What Constitutes Treatment Progress?

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Overview

- Evaluation
  - Evaluator perspectives
  - Evidence base
  - Protective factors
- Treatment Perspective
  - Challenges
  - What We Do
  - Final Thoughts
- Case Examples

Evaluator perspectives

- Attitude to risk
  - Risk averse vs. risk accepting
  - Fear of a serious re-offense → one-way over-rides
  - Low base rates requiring more extreme evidence of risk →more release recommendations
- Allegiance effects
- View of the evidence
  - Regarding static instruments
  - Regarding change

Evidence Base

- Two Change scores have shown a significant relation to sexual recidivism
  - VRS-SO
  - SAPROF
- VRS results come from much larger samples as regards sexual recidivism

Sources: VRS-SO Change Score

- Olver, M. E., Beggs-Christofferson, S. M., Grace, R. C., & Wong, S. C. P. (2014). Incorporating change information into sexual offender risk assessments using the Violence Risk Scale – Sexual Offender version. Sexual Abuse: A Journal of Research and Treatment, 26, 472–499.
- Olver, M. E., Beggs-Christofferson, S. M., & Wong, S. C. P. (2015). Evaluation and applications of the clinically significant change method with the Violence Risk Scale – Sexual Offender Version: Implications for risk-change communication. Behavioral Sciences & the Law, 33, 92–110.
- Olver, M. E., & Wong, S. C. P. (2011). A comparison of static and dynamic assessment of sexual offender risk and need in a treatment context. Criminal Justice and Behavior, 38, 113–126.
- Olver, M. E., Wong, S. C. P., Nicholaichuk, T., & Gordon, A. (2007). The validity and reliability of the Violence Risk Scale – Sex Offender version: Assessing sex offender risk and evaluating therapeutic change. Psychological Assessment, 19, 318–329.

Key Findings

- Change assessed for 17 LTVs
- Change score adds prediction that is incremental to static and initial dynamic assessment
- Results robust across four samples
- As Change gets larger, initial risk level becomes less predictive
- VRS-SO Calculator available
- http://www.psynergy.ca/VRS_VRS-SO.html
- You need to get properly trained

A Closer look at the Change Score

- Only scored if the initial dynamic risk assessment indicate there is an enduring problem in this area
- A modified version of the Stage of Change concept
- Weights behavioral evidence for change more heavily
- Modified SOC stages are defined in a largely similar way across different dynamic risk factors (see next slide)
- Essentially this is a mixture of your attitude to the LTV and the consistency with which you regulate it in the current setting

Modified SOC

- **Precontemplation** – no awareness of the problem; no motivation to change
- **Contemplation** – Recognizes the problem; wants to change but relevant behavioral changes not observable
- **Preparation** – Recognizes problem, has made observable efforts at overcoming them, but changes are recent and/or not to stable over time
- **Action** - Recognizes problem, has made observable efforts at overcoming them, changes are reliable and over time, lapses are rare, but the individual hasn't been adequately tested across relevant high-risk situation
- **Maintenance** – Stable change that has been tested across a variety of situations related to the individual's problems

- No Risk Reduction until you get into Preparation
- Half a point for each improvement in SOC
- So if you start with 10 areas where you have problems and you move into Preparation on 8 of them you get 4 points of Change
- This is the typical level of change observed in a good intensive DOC treatment program (say of 12 months duration)
- Static-99R = 7 & Initial Dynamic Risk = 32
  - Change = 0 → 48% 10 year sexual recidivism
  - Change = 4 → 36% 10 year sexual recidivism
  - Change = 8 → 25% 10 year sexual recidivism

SAPROF-SO (Gwen Willis & Sharon Kelley)

- SAPROF items tweaked to make them more relevant to sex offending and additional items added
- Each item has a rationale in empirical research and comes with a little research summary that justifies its relevance
- Pilot version currently being tested but could be of clinical value now
- Protective Factors requires demonstrating the presence of something positive, not just the absence of risky behavior
- Items organized into subscales that reflect concepts from the Desistance literature

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Mechanisms underlying protective factors: *Three Layers of Understanding*

- Potential protective process
  - The most abstract and generalizable layer
- Protective factors
  - Arenas within which protective processes can operate
  - The level the SAPROF attends to
- Needs and Responsivity of the Individual
  - Determines the form that PFs will have to take to be personally relevant

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Mechanisms underlying Protective Factors: *Two Varieties of Potential Protective Processes*

- Control refers to processes that mitigate the operation of risk factors or urges to engage in antisocial behavior.
- Prosocial Reward refers to processes that lead the person to experience a prosocial life as satisfying
- So when someone exercises self-control one can ask
  - (a) does this mitigate risk factors or antisocial behavior?
  - (b) does this make his life more satisfying?

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Examples - 1

- Sometimes exercising **self-control** actually makes life feel less satisfying (PG Translation: "When he said XXX I really wanted to hit him, but I controlled myself, so he got away with it and I am left simmering with frustration").
- But the person later in treatment might say, "it is getting easier to control myself now. When someone mouths off I just think he is an idiot and ignore him. I am proud of keeping out of trouble." Here he is connecting self-control to something he values (sense of Agency).

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Examples - 2

- A person who previously used to make sharp disdainful arrogant remarks might
  - reduce this as they became more responsive to empathic awareness of the distress caused (antisocial behavior controlled by **empathy**)
  - and then later discover that they enjoyed the way people were more friendly to them now that they behaved less obnoxiously (empathy leading to prosocial reward).

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Examples - 3

- Regular **work** may be a source of Prosocial Reward if
  - the person enjoys their work,
  - feels good about working,
  - enjoys the company of co-workers,
  - is less bored than they would be without work etc.
- It may also be a source of Control because of
  - job requirements that crowd out opportunities for ASB
  - informal social policing of behavior in the work place
  - peers modeling prosocial behavior create normative pressure.

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Classes of PF

- PF can be grouped according to the degree to which they are internal, external or arise from an interaction of internal and external
- This is a continuum
  - Internal Capacity & Prosocial Identity
  - Prosocial Connection & Stability
  - Professionally Provided Support
- In each class both Control and Prosocial Reward mechanisms can operate but factors differ in the degree to which they afford the opportunity for particular protective processes
  - Some PFs provide control through reduced victim access but little opportunity for prosocial reward

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Mechanisms & Provisional Subscales

SAPROF-SO subscale	Control	Prosocial Reward
Internal Capacity	Greater capacity for self-restraint & more awareness of reasons for restraint	Greater capacity to achieve goals in a prosocial way
Prosocial Identity	Commitment to self-restraint	Prosocial life goals
Prosocial Connection	Informal social policing & structure	Opportunities for prosocial reward
Stability	Stability allows resources for self-control	Stability allows prosocial routes to reward to develop
Professionally-Provided Support	Builds internal controls Bonds with prosocial agents Reduced victim access	Coaches seeking prosocial reward

Sexual Self-regulation: Regulation of sexual impulses & evidence of a normative sex drive

Sexual Self-regulation should involve

- A lifestyle that deliberately avoids situations which either trigger offense-related sexual impulses or which provide opportunities for offending;
- Well worked out strategies for safely negotiating inadvertently encountered situations of this kind;
- Offense-related sexual impulses arising rarely and are effectively interrupted when they occur so that they do not result in masturbation or behaviour directed towards others;
- Healthy expression of sexual drive so that sexual thoughts and fantasies are focused on consensual sex with adults who are (and appear to be) at least 18, normative sexual impulses are expressed in a contextually-appropriate way, and sex is not used to cope with negative affect or stressful situations.

Scoring

- **A score of 4** is indicated when all four elements of sexual self-regulation have been clearly present for at least 12 months in an uncontrolled environment, and that this is now achieved without great effort. A score of 3 is appropriate when all four elements have been clearly present for at least 12 months in a controlled environment.
- **A score of 2** is indicated when
  - Sexual self-regulation with occasional minor lapses has been present for 6 months (e.g., masturbating to a deviant fantasy 1 – 3 times in the past 6 months). If sexual self-regulation with occasional minor lapses has been present for 12 months then a score of 3 would be indicated.
  - Sexual self-regulation has been maintained for 12 months but only with great effort. To illustrate, a man who had brief sexual thoughts about children most days but regularly interrupts them before they turned into sexual fantasies using a conscious coping strategy such as telling himself that children are dirty would receive a 2.
  - Three of the four elements of sexual self-regulation are reliably present.
- **A score of 0** is indicated when an individual repeatedly engages in behaviour that demonstrates an absence of all four elements of sexual self-regulation. Someone who repeatedly masturbates to offense-related sexual fantasies in private, but showed elements 1 & 2 of sexual self-regulation should be scored a 1.

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Relationship with VRS-SO (*N* = 20)

- Age *M* = 51.6 (*SD* = 11.12), range 31 – 71 years
- Static-99R *M* = 5.25 (*SD* = 1.68); 50% High risk, 30% Mod-high, 20% Low-mod
- 80% in secure perimeter, 20% on supervised release

Pearson *r*	Static-99R	VRS:SO pre-tx dynamic	VRS:SO change	VRS:SO post-tx dynamic
SAPROF-SO (overall *M*)	-.32	-.02	.53*	-.51*

* $p < .05$

What Constitutes Treatment Progress?

Ernie Marshall, LCSW

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Agenda

- Challenges
- What we do
- Final thoughts

Challenges

Risk instruments were designed for just that, risk prediction.

Research methods affect conclusions

- What does treatment mean?
- What are you really measuring?

Challenges

Are the risk factors really dynamic?

- Sexual Interest
- LEIRA
- Different etiology, different intervention

Challenges

Individual human in actuarial data set.

- "Weighting" of risk factors for an individual
- Some individuals may have risk factors that are not empirically based

Challenges

Different definitions of factors with different researchers then applying those concepts towards current functioning.

- Multiple risk instrument operationalize differently
- Interpreting current behavior
- Multiple pathways

Challenges

- Interpreting current functioning
  - Over pathologizing
  - Bias
  - Desensitization

Challenges

What doesn't work: checklist of assignments, equating assessment completion as progress towards management?

- Tempting and easy
- Bias towards higher IQ and maybe psychopathy
- Trained seals

Challenges

Sometimes the easiest things to measure are least important and the most important things are hard to measure.

- Intentions
- SOTEP "Got it" group
- The relationship (adversarial system)

Challenges

Goals of program: reduce recidivism or convince evaluator?

- Treatment resource allocation
- Suppression
- Two year evidence
- Self esteem

Challenges

- Documentation (Communicating with Evaluators)
  - Observations that are difficult to operationalize

What are we really asking?

Treatment Progress

Or

Risk management/change

What we do

- Common Factors
- RNR
  - Includes protective factors and desistance

Treatment Targets Foundation

- de Vogel, V., de Ruiter, C., Bouman, Y., & de Vries Robbé, M. (2012). *SAPROF: Guidelines for the assessment of protective factors for violence risk. 2nd Edition.* Utrecht, The Netherlands: De Forensische Zorgspecialisten.
- 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. doi: 10.1177/ 1079063210366039
- Maruna, Shadd. Making good: How ex-convicts reform and rebuild their lives. Washington, DC, US: American Psychological Association Making good: How ex-convicts reform and rebuild their lives. (2001). xix 211 pp. http://dx.doi.org/10.1037/10430-000

Phases

- Phase One: engagement, general self management, beginning to develop a pro-social identity
- Phase Two: assessment phase, motivation
- Phase Three: Continued management/maintenance of change until the magic "sufficient progress in treatment"

Measuring Progress

- Individualize SMART Goals (Approach)
  - Specific, measurable, achievable, realistic, time limited
- Dynamic Treatment Plans
- Case Conceptualization

Clinical Meetings

Monthly Meetings

Notes, group and monthly

- Linking Tx Targets to Phase Advancement and Standardizing

INTRODUCTION
☐ Meeting date
☐ Purpose of meeting
☐ Phase
☐ Treatment track
☐ Participation in monthly meeting (e.g., collaborative, prepared, guarded, etc.)
☐ Listing of records reviewed (e.g., group notes, unit notes, education, work therapy, etc.)
☐ Review period dates
TREATMENT ENGAGEMENT
☐ If applicable, phase or group transfers, including rationale
☐ If applicable, engagement-focused status noted
☐ Group absences, including explanation, whether or not absences relate to engagement
☐ Rapport, alliance, or collaboration with facilitators
☐ Frequency of participation in group sessions
☐ Quality of patient's participation in group session
☐ Topics/insights from supplemental groups, including incorporation of topics/insights into daily living
☐ Interventions identified in this area, including clinical justification for interventions
FUTURE THINKING
☐ Personal identity
☐ Belief that change is possible; hope
☐ Life purpose and meaningful life goals
☐ Interventions identified in this area, including clinical justification for interventions
SELF-MANAGEMENT
☐ Behavioral sanctions (e.g., counsels, warnings, BDRs) and how patient addressed in group
☐ Psychiatric care and patient's response (e.g., medication adherence, collaboration with provider, etc.)
☐ Dysfunctional or healthy coping
☐ Ability to solve problems effectively and use responsible decision-making
☐ Self-management related to various settings (e.g. employment and housing unit)
☐ Daily routines
☐ Impulse control
☐ Openness to external control (e.g., defiant attitude toward authority, oppositional behavior, deceiving authority figures, openness to SR, DOC supervision, etc.)
☐ Interventions identified in this area, including clinical justification for interventions
CRIMINAL THINKING
☐ Attitudes supporting or opposing sexual offending
☐ Insight or management of criminal thinking errors (or lack thereof)
☐ Prosocial or antisocial attitudes or behaviors toward authority
☐ Interventions identified in this area, including clinical justification for interventions
WORLD VIEW
☐ Personal values or principals that guide the patient's behaviors
☐ Esteem, view of self, or evaluation of self-worth
☐ Locus of control (i.e., ability to accurately evaluate causes of events)
☐ Presence or absence of a hostile world view
☐ Interventions identified in this area, including clinical justification for interventions

Phase Advancement Determination

- A modified goal attainment scaling (GAS) process will be used to measure a patient's progress towards advancing to the next phase of treatment. GAS is not used to assess which individual patient goals are achieved in the treatment plan. However, the achievement of goals in the treatment plan, as well as other documentation, is used to determine if the phase advancement criteria are achieved. This allows for individualization treatment progress at the treatment plan level and consistency across phase advancement criteria at the phase advancement level.

Final Thoughts

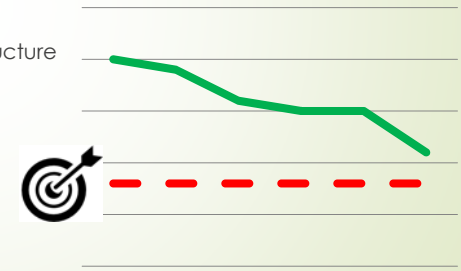
- Improve conditions of confinement
- Staff attitudes
- Increased autonomy

KINDNESS. IT DOESN'T COST A DAMN THING. SPRINKLE THAT SHIT EVERYWHERE.

Case Examples

Impact of…

- Role
  - Treatment Provider vs. Forensic Evaluator
- Markers
  - VRS-SO Change Score
  - Progress through SOT Phase Structure
  - Statutory Criteria
- Focus
  - Relative vs. Absolute
  - Time Period



Phase Structure

- Phase One - develop self-management skills to ameliorate personality disorder traits or other factors that might affect treatment engagement
- Phase Two - identify re-offense risk factors and understand how they manifest in his current functioning
- Phase Three - learn to manage re-offense risk factors reliably and replace them with adaptive behaviors; prepare for transition into the community.

Significant Progress in Treatment

- (A) Meaningfully participating in the treatment program specifically designed to reduce his or her risk to reoffend offered at a facility described under s. 980.065
- (B) Participating in the treatment program at a level that is sufficient to allow the identification of his or her specific treatment needs and then demonstrating, through overt behavior, a willingness to work on addressing the specific treatment needs;
- (C) Demonstrating an understanding of the thoughts, attitudes, emotions, behaviors and sexual arousal linked to his or her sexual offending and an ability to identify when the thoughts, emotions, behaviors, or sexual arousal occur;
- (D) Demonstrating sufficiently sustained change in the thoughts, attitudes, emotions, behaviors and sufficient management of sexual arousal such that one could reasonably assume that, with continued treatment, the change could be maintained.

Context - VRS-SO at SRSTC

Score	*N*	*M (SD)*
Pre-Tx Dynamic	186	39.4 (4.9)
Post-Tx Dynamic	182	35.1 (5.7)
Change	182	4.4 (3.0)

Phase	*N*	Change Score *M (SD)*
Pre-Treatment	9	2.1 (1.0)
1	13	1.9 (1.3)
2	86	3.6 (2.2)
3	55	6.3 (2.2)

Treatment	*N*	*M (SD)*
Engagement-Focused	24	3.1 (1.9)
Standard	139	4.5 (2.6)

Case Examples

Case SZ - Background

- 46 yo
- Hx of abuse, chaotic upbringing, conduct problems
- No sustained romantic relationships
- Substance use - alcohol, marijuana, cocaine, meth
- PCL-R scores 29 - 35
- Above average FSIQ
- Static-99R = 5
- Dx - ASPD
- Offense Hx – theft, burglary, sex offenses, disorderly conduct, battery/resist/obstruct (in institutions)
- Victims - teenage female acquaintances
- Sexual harassment of young adult female co-worker
- Poor adjustment under supervision
- Lengthy institutionalization

Case SZ – Treatment Overview

- Currently Phase 3 – Engagement Focused
- Inconsistent motivation / engagement
- Tried, but discontinued anti-androgens to manage sex drive/fantasies
- Behavior Therapy
- PPG – adult female consensual
- Regressed following evaluator recommendation for release
- Repeated fraternization, including recent incident

Case SZ - Treatment Perspective

- Tx Engagement
  - Poor attendance
  - Poor attitude, unprepared
  - Disruptive
  - Minimal work on treatment issues; missing the mark on treatment assignments
- Future Thinking
  - Some hope for the future, but little direction/purpose
  - Some movement towards pro-social identity
- Self-Management
  - No very recent rule violations, yet poor coping
  - Focus: outward blame rather than potential for change
- Criminal Thinking
  - Fraternization attitudes (offense-paralleling?)
  - Claims circumstances warrant aggression
  - Issues with authority / the "system"
  - Entitlement

Case SZ - Treatment Perspective

- World View
  - Hostile
  - External locus of control
  - Others out to get him
  - Bandwagoning on others' grievances
- Relational Style
  - Ongoing contact with family
  - Unhealthy (e.g., frat)
  - Self-centered
- Sexual Interests
  - No reported difficulty focusing on adult, consensual themes
  - No recent poly-assisted SFM Logs
- Re-entry
  - Plans to live with father; parasitic?
  - No $ saved
  - No plans for or interest in seeking employment

Case SZ – Evaluator Perspective VRS-SO

- Sexual Deviancy
  - Sexually Deviant Lifestyle
  - Sexual Offending Cycle
  - Deviant Sexual Preference
  - Offense Planning
- Criminality
  - Interpersonal Aggression
  - Community Support
  - Impulsivity
- Treatment Responsivity
  - Cognitive Distortions
  - Insight
  - Release to High Risk Situations
  - {-} Treatment Compliance

Factor	Pre	Post
Sexual Deviancy	13	11
Criminality	17	15.5
Treatment Responsivity	9	8
Total Dynamic	42	37.5

- Change Score = 4.5
  - previously 6

Case SZ – Evaluator Perspective Sexual Deviancy

- Understanding of risk/protective factors
- Believes sexual contact with underage girls is inappropriate
- Strongest PPG response to adult female consensual
- BT to strengthen/maintain arousal to consenting sex with adults
- Recognized living with brother (who had female teen daughter) not viable
- No focus on victim-related materials, requested BT / adult materials

Case SZ – Evaluator Perspective Criminality

- Overall, reduced aggression, though sometimes still intimidating / hostile
- Several examples of socializing appropriately
- Contact with family, friends
- Report employment plans, housing options
- Performed well at institutional job
- Demonstrates ability to think before acting, though not consistently

Case SZ – Evaluator Perspective Treatment Responsivity

- Realistic perspective of offenses
- Replacing cognitive distortions with rational thinking
- Able to articulate factors precipitating his offending
- Relevant SOT assignments completed
- Less likely to be in social settings with teenagers (current age)
- Housing option

- {-} Inconsistent motivation
- {-} Unexcused absences from groups
- {-} Points to external causes for this

Case SZ – Evaluator Perspective VRS-SO Calculator

10 Year Sexual Recidivism Risk Using Static-99R, VRS-SO (Pre), and VRS-SO Change

Static 99R	VRS-Pre	VRS-Change
5	42	4.5

B0	B1	B2	B3
-3.736	0.254	0.059	-0.13

10-Year Predicted Sexual Recidivism = 36.1 %

Case SZ – Evaluator Perspective Significant Progress in Treatment

- Not consistently meaningfully participating..
- Not currently showing a willingness to work on treatment needs
- Partially demonstrates understanding of thoughts, attitudes, emotions…
- Not demonstrating sufficiently sustained change

Case SZ Comparing Markers of Treatment Progress

- VRS-SO Change Score
  - About average for SRSTC patients (who've been there roughly 9-10 years on average)
  - Enough to tip scales → discharge recommendation
    - Static-99R = 5 , VRS-SO Pre-Tx = 42, Change Score = 4.5
- Statutory Criteria not met
- Progress through SOT Phase Structure
  - Engagement Focused Plan

Case SZ

- Comments?

Case IO - Background

- 59 yo
- Impoverished, abusive, dysfunctional upbringing
- Divorced
- Substance use – alcohol, inhalants, marijuana
- PCL-R scores 32 - 35
- Static-99R = 7
- Dx – ASPD; MMI (?); ID, mild
- Hx of psychiatric hospitalization (Ø active sx for several years); reported feigning sx for secondary gain
- Offense Hx – rape (severely beat older victim); OMVWOC; escape; burglary; obscene phone calls; exposure and battery (institution)
- Victims – older adult female
- Stalking female staff; boundary issues (not within last few years)
- Violations while on supervision
- Some recent rule violations
- Limited work hx; incarcerated for bulk of adult life

Case IO – Treatment Overview

- Currently Phase 3
- Individual sessions for several months before returning to group
- Invalid PPG several years ago
- No SFM logs/polygraphs (reports no deviant fantasies, no masturbation)

Case IO - Treatment Perspective

- Tx Engagement
  - Attends all groups, prepared and on time
  - Applies treatment concepts to daily living
  - Consistent pro-treatment attitude
- Future Thinking
  - Shifting towards prosocial identity
  - Hopeful about future and being able to use treatment tools
- Self-Management
  - No recent rule violations
  - Adaptive self-management
  - Coping effectively
  - Practices mindfulness and participates in biofeedback
  - Effective problem-solving
- Criminal Thinking
  - Not expressing negative attitudes toward authority, some progress on sex offense supporting attitudes

Case IO - Treatment Perspective

- World View
  - No hostility
  - Values treatment, rapport with providers, socializing with peers and encouraging them
- Relational Style
  - Reports more interest in friendships than sexual intimacy
  - No callous behavior, no grievance thinking
  - Trusts only a few staff, but gets along with all
  - Empathic, good emotional regulation dealing with difficult peer
- Sexual Interests
  - Reports no deviant sexual interest, does not think about sex frequently
  - Suffered penile fracture, which could affect ability to achieve and maintain erection (limiting utility of PPG)
  - Signed up for healthy sexuality supplemental group
- Re-entry
  - Positive custodial work reviews
  - Some leisure with peers
  - Ø $ saved, no housing plans

Case IO – Evaluator Perspective VRS-SO

- Sexual Deviancy
  - Sexual Compulsivity
  - Offense Planning
- Criminality
  - Interpersonal Aggression
- Treatment Responsivity
  - None
- Emotional Control

Factor	Pre	Post
Sexual Deviancy	10	9
Criminality	15	14.5
Treatment Responsivity	10	10
Total Dynamic	39	37

- Change Score = 2

Case IO – Evaluator Perspective Sexual Deviancy

- Sexual preoccupation / compulsivity demonstrated earlier on during civil commitment (exposing genitals, stalking behavior, possession of pornographic images)
- Boundary violations with female staff as recent as 2014
- Lacks ability to identify thoughts, feelings, attitudes, arousal linked to past offending
- Lacking awareness / insight
- Not maintaining SFM logs / self-reports not verified by polygraph
- Taking commendable steps to intervene, improving boundaries with female staff

Case IO – Evaluator Perspective Criminality

- Again, evidence from earlier period of civil commitment
- Physical assault and threats to staff early to mid-2000s
- Pushed/grabbed staff member's throat in 2007
- Conning / manipulation in the form of boundary violations
- 2016 BDRs
  - Theft/damage of property (ripping out library book pages)
  - Unauthorized use of mail (unapproved correspondence, addressed it using another patient's name)
- Declining overt aggression, but relatively recent evidence of impulsive behavior and criminal attitudes

Case IO – Evaluator Perspective Treatment Responsivity

- More openness / willingness to disclose recently
- Lacks ability to identify DRFs
- No SFM log / polygraph
- Struggles to identify distorted attitudes, vague/minimizing account of violent sexual assault of older woman

Case IO – Evaluator Perspective VRS-SO Calculator

10 Year Sexual Recidivism Risk Using Static-99R, VRS-SO (Pre), and VRS-SO Change

Static 99R	VRS-Pre	VRS-Change
7	39	2

B0	B1	B2	B3
-3.736	0.254	0.059	-0.13

10-Year Predicted Sexual Recidivism = 52.1 %

Case IO – Evaluator Perspective Significant Progress in Treatment

- Meaningfully participating…
- Showing a willingness to work on treatment needs
- Not demonstrating understanding of thoughts, attitudes, emotions…
- Not demonstrating sufficiently sustained change…

Case IO Comparing Markers of Treatment Progress

- VRS-SO Change Score
  - Lower than SRSTC patients on average (who've been there roughly 9-10 years on average)
  - No discharge recommendation
    - Static-99R = 7 , VRS-SO Pre-Tx = 39, Change Score = 2.0
- 2 of 4 Statutory Criteria met
- Progress through SOT Phase Structure
  - Phase 3

Case IO

- Comments?

Comparing Case SZ & Case IO

Case SZ

- Static-99R = 5
- Phase 3 – Engagement Focused
- Post-Treatment Dynamic = 37.5
- Change Score = 4.5 (previously 6)
- SPT criteria – partially demonstrates understanding of thoughts, attitudes, emotions…
- Discharge recommendation

Case IO

- Static-99R = 7 (soon, 5)
- Phase 3
- Post-Treatment Dynamic = 37
- Change Score = 2
- SPT criteria – meaningfully participating and demonstrating willingness to work on treatment needs
- No discharge recommendation

10 Year Sexual Recidivism Risk Using Static-99R, VRS-SO (Pre), and VRS-SO Change

Static 99R	VRS-Pre	VRS-Change
5	42	4.5

B0	B1	B2	B3
-3.736	0.254	0.059	-0.13

10-Year Predicted Sexual Recidivism = 36.1 %

10 Year Sexual Recidivism Risk Using Static-99R, VRS-SO (Pre), and VRS-SO Change

Static 99R	VRS-Pre	VRS-Change
5	39	2

B0	B1	B2	B3
-3.736	0.254	0.059	-0.13

10-Year Predicted Sexual Recidivism = 39.5 %

Olver et al. (in press)

- "Because the change score is incrementally predictive, a given posttreatment score could have very different meanings depending on the magnitude of change used to generate it."

10 Year Sexual Recidivism Risk Using Static-99R, VRS-SO (Pre), and VRS-SO Change

Static 99R	VRS-Pre	VRS-Change
5	25	0

B0	B1	B2	B3
-3.736	0.254	0.059	-0.13

10-Year Predicted Sexual Recidivism = 27.1 %

10 Year Sexual Recidivism Risk Using Static-99R, VRS-SO (Pre), and VRS-SO Change

Static 99R	VRS-Pre	VRS-Change
5	30	5

B0	B1	B2	B3
-3.736	0.254	0.059	-0.13

10-Year Predicted Sexual Recidivism = 20.7 %

Olver et al. (in press)

- "If one begins with an even higher baseline, say 40 points, and the individual accumulates 10 points of change (which may be observed in longer term, high intensity programs) to generate a posttreatment score of again 30, the resulting 5 and 10-year sexual recidivism estimates drop to 6.0% and 9.9%, respectively…the higher the baseline risk as a starting point (e.g., 40 points up to 60 points), the larger such disparities become."

10 Year Sexual Recidivism Risk Using Static-99R, VRS-SO (Pre), and VRS-SO Change

Static 99R	VRS-Pre	VRS-Change
5	30	0

B0	B1	B2	B3
-3.736	0.254	0.059	-0.13

10-Year Predicted Sexual Recidivism = 33.3 %

10 Year Sexual Recidivism Risk Using Static-99R, VRS-SO (Pre), and VRS-SO Change

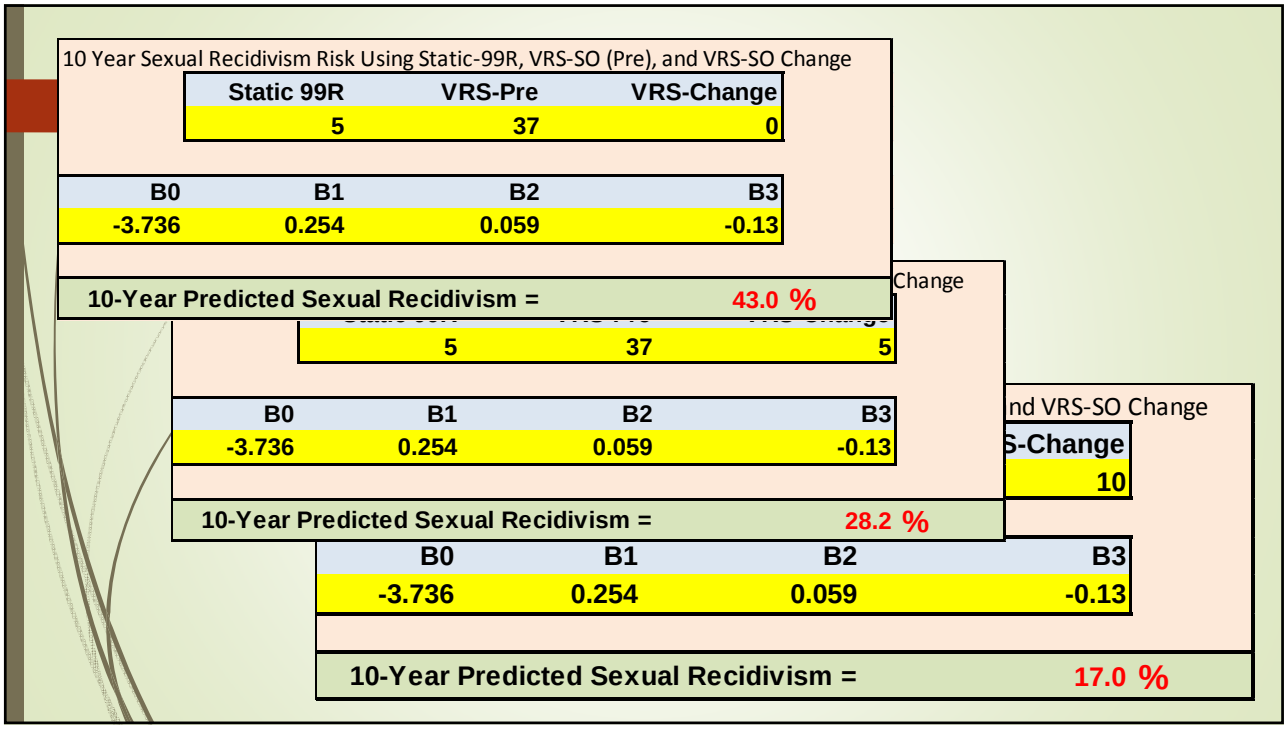
Static 99R	VRS-Pre	VRS-Change
5	40	10

B0	B1	B2	B3
-3.736	0.254	0.059	-0.13

10-Year Predicted Sexual Recidivism = 19.7 %

Case UL

- Above average change
- Converging markers of treatment progress



Case UL - Background

- 41 yo
- Chaotic childhood environment
- Sexual abuse, neglect, poor sexual boundaries within the family
- Never married, no children
- Ø substance use issues
- PCL-R scores 13.7 – 16.5
- Static-99R = 5
- FSIQ in the average range
- Dx – Pedophilic Disorder, both, non-exclusive
- Offense Hx & Victim Profile – sexual assault of younger sister and niece; 9 counts sexual assault male and female victims aged 2 to 9
- Brief work hx – grocery store, fast food, manufacturing

Case UL – Treatment Overview

- Phase 3 (since 2015)
- Consistent engagement
- Completes all treatment tasks as required
- Mainstream SOT, BT
- Participated in several supplementary groups (e.g., healthy sexual functioning, establishing and developing relationships, community re-entry)
- Positive work evaluations
- Participates in education and therapeutic recreation activities

Case UL - Treatment Perspective

- Tx Engagement
  - Consistent engagement
  - Maintenance
- Future Thinking
  - Participated in role play scenarios
  - Maintenance
- Self-Management
  - Processes feelings in group
  - 7 universal needs supplemental group
  - Challenging beliefs re: corrupt system/mistrust
- Criminal Thinking
  - Maintenance

Case UL - Treatment Perspective

- World View
  - Maintenance
- Relational Style
  - Maintenance
- Re-entry
  - Working with SR team
  - Positive work evaluations
- Sexual Interests
  - Continued in BT support group
  - Maintains SFM log; reports adult female consensual fantasies; intervened in response to 1 about 16 yo
  - Sexualized coping on 1 occasion (in response to feeling hopeless about current legal status)
  - Demonstrated insight

Case UL – Evaluator Perspective VRS-SO

- SOC movement on all factors scored 2 or 3 except
  - Treatment Compliance
  - Intimacy Deficits

Factor	Pre	Post
Sexual Deviancy	12	7
Criminality	10	8
Treatment Responsivity	11	9
Total Dynamic	37	27

- Change Score = 10

Case UL – Evaluator Perspective Sexual Deviancy

- Good grasp of sexual offense cycle
- Replaced pro-offending beliefs with pro-social beliefs
- Identified boredom as risk factor – developed and maintained busy, productive lifestyle at SRSTC
- No recent evidence of sexual preoccupation
- Restricts masturbation to adult consensual stimuli
- Able to successfully suppress deviant arousal on PPG
- Completed BT

Case IO – Evaluator Perspective Criminality

- Has developed and makes use of assertive communication skills
- Addressed issues with ruminating
- Took responsibility for physical altercation a couple years ago
- Keeps coping logs, maintains appropriate problem solving
- Good work evaluations
- Positive contact with family members
- Re-entry and vocational groups

Case IO – Evaluator Perspective Treatment Responsivity

- Concerns several years ago about being deceptive
- Addressed this and has consistently been open/compliant for years
- Identified factors linked to offending

Case UL – Evaluator Perspective Significant Progress in Treatment

- Meaningfully participating…
- Showing a willingness to work on treatment needs
- Demonstrating understanding of thoughts, attitudes, emotions…
- Demonstrating sufficiently sustained change…

Case UL
Comparing Markers of Treatment Progress

- VRS-SO Change Score
  - Almost 2 SDs > SRSTC patients on average (who've been there roughly 9-10 years on average)
  - Discharge recommendation
    - Static-99R = 5 , VRS-SO Pre-Tx = 37, Change Score = 10
- Statutory Criteria met
- Progress through SOT Phase Structure
  - Phase 3

Case UL

- Comments?

Reference

- Olver, M. E., Mundt, J. C., Thornton, D., Beggs Christofferson, S. M., Kingston, D. A., Sowden, J. N., Nicholaichuk, T. P., Gordon, A., & Wong, S. C. P. (in press). Using the Violence Risk Scale-Sexual Offense Version in Sexual Violence Risk Assessments: Updated Risk Categories and Recidivism Estimates from a Multisite Sample of Treated Sexual Offenders. *Psychological Assessment*.