidivism (Vivienne, 2001). SAPROF would be used as an outcome measure for treatment in the service as it would take into account the individual's prosocial goals for the future as well as his past achievements. Thus it is a powerful tool for clinicians to reach a better understanding of the development of the offender's own resources and strengths and compare them between pre-treatment and post-treatment phases.

Alongside the mentioned outcome measures, monitoring staff performance would also be regarded in order to maintain the high-standard of the service. This would include:

- Ongoing staff training (e.g. working with sex offenders, understanding personality disorders, DBT group skills)
- Regular MDT meetings which would focus on reflective practice, clinical formulation, teaching sessions, risk assessments (e.g. group discussion on RSVP / HCR-20)
- Regular clinical supervision to address the difficulties in working with these type of offenders

FINAL CONSIDERATIONS

Sexual offending is an ongoing problem that society must tackle with perseverance and involvement, considering the overwhelmingly harmful consequences of this type of offence. Clinical interventions for sex offenders are an enduring issue within the criminal justice system which constantly aims to reduce recidivism and avert future crimes.

This essay aimed to design an inpatient sex offender treatment programme with focus on the assessment tools and the treatment approach to be employed. It also covered a service evaluation protocol using appropriate clinical and service outcome measures with strategies to monitor successfully maintain the service at high-standards.

Regardless the boundless controversies around the SOTP, and its lack of robust empirical studies, it is still regarded as the variety of treatment for sex offenders associated with most successful rates of reduce recidivism.

In terms of future directions, further research should consider the heterogeneity of sex offenders and hence their assessment should regard their differences. That is, the key debate should be set on the debate on which interventions and treatment programmes are effective for different types of offenders as opposed to establish whether treatment is effective or not. Also, regarding sex offenders as a homogeneous class will continue to fuel the risk of covering major treatment outcomes with specific type of sex offenders (e.g. child sex offenders), a variable that has possibly been contributing to the ongoing debate in this field.

Despite the provocative outcomes from treatment program evaluations, their results underscore the importance of employing rigorous research design accessible to precisely estimate treatment effectiveness. Besides, even when facing modest rates of recidivism, they still represent a reduction in the impact of psychological distress and physical injuries in future victims in the community.

Together, this awareness is thus critical for clinicians and researchers who put their effort in understanding the nature of treatment efficacy whilst improving treatment outcomes.

REFERÊNCIAS BIBLIOGRÁFICAS

1. Barbaree, H. E. (1997). Evaluating treatment efficacy with sexual offenders: The insensitivity of recidivism studies to treatment effects. *Sexual Abuse: A Journal of Research and Treatment*, 9, 111-128.

2. Barbaree, H., Langton, C. & Peacock, E. (2006). Sexual offender treatment for psychopaths: is it harmful? In *Sex Offender Treatment: Controversial Issues* (eds W, Marshall., Y, Fernande., L, Marshall, et al.), 159-171, John Wiley & Sons.

3. Barkham, M., Gilbert, N., Connel, J., Marshall, C., & Twigg, E. (2005). Suitability and utility of the CORE-OM and CORE-A for assessing severity of presenting problems in psychological therapy services based in primary and secondary care settings. *The British Journal of Psychiatry*, 186 (3) 239-246.

4. Deanna, M., & Wesley, J. (2012). Treatment behind bars: the effectiveness of prison-based therapy for sex offenders. *Journal of Crime and Justice*, 35:3, 435-450

5. Donato, R., & Shanahan, M. (2001). The economics of child sex-offender rehabilitation programs: Beyond Prentky & Burgess. *American Journal of Orthopsychiatry, 71*, 131-139.

6. Douglas, K., Hart, S., Webster, C., Belfrage, H., Guy, L., & Wilson, C. (2014) Historical-Clinical-Risk Management-20, Version 3 (HCR-20V3): Development and Overview, *International Journal of Forensic Mental Health*, 13(2), 93-108.

7. Grubin, D. (2008) Medical models and interventions in sexual deviance. In *Sexual Deviance: Theory, Assessment and Treatment* (2nd edn) (eds Laws DR, O'Donoue WT): 594–610. Guilford Press.

8. Hale. C., Hayward. K., Wahidin, A., & Wincup, E. (2005) *Criminology*. Oxford: Oxford University Press.

9. Hanson, R. & Thornton, D. (2003). Notes on the development of Static-2002. Available online from: http://ww2.psepc-sppcc.gc.ca/publications/corrections/200301_Static_2002_2.asp

10. Hanson, R. & Thorton, D. (2000). Improving risk assessment for sex offenders: A comparison of three actuarial scales. *Law and Human Behaviour*, 24, 119-36.

11. Hanson, R. K., Gordon, A., Harris, A. J. R., Marques, J. K., Murphy, W. D., Quinsey,

V. L., & Seto, M. C. (2002). First report of the collaborative Outcome Data Project on the Effectiveness of Psychological Treatment of Sex Offenders. Sexual Abuse: *A Journal of Research and Treatment*, 14, 169-195.

12. Hanson, R., & Bussiere, M. (1998). Predicting relapse: a meta-analysis of sexual offender recidivism studies. *Journal of Consulting and Clinical Psychology*, 66(2), 348-362.

13. Hanson, R., Bourgon, G., Helmus, L., & Hodgson, S. (2009). *A meta-analysis of the effectiveness of treatment for sexual offenders: risk, need, and responsivity*. Ottawa: Public Safety Canada, Research Report No. 2009-01. Available from: http://www.publicsafety.gc.ca/res/cor/rep/_fl/2009-01-trt-so- eng.pdf [Accessed 24 May 2011].

14. Hart, S. & Boer, D. (2010). Structured professional judgment guidelines for sexual violence risk assessment: The sexual violence risk-20 (SVR-20) and risk for sexual violence protocol. In R.K. Otto & K.S. Douglas (Eds.). *Handbook of violence risk assessment tools* (pp. 269- 294). Milton Park, UK: Routledge.

15. Hart, S., Kropp, P.R., & Laws, D.R.; with Klaver, J., Logan, C, & Watt, K.A. (2003). *The Risk for Sexual Violence Protocol (RSVP): Structured professional guidelines for assessing risk of sexual violence*. Vancouver, B.C.: The Institute Against Family Violence.

16. Home Office. (2006). *Crime in England and Wales: Quarterly Update to June 2006*. London: HMSO.

17. Langton, C., Barbaree, H., Seto, M., Peacock, J., Harkins, L., & Hansen, K. (2007). Actuarial assessment of risk for re-offense among adult sex offenders: Evaluating the predictive accuracy of the Static-2002 and five other instruments. *Criminal Justice and Behavior*, 34, 37-59.

18. Lloyd, C. (1987). Sex offender programs: Is there a role for occupational therapy? *Occupational Therapy in Mental Health*, 7(3), 55-67.

19. Loranger, A. (1999) *International Personality Disorder Examination Manual*. Psychological Assessment Resources.

20. Losel, F., & Schmucker, M. (2005). The effectiveness of treatment for sexual offenders: a comprehensive meta-analysis. *Journal of Experimental Criminology*, 1, 117–146.

21. Marques, J., Weideranders, M., Day, D., Nelson, C., & van Ommeren, A. (2005). Effects of a relapse prevention program on sexual recidivism: Final results from California's Sex Offender Treatment and Evaluation Project (SOTEP). *Sexual Abuse: A Journal of Research and Treatment and Evaluation*, 1-107.

22. Marshall, W. (2006). Appraising treatment outcome with sexual offenders. In W. L. Marshall, Y. M.Fernandez, L. E. Marshall, & G. A. Serran (Eds.), Sexual offender treatment: Controversial issues (pp. 255-273). Chichester, UK: Wiley.

23. Marshall, W. L. (2006). Appraising treatment outcome with sexual offenders. In W. L. Marshall, Y. M. Fernandez, L. E. Marshall, & G. A. Serran (Eds.), *Sexual offender treatment: Controversial issues* (pp. 255-273). Chichester, UK: John Wiley & Sons.

24. Martinson, R., 1974. What works? Questions and answers about prison reform. *The Public Interest*, 35, 22–54.

25. McGrath, R., Lasher, M., & Cumming, G. (2012). The Sex Offender Treatment Intervention and Progress Scale (SOTIPS): Psychometric properties and incremental predictive validity with the Static-99R. *Sexual Abuse: A Journal of Research and Treatment, 24*, 431-458.

26. Nicholaichuk, T., Gordon, A., Gu, D., & Wong, S. (2000). Outcome of an institutional sexual offender treatment program: a comparison between treated and matched untreated offenders. *Sexual Abuse: A Journal of Research and Treatment*, 12, 139–153.

27. Olver, M., Wong, S., Nicholaichuk, T., & Gordon, A. (2007). The validity and reliability of the Violence Risk Scale-Sexual Offender version: Assessing sex offender risk and evaluating therapeutic change. *Psychological Assessment*, 19(3), 318-329.

28. Pithers, W. (1990). Relapse prevention with sexual aggressors: A method for maintaining therapeutic gain and enhancing external supervision. In W. L. Marshall, D. R. Laws, & H. E. Barbaree (Eds.), *Handbook of sexual assault: Issues, theories and treatment of the offender* (pp. 343 – 361). New York7 Plenum.

29. Prochaska, J., Norcross, J., & DiClemente, C. (1994). *Changing for good*. New York: William Morrow.

30. Quinsey, V., Harris, G., Rice, M., & Cormier, C. (2006). *Violent Offenders: Appraising and Managing Risk* (2nd edn). Washington D.C.: American Psychological Association.

31. Quinsey, V., Khanna, A., & Malcolm, P. (1998). A retrospective evaluation of the regional treatment centre sex offender treatment program. *Journal of Interpersonal Violence*, 13, 621–644.

32. Russel, K., & Darkee, R. (2013). Practical assessment and management of risk in sexual offenders. *Advances in Psychiatric Treatment*, 19 (1) 56-6.

33. Schweitzer, R., & Dwyer, J., 2003. Sex crime recidivism: evaluation of a sexual offender treatment program. *Journal of Interpersonal Violence*, 18, 1292–1310.

34. Seligman, M., & Peterson, C. (2003). Positive clinical psychology. In L. G. Aspinwall, & U. M. Staudinger (Eds.), *A psychology of human strengths: Fundamental questions and future directions for a positive psychology* (pp. 305–317). Washington, DC7 American Psychological Association.

35. Spencer, A. (1998). Peterhead Prison program. In W. L. Marshall, Y. M. Fernandez, S. M. Hudson & T. Ward (Eds.), *Sourcebook of treatment programs for sexual offenders* (pp. 29-46). New York, NY: Plenum Press. Hanson, R. K., & Morton-Bourgon, K. E. (2005). The characteristics of persistent sexual offenders: A meta-analysis of recidivism studies. *Journal of Consulting and Clinical Psychology, 73*, 1154-1163.

36. Thomas, T. (2000). *Sex Crime: Sex Offending and Society*. Cullompton: Willan.

37. Vogel, V., Robbé, M., Ruiter, C., & Bouman, Y. (2011). Assessing Protective Factors in Forensic Psychiatric Practice: Introducing the SAPROF. *International Journal of Forensic Mental Health*, 10(3), 171-177

38. Ward, T. & Beech, A. (2004). The etiology of risk: a preliminary model for sexual offenders. *Sexual Abuse: A Journal of Research and Treatment*, 16, 271-284.

39. Ward, T. & Gannon, T. (2006). Rehabilitation, etiology, and self-regulation: The comprehensive good lives model of treatment for sexual offenders. *Aggression and Violent Behaviour*, 11, 77-94.

40. Ward, T., & Hudson, S. M. (2000). A self-regulation model of relapse prevention. In D. R. Laws, S. M. Hudson, & T. Ward (Eds.), *Remaking relapse prevention with sex offenders: A sourcebook* (pp. 79–101). Thousand Oaks, CA7 Sage.

41. Ward, T., & Marshall, W. L. (2004). Good lives, etiology, and the rehabilitation of sex offenders: A bridging theory. *Journal of Sexual Aggression*, 10, 153–169.

42. Ward, T., & Stewart, C. A. (2003). The treatment of sex offenders: Risk management and good lives. *Professional Psychology, Research and Practice*, 34, 353–360.

43. Wong, S., Olver, M. E., Nicholaichuk, T. P., & Gordon, A. (2003). *The Violence Risk Scale: Sexual Offender version* (VRS-SO). Regional Psychiatric Centre and University of Saskatchewan, Saskatoon, Saskatchewan, Canada.