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SEX OFFENDERS

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SEX CRIMES AND THE PUBLIC

Sexually-motivated crimes undermine the sense of security within communities, they are especially shocking if they occur under circumstances that are normally perceived to be safe (Laws 2000). In March 2011, news media reported a violent rape offence during which an adult female was raped on a pavement in front of passing drivers in England (ASIAONE 17MAR2011). In this incident, the perpetrator, Gary Gunstone, had just finished his prison sentence two weeks earlier for a previous rape offence during which he raped another woman in front of her sister. The public's concern and worries of having sex offenders living within the community goes beyond the atrocity of the offensive acts and the lasting physical and psychological trauma on the victims, it is also about the risk of sex crime recidivism when they are back in the community (Laws 2000).

SEX OFFENDERS REGISTER

Sex offences refer to acts or conducts with sexual nature which unjustifiably and inexcusably inflict or threaten substantial harm to an individual or public interests (Ormerod 2008). Since 1997, sex offenders in the United Kingdom have been required to register with the police within 14 days of release from detention or going on leave from hospital under the Sex Offenders Act 1997 (DHO 1997). This Act was later repealed by the Sexual Offences Act 2003 under which a database, the Violent and Sex Offender Register (ViSOR) was set up (DHO 2003).

The notification period for sex offenders in the ViSOR varies depending on the duration of prison sentence. For sex offenders given a caution or incarceration of less than 30 months duration, the notification period is from 2 to 10 years. For sex offenders who had prison sentences exceeding 30 months, imprisoned for public

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protection, admitted to hospital under restriction order or subjected to an Order for Lifelong Restriction, the period of notification on the ViSOR is indefinite (DHO-NPIA). Restrictions imposed on sex offenders in the ViSOR include restrictions on housing, working with children and even access to the internet.

The sex register had been reported to have led to shaming and discrimination of sex offenders and even vigilante-style victimization of some on the list (Pratt 2000). The indefinite lifelong registration of sex offenders has been challenged successfully in Courts as infringements upon the rights of sex offenders and being incompatible with Article 8 of the European Convention of Human Rights (The Times 16Feb2011).

ROLE OF FORENSIC MENTAL HEALTH IN SEX CRIME RECIDIVISM

Psychiatrists are involved in the risk assessments of sex crime recidivism either as part of a multidisciplinary team such as the Multi-Agency Public Protection Agreements (MAPPA 2005) or as a mental health professional working in a forensic setting. The outcome of such evaluation often results in dichotomous recommendations to decision makers such as either having the sex offender remain, or be taken off the ViSOR. This "policing" role for mental health professionals had evolved along with the changes in the organisation of forensic mental health services through the Butler and Glancy reports (DHSS 1975; DHSS 1974) and the Reed review (DHHO 1992) (Scott 1974; Bluglass 1990; Rose 2008). In recent years, Section 3 of the Mental Health Act 2007 reaffirms the legality of compulsory detention in hospital of people who are not convicted by the Courts, but are assessed to need mental health intervention for the protection of others because of high risk of "sexual assault" and "serious emotional harm" (Maden 2010).

RECIDIVISM RATES AND HETEROGENEITY OF SEX OFFENDERS

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The term “sex offenders” refers to a complex group of people who are heterogeneous in their attitudes, beliefs, personalities, socio-economic backgrounds, forensic histories and nature of sexual offences (Saleh 2003; Rose 2008). Various theories have been put forward to conceptualize the etiology of sex offences over the past years such as the Precondition Theory (Finkelhor 1984), the Integrated Theory (Marshall 1990) and the Pathway Model (Ward 1998). The multitude of theories reflect the complex inter-play of static historical factors and changeable dynamic factors involved in sex crimes and underscores the momentous task involved for risk assessment of individuals among this group of offenders (Laws 2008).

Sex crime recidivism is measured using “base rate” which refers to the percentage of cases that can be expected to reoffend within a given period of time (Craig 2003). In two large scale meta-analysis studies, the overall recidivism rates among sex offenders ranged from 13.4% to 17.5% over a 5 year follow-up period (Hansen & Bussiere 1998; Losel 2005). One smaller meta-analysis study found higher rate of sexual recidivism of 27% (Hall 1995). Recidivism rate increases with the time, the recidivism rate for 315 sex offenders increased progressively from 15% at 5 years follow-up, to 22% at 10 years follow-up and at 25-years follow-up, the recidivism rate increased to almost 40% for child molesters (male victims) (Bonta 1994).

RISK ASSESSMENT IN SEX OFFENDERS

The prediction of sexual crime is a very difficult and challenging task due to the multiple etiological and phenomenological factors which interact and build up towards their occurrences (Borum 1996; Monahan 1984). The presence of psychopathology such as paraphilias in sex offenders (SALEH 2003) and the engagement of sex offenders in general criminal behavior further complicates the difficulties involved in the prediction of sex crime recidivism (Craig 2003). Factors such

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as the heterogeneity of sex offenders, changing base rates of recidivism and presence of multiple dynamic factors pose formidable challenges to the reliable assessment of sex crime recidivism (Hanson 2000; Quiensy 1995).

Unreliability Of Empirical Clinical Judgement

Clinicians' empirical judgments of sex crime recidivism risks are unreliable with poor statistical findings of their accuracies (Goggin 1994;Cannon 1995;Quinsey 1983). This finding mirrors the result of violence risk assessments that used empirical clinical judgment which had resulted in over-estimation of dangerousness (Steadman 1987) and unnecessary restrictions being imposed on offenders (Hagen 1997; Grisso 1992). Unstructured clinical judgments' proven lack of predictive accuracy threatened the risk-based legal sanctions for sex offenders due to their widespread use in criminal courts or parole hearings previously (Janus 1997).

Actuarial Risk Assessment In Sex Offenders

The development of risk assessment tools based on findings from actuarial analysis of sex offenders' characteristics was initially statistically challenging. For example, the changing base rates of sex crime recidivism posed difficulty due to the high number of false positives when the base rate was low and the high number of false negatives when the base rate increase over time (Bonta 1994). The use of Receiver Operating Characteristic (ROC) analysis technique in forensic psychiatric assessments in the 1990s allowed the confounding factor of changing base rates among sex offenders recidivism to be overcome (Rice 1995, 2005).

Actuarial scales developed for the assessment of sex offenders include the Sex Offender Risk Appraisal Guide (SORAG), the Violence Risk Appraisal Guide (VRAG) (Quinsey 1998) and the Rapid Risk Assessment for Sex Offence Recidivism (RRASOR)

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(Hanson 1997). They have been validated and are now assessed to be sufficiently statistically robust for the practical assessment of dynamic characteristics which affect a sex offender's recidivism risk (Hansen 2000; Craig 2003).

a) *Static Risk Factors*

Static risk factors are derived from historical information of the sex offender and cannot be changed. They have an important role to play in the ongoing risk assessment of sex offenders because of their actuarial association with long term risks of recidivism. Static factors that are significantly associated with increased risks of sexual recidivism include prior general criminality (Smallbone & Wortley, 2000; Quinsey 1995; Monahan 1995), established sexual deviancy with more diverse profiles of victims (Quinsey 1995; Hansen & Bussiere 1998; Roberts 2002), having extra-familial stranger male victims (Bonta 1994; Waterhouse 1994), history of impaired interpersonal relationships (Scalora 2003; Hansen & Bussiere 1998), history of juvenile sexual offences, paraphilias, personality disorders (Hanson 1995; Hansen & Bussiere 1998) and high psychopathic traits (Quinsey 1998). For sex offenders who have static risk factors that are significantly associated with recidivism, they would need to attend long term treatment programs to minimize recidivism risk (Fisher 2000; Hanson 1993).

b) *Stable And Acute Dynamic Risk Factors*

Stable dynamic risk factors are characteristics of a sex offender which are long term risk factors that will take months or even years to change. However, when they do change, it will result in a corresponding increase or decrease in recidivism risk (Hanson 2000). Examples of stable dynamic risk factors associated with increased sex crime recidivism include erroneous attitudes that justify sexual offences, cognitive distortions which sexualised children, victim blaming, low victim empathy, sexual preoccupation, sexual deviancy, substance misuse, unfavourable social environment, poor social support networks, lack of insight into one's own recidivism risks, access to

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victim as well as poor compliance to treatment and supervision (Hanson 2000; Craig 2003; Roberts 2002). Stable dynamic risk factors have most strongly differentiated the sex crime recidivists from the non-recidivists (Pithers 1988; Quinsey 1997). They are thus useful treatment targets for sex offenders and should be routinely evaluated during supervision.

Acute dynamic risk factors are characteristics of a sex offender that change rapidly over days and even minutes. Examples of acute dynamic risk factors are psychological distress, negative emotions and substance intoxication. (Hanson 2000; Craig 2003; Roberts 2002). They have been identified to be immediate antecedents to the occurrence of sex crimes and their presence warrant timely intervention to prevent recidivism.

RISK MANAGEMENT AS PART OF RISK ASSESSMENT

Risk assessment of sex offenders needs to go beyond an actuarial or descriptive assessment of the probability of sex crime recidivism within the community (Haque 2007). It has to involve identification of dynamic factors such as at-risk psychological states, social adjustment problems or sexual preoccupation that could escalate the recidivism risk in the short to medium term, as well as encompass proactive scenario-planning and risk management strategies that can be used for timely intervention to prevent recidivism (Hart 1993; Mills 2011).

TREATMENT EFFICACY AS PART OF RISK ASSESSMENT

In a meta-analysis of 69 studies involving sample population of 22,181, the effect size of the reduction in sexual recidivism rate in the treated group was 37% when compared with the untreated group (LOSEL 2005). Cognitive behavioural therapy was more successful than other psychological treatment programs in reducing

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recidivism. This beneficial effect of treatment in reducing sexual recidivism was replicated in another meta-analysis involving 9,454 sex offenders where the effect size of intervention was 17% (HANSON 2000). The beneficial effects of treatment intervention was however not replicated in the Sex Offender Treatment and Evaluation Project (SOTEP), a randomized controlled trial that compared the re-offense rates of sex offenders treated in a structured relapse prevention program with the re-offence rates of untreated offenders (Marques 2005; Berliner 2002). The investigators of this study emphasized the importance of having treatment programs that are of sufficient content, intensity coupled with regular monitoring of treatment goals for sex offenders in their report (Marques 2005). In summary, the above underscores the importance of adequate treatment and compliance with treatment programmes as an important dynamic factor of sex crime risk assessment.

REMOVAL OF SEX OFFENDERS FROM SEX REGISTER LIST

Factoring in a sex offender's dynamic risk factors alongside his historical static risk factors allows one to make an informed and evidence-based judgement of a sex offender's risk of recidivism over the medium to long term based on actuarial findings (Craig 2003). A sex offender who has shown compliance with treatment and supervision programs over a sustained period of at least two years (Hanson 2000) and possesses insight and self-awareness of his recidivism risk would be a suitable candidate to be reviewed with regards to removal from the sex register list.

His chances of success would be enhanced if he is able to demonstrate stability or improvements in stable dynamic risk factors such as socio-economic status, social support. The absence of sexual preoccupation, sexual deviancy, substance misuse and absence of psychopathic traits are also key determinants supporting his application for removal from the sex register list.

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Caution has to be exercised for male sex offenders with high psychopathic traits. Male sex offenders with high psychopathy scores and had good treatment behavior were found to be 3 to 5 times more likely to commit new or serious offences compared to male offenders with low psychopathy scores or male offenders with high psychopathy scores but showed poor treatment behavior (Quinsey 1998). Their compliance to therapy and display of good treatment behavior must not be used as the main deciding factor for their removal from sex offender list.

In view of the association with personality disorders and general recidivism among sex offenders (Hanson 1995; Monahan 1995), as well as the rising base rate of recidivism over time (Bonta 1994), there should be conditions to allow continued monitoring and supervision of sex offenders who are removed from the sex register. These conditions would include agreement for continued supervised attendance of treatment programs, demonstrated self-awareness of risk factors for relapse and agreement to collaborate with measures to minimise unnecessary contact with potential victims.

The Risk for Sexual Violence Protocol (RSVP) was developed to provide a disciplined approach for guided clinical judgment of risk assessment of sex offenders (Hart 2003c). Its framework incorporates features of actuarial static factors, dynamic characteristics and requires forward planning of at-risk scenarios and intervention measures. Structured professional judgment tools (Hanson 1998; Borum 1996) such as the RSVP may be considered for use in the holistic risk assessment of sex offenders when they are in the community.

Electronic tagging of this group of offenders could be made an unconditional requirement prior to their removal from the sex register list. This would allow a cost effective and minimally invasive way of ensuring that the offender does not go to places where he has access to potential victims. Such a system, “BUDDI”, has

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already been implemented at the South London and Maudsley Trust for monitoring of forensic patients on home leave with proven effectiveness (SLaM 2011). The presence of a clear and tamper-proof method of monitoring would provide assurance to the public that supervision can still be adequately maintained in the community when sex offenders are released among them even without the offenders being registered on the sex register. Indirectly, this would minimise the frenzy of emotions which can arise from learning via the sex register about the presence of a sex offender living in the community. This could potentially reduce the discrimination that these offenders face.

However, there is still a place for the sex register for offenders who are at high risk of recidivism. This include those with high psychopathy score, persistent sexual preoccupation and sexual deviancy, poor treatment behaviour and lack of improvements on their stable dynamic risk factors as well as those who do not agree to the conditions for their removal from the sex register.

CONCLUSION

Psychiatrists and mental health workers are increasingly being held responsible and accountable for their decisions in risk assessments (Holloway 2002; Rose 1996). It is thus only prudent that evidence-based “best practices” using actuarial results and clinical framework be adopted for the risk assessments of sex offenders prior to them being taken off the sex register.

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