Defining and Developing Good Evidence for Policy and Practice

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Overview

Reflections on the treatment effectiveness literature from an evidence based policy perspective

Targets for change for therapeutic work with sex offenders

Evidence-based methods & new ideas
From sex offender treatment to evidence based commissioning: A change in perspective

- From sex offender treatment lead to commissioning strategy
- An organisation committed to evidence-based policy
- Setting standards for evidence based policy
- Assessing the evidence base to inform commissioning strategy
- Colleagues and Collaborators
Working in an evidence-led agency

NOMS is committed to evidence-based commissioning. Wherever possible, we will use sound evidence to inform the commissioning decisions we will take to obtain our outcomes. Evidence will count more strongly than intuition or habit as we prioritise services and subgroups or “segments” of offenders.
Two aspects of evidence-based policy as opposed to policy-based evidence

**Develop policies based on evidence**
Identify and read the appropriate evidence, identify the evidence based principles and conditions, develop the policy, acknowledge limitations

**Evaluate policies during implementation**
Using a high quality research design
Threats to Evidence Based Policy-Making

Vs. the “evil twin”: Policy-based Evidence-Making
What is the evidence for sex offender treatment effectiveness?
PREVENTING SEXUAL ABUSERS OF CHILDREN FROM REOFFENDING: SYSTEMATIC REVIEW OF MEDICAL AND PSYCHOLOGICAL INTERVENTIONS

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1 Institute of Psychology, University of Erlangen-Nuremberg, Germany
2 Institute of Criminology, University of Cambridge
RCTs only, any outcome

10 studies, of which 5 had some sort of reconviction outcome, and 2 were large scale robust reconviction studies.

CBT, Behavioural and Psychodynamic

3 studies had outcome variables not now judged criminogenic
RCTs and prospective observational studies, broad reoffending outcome.

Sexual abusers of children only (adults, adolescents, children with sexual behaviour problems).

8 studies included; 5 with adult perpetrators.
The effects of sexual offender treatment:

An international meta-analysis of sound quality evaluations

Martin Schmucker¹ & Friedrich Lösel²

¹Institute of Psychology, University of Erlangen-Nuremberg, Germany
²Institute of Criminology, University of Cambridge

Meta-analysis of outcome studies with equivalent treatment and control groups (Maryland 3-5).

Outcome criterion was official measures of sexual recidivism.

28 comparisons identified.
Meta-analysis of outcome studies rated as good or weak (accepted weaker studies than Langstrom et al. or Dennis et al.). Only 5 rated as “good” design.

22 studies, recidivism outcome (incl self report).

Rated according to compliance with RNR criteria.
What do the systematic reviewers conclude about the quantity and quality of the evidence?

“The main finding of this systematic review is that there was no evidence from any of the trials in favour of the active intervention in a reduction of sexual recidivism”.

(Dennis et al., 2012)

“The scientific evidence was insufficient to determine if cognitive behavioural therapy with relapse prevention reduces reoffending. No scientific evidence was available to determine if [other] psychological interventions reduce sexual reoffending”.

(Langstrom et al., 2013)
What do the systematic reviewers conclude about the quantity and quality of the evidence?

“The sexual and general recidivism rates for treated sex offenders were lower than the rates observed for comparison groups… [but] Reviewers restricting themselves to the better quality, published, studies could reasonably conclude that there is no evidence that treatment reduces sexual offence recidivism”
(Hanson et al., 2009)

“The analyses suggest that treatment of sexual offenders can be effective. Sexual offender treatment is a promising part of an evidence-oriented crime policy”.
(Schmucker & Losel, 2013).
More research is always needed…

“[There were] far fewer than the number [of studies] that would give one any confidence in the findings…Our inescapable conclusion is the need for further RCTs”. (Dennis et al., 2012)

“Better coordinated and funded high quality studies including several countries are needed”. (Langstrom et al., 2013)
...In this case, it seems to be essential.

“Strong studies are needed. Of the 128 studies examined, none were rated as strong. Skeptics will only be compelled to change their opinions by the strongest possible evidence”.
(Hanson et al., 2009).

“More randomized trials and high-quality quasi-experiments are needed, particularly outside of North America. In addition, there is a clear need of more differentiated process and outcome evaluations that address the question of what works for whom under what circumstances and with regard to what outcomes”.
(Schmucker & Losel, 2013)
So, what’s the evidence-based position? Are we OK just to carry on?

“If the programme is of unknown efficacy, is it legitimate to detain individuals [for treatment]?… In practice, it is likely that both pharmacological and psychological therapies will need to be used in unison in order to obtain the greatest benefit”

(Dennis et al., 2012)

“The most ethically defensible position would be to assess the presence of treatable risk factors… and offer individualised treatment. Ensure that the model complies with the risk, need and responsivity principles”.

(Langstrom et al., 2013)
It seems not. We may need to think differently.

“Attention to the need principle would motivate the largest changes in the interventions given to sexual offenders…Consequently it would be beneficial for treatment providers to carefully review their programmes to ensure that the treatment targets emphasised are those empirically linked to sexual recidivism”.

(Hanson et al., 2009).

CBT may not be the most important feature of an effective approach; inclusion of individual sessions may produce better results (but confounded); flexible manuals; focus on high risk offenders.

(Schmucker & Losel, 2013)
Getting the Treatment

Targets right
Assessing Risk for Sexual Recidivism: Some Proposals on the Nature of Psychologically Meaningful Risk Factors

Ruth E. Mann\(^1\), R. Karl Hanson\(^2\), and David Thornton\(^3\)

Attitudes Supportive of Sexual Offending Predict Recidivism: A Meta-Analysis

Leslie Helmus\(^1\), R. Karl Hanson\(^2\), Kelly M. Babchishin\(^1,2\), and Ruth E. Mann\(^3\)
We have a good understanding of what factors best predict reconviction…

<table>
<thead>
<tr>
<th>Category</th>
<th>Factors</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sexual interests</td>
<td>• Sexual preoccupation, deviant sexual interests</td>
</tr>
<tr>
<td>Attitudes and beliefs</td>
<td>• Offence supportive attitudes; hostile schemas</td>
</tr>
<tr>
<td>Relationships</td>
<td>• Lack of intimacy with adults, emotional congruence with children</td>
</tr>
<tr>
<td>Self regulation</td>
<td>• Impulsivity, poor problem solving, non-compliance with rules</td>
</tr>
</tbody>
</table>
We are starting to think about what protects people from reoffending...

- Healthy sexual interests
- Capacity for emotional intimacy
- Constructive social and professional support network
- Goal directed living
- Good problem solving
- Engaged in employment or constructive leisure activity
- Sobriety
- Hopeful, optimistic and motivated attitude to desistance
An Exploration of Protective Factors Supporting Desistance From Sexual Offending

Michiel de Vries Robbé¹, Ruth E. Mann², Shadd Maruna³ and David Thornton⁴
...And we know there are some things that seem not to be related to reoffending.

- Victim empathy
- Taking responsibility for offending
How should “acceptance of responsibility” be addressed in sexual offending treatment programs?

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Victim Empathy Intervention With Sexual Offenders: Rehabilitation, Punishment, or Correctional Quackery?

Ruth E. Mann and Georgia D. Barnett
Evidence-based methods for addressing criminogenic attitudes and beliefs
Beliefs about sexual offending have been found to be related to recidivism…

Offence-supportive attitudes, including child molester attitudes (e.g., children are not harmed by sex with adults), pro-rape attitudes (e.g., rape victims enjoy or deserve rape), sexual entitlement (e.g., sexual needs must be met), general assessments of the immediate, emotional evaluation (valence) of sexual offending (e.g., sexual offending is fun).

These beliefs may surface in relation to particular offences in the form of minimisation of harm (the belief that the victim was unharmed by or even enjoyed the abusive behaviour) and victim blaming (the belief that the victim encouraged or was responsible for the abusive behaviour).
And some beliefs about the self and the world (schemas) are also indicated, although the evidence is less extensive.

- A view of oneself as **disadvantaged** by events of life
- A view of oneself as **dangerous, deviant, and/or disgusting** (because of one’s sexual desires or sexual behaviours)
- A hostile attributional bias, where the behaviour of others is habitually interpreted as hostile and malign
- A belief that **children are sexual beings** who are capable of sexually mature desires and behaviour, including sexual provocation, and who are not harmed by sexual relations with adults
- A belief that **the world is dangerous** and that people must attack, dominate and get revenge in order to survive it
- A need for respect from others, which if not forthcoming must be obtained through dominance
Methods for addressing criminogenic cognitive content & process

Cognitive restructuring
Schema therapy
Empathy training
Assessment and Treatment of Distorted Schemas in Sexual Offenders

Anthony R. Beech¹, Ross M. Bartels¹, and Louise Dixon¹

Abstract
The aim of this review is to examine the literature related to the assessment and treatment of sex offenders’ distorted schemas. Where appropriate, the review draws upon current insights from the field of social cognition to aid in the critical evaluation of the findings. First, the review considers the various different methodologies for assessing distorted schemas, discussing their strengths and limitations. Second, the review examines the work related to the treatment of sex offenders’ schemas. Suggestions for future research, and the implications for clinical practice, are highlighted in the article.
What does “cognitive restructuring” involve?

Collaboratively, therapist and client identify problematic cognitions and agree that they are problematic.

The therapist applies Socratic questioning to assist the client to evaluate the problematic cognition in terms of its rationality and evidence base.

The client is encouraged to identify rational rebuttals to the original problematic cognition,

The client is invited to consider and weigh up the evidence for both the original belief and the newly articulated rebuttal.
Cognitive restructuring: Evidence review suggests it’s “effective”

According to a survey of treatment providers in the USA, cognitive restructuring is the most common procedure adopted to change sexual offenders’ cognitions (McGrath et al., 2010), although this survey relied on self-report and so could not verify that the techniques used in these programmes actually met the definition of cognitive restructuring.

Beech et al (2013) identified three studies that evaluated the impact of cognitive restructuring on sex offenders’ cognitions (Bumby, 1996; Bickley & Beech, 2003; and Williams, Wakeling & Webster, 2007) and concluded that this technique is effective in relation to beliefs about children and sex.
But “cognitive restructuring” may be incorrectly understood in our typical treatment approach.

Cognitive restructuring is not a process designed to change an offenders’ account of his offence and is not a method to push someone to take responsibility for his offending (i.e., present his offence account without minimisation, justification or denial).

While the majority of US programmes have reported that cognitive restructuring is one of their main treatment methods, they have simultaneously reported that “taking responsibility for the offence” is one of their main goals.
What does “schema therapy” involve?

1. Explain the concept of schemas to the client.
2. Teach the client to identify and articulate their individual schemas through a process of recognising patterns in their thinking across their lives.
3. Teach the client self-challenge techniques, especially the need to consciously create alternative explanations and then gather evidence both for the original schema-driven interpretation as well as for alternative interpretations.
4. The client practices in the therapy setting.
Schema therapy: Evidence review suggests it’s “useful”

Limited research, none examining reoffending outcomes

Schema therapy seems to reduce grievance thinking (Barnett, 2011) and entitlement and suspiciousness schemas (Thornton & Shingler, 2001).

A different programme developed just for rapists (Eccleston & Owen, 2007) fared less well: the schemas held by group members were “intractable and highly resistant to change”.

A randomised controlled trial (RCT) of Schema Modal Therapy for personality disordered patients in a high security hospital (Tarrier, Dolan, Doyle, Dunn, Shaw & Blackburn, 2010) reported no statistically significant impact on a range of schema measures.
Should we move our focus from “victim empathy” to “empathy training”?

“Empathy deficits” in sexual offenders could more usefully be viewed as cognitive deficits. That is, they arise from weaknesses across a range of cognitive processes, including weaknesses in perspective taking.

Empathy-enhancing sessions often utilise methods that are highly experiential, often involving psychodramatic activities (e.g., Mann, Daniels, & Marshall, 2002; Webster, Bowers, Mann, & Marshall, 2005).
Empathy training: Evidence review suggests it changes attitudes

Analyses of the effects of these sessions on cognition have established that they appear to bring about reductions in offence-supportive beliefs such as attitudes that children enjoy and provoke sexual contact with adults (e.g. Pithers, 1994; Beech, Fisher & Beckett, 1998).
A move from victim to general focus retains our strong methods but enables more generalisation.

Such experiential methods are effective approaches for challenging relevant attitudes, but, to avoid inducing shame or undermining the development of a nonoffending identity that can aid desistance from offending, as well as to avoid conflation of treatment with punishment, they should be focused on enhancing the general cognitive skill of perspective taking, rather than narrowly focused on enhancing empathy for the particular victim of a participant’s offence.
Methods for improving self regulation

Cognitive skills training
Mindfulness training
What is cognitive skills training? The example of ETS

ETS: 20 two-hour sessions delivered to groups of participants by two trained facilitators.

ETS: designed to boost as problem-solving, perspective taking, empathy, impulse control, and critical reasoning.

A variety of cognitive-behavioral techniques are used including practical tasks, discussions, role-play, and games.

Facilitators are trained to make the training materials relevant to the everyday lives of the participants and to make the sessions as interactive and as little like school as possible.

More complex skills are introduced only after the basic constituent skills have been introduced. Over-learning and repetition enables the assimilation of these new skills.
WHO BENEFITS FROM COGNITIVE SKILLS PROGRAMS?

Differential Impact by Risk and Offense Type

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We found differential responses to ETS according to nature of index offence

ETS in custody 2000-2005, for adult males. N = 21,373
Reoffending after ETS – sexual offenders with adult victims

Sex offenders in custody, 2000-2005, N = 589
Reoffending after ETS – sex offenders with child victims

Sex offenders in custody, 2000-2005, N = 1235
STRENGTHS

Real world delivery

Consistent with Robinson, 1995.

CAVEATS

No sexual offence specific information

Unusual for sex offenders to complete ETS only—Denial may be the protective factor?

Small n, especially at higher risk levels

Not a prospective, matched, study; no comparison group.
If ETS did reduce sexual reoffending, what can we learn from this?

- No need for an offence focus?
- Teaching skills is the most important thing?
- Better for an intervention to avoid implying a sex offender identity?

Let’s look at some other approaches that fit these principles.
Treating disturbed emotional regulation in sexual offenders: The potential applications of mindful self-regulation and controlled breathing techniques

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The case for mindfulness training is mainly theoretical...

Negative emotional states can lead to disturbances in individuals’ ability to control sexual behaviours.

Teaching mindfulness techniques to those convicted of sexual offences can change prefrontal activity and improve heart rate variability, reducing anxiety and worry and improving emotional control.

Training in mindful breathing meets the criteria for responsive treatment – it is a physical rather than cognitive activity, it does not require introspection, and it produces immediate benefits in terms of a subjective sense of well-being.
But review of the early evidence suggests there’s an impact on criminogenic factors.

Tested variants with psychiatric and forensic samples:
- meditation on the soles of the feet
- controlled breathing with biofeedback
- mindful observation of thoughts

Early studies suggest impact includes:
- Enhanced frontal/amygdala functioning
- Decreased anger & hostility
- Increased emotional regulation
- Decreased anxiety and worry
- Improved affect labelling
The “wise intervention” literature offers important evidence-based principles about intervention design
What are “wise interventions”? 

Wise interventions draw on a long tradition of research (e.g., Dimidjian et al., 2006; Lewin, 1952; McCord, 1978). But they are novel in that they are psychologically precise, often brief, and often aim to alter self-reinforcing processes that unfold over time and, thus, to improve people’s outcomes in diverse circumstances and long into the future. By changing the self over time, many wise interventions go beyond simple “nudges”—changes to a specific situation or decision framework to encourage better behavior in that context (Thaler & Sunstein, 2008). Wise interventions are special remedies for social problems and afford important implications for theory.
"Do Good Be Good" – a wise intervention principle that fits with the desistance literature on identity.

Accumulating meaning, purpose and opportunities to change ‘drip by drip’: the impact of being a listener in prison

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Established in 1991, the Listener scheme, regulated by the Samaritans, is currently the best-established peer support scheme in place to help reduce suicide in prisons. Each prison Listener team is comprised of a group of inmate volunteers who provide face-to-face emotional support to their peers. Although the scheme has been in operation for over 20 years, empirical research on the scheme is limited. A deeper understanding of how being a Listener affects prisoners’ attitudes, beliefs, emotions and experiences of imprisonment is needed. The present study is a qualitative analysis on the experience of being a Listener and the impact it has on individuals and their prison experience. Interviews were analysed using interpretative phenomenological analysis. The analysis revealed two main superordinate themes: ‘Listening and Personal Transformation’ and ‘Countering Negative Prison Emotions’. These themes are unpacked and the analysis focuses on their implications for desistance and offender reform. Results suggest that prisoners who adopt Listener roles experience profound internal changes, shifts in self-identity and gain meaning and purpose from prison. Implications for how such schemes may be utilised in the future and suggestions for further research are offered.

Keywords: desistance; rehabilitation; prison inmates; offending behaviour; peer support
Five Minutes Daily – a wise intervention that improves goal setting
Conclusion 1

The evidence for our current approach to treating sex offenders is not strong in quality or quantity. The evidence that we do have is not convincing enough.
A constant theme from the systematic reviews is that we need to get our treatment content more firmly fixed on what we know to be criminogenic needs for sexual offenders.
“Evidence-based” means precise targeting, strong theory of change, wise methods, appropriate dose, and a demonstrated impact.
Thank you

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