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# The Status of Evidence Based Practices with Sexual Abusers: Recommendations for the Use of a True EBP Model - Adam Deming, Psy.D.

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# Session Goals/Learning Objectives:

Participants will be able to:

1. Demonstrate a knowledge of the history, definition, goals, and clinical scope of evidence-based practices in mental health and with sexual abusers.
2. Summarise past and ongoing efforts within the field to establish an evidence base for use with sexual abusers.
3. Recognize trends and paradigm shifts in sexual abuser theory and treatment that have played a role in delaying the development and implementation of evidence-based practices with sexual abusers.
4. Summarise four recommendations that are aimed at moving the field of sexual abuser treatment toward the use of a true evidence-based practice model.

# Introduction

There has been significant growth in the field of sexual abuser treatment during the past 30 years:

More research, treatment programs, books, client workbooks, conferences/training, and professional organizations.

However, while the field of mental health has established many of its interventions to be evidence-based, the field of sexual abuser treatment has not yet come to a consensus on what interventions and treatment approaches are considered evidence-based.

# Evidence-Based Practices (EBPs)

The term “evidence-based practice” (EBP) first appears in the literature of the 1990’s, and developed out of the concept of evidence-based medicine (EBM).

Archibald Cochrane:

*Effectiveness and Efficiency: Random Reflections on Health Services* (1972). Criticized the absence of evidence behind many healthcare approaches, and advocated for the use of randomized trials to help identify and verify the effectiveness of healthcare interventions.

(Cochrane Collaboration and Cochrane Reviews)

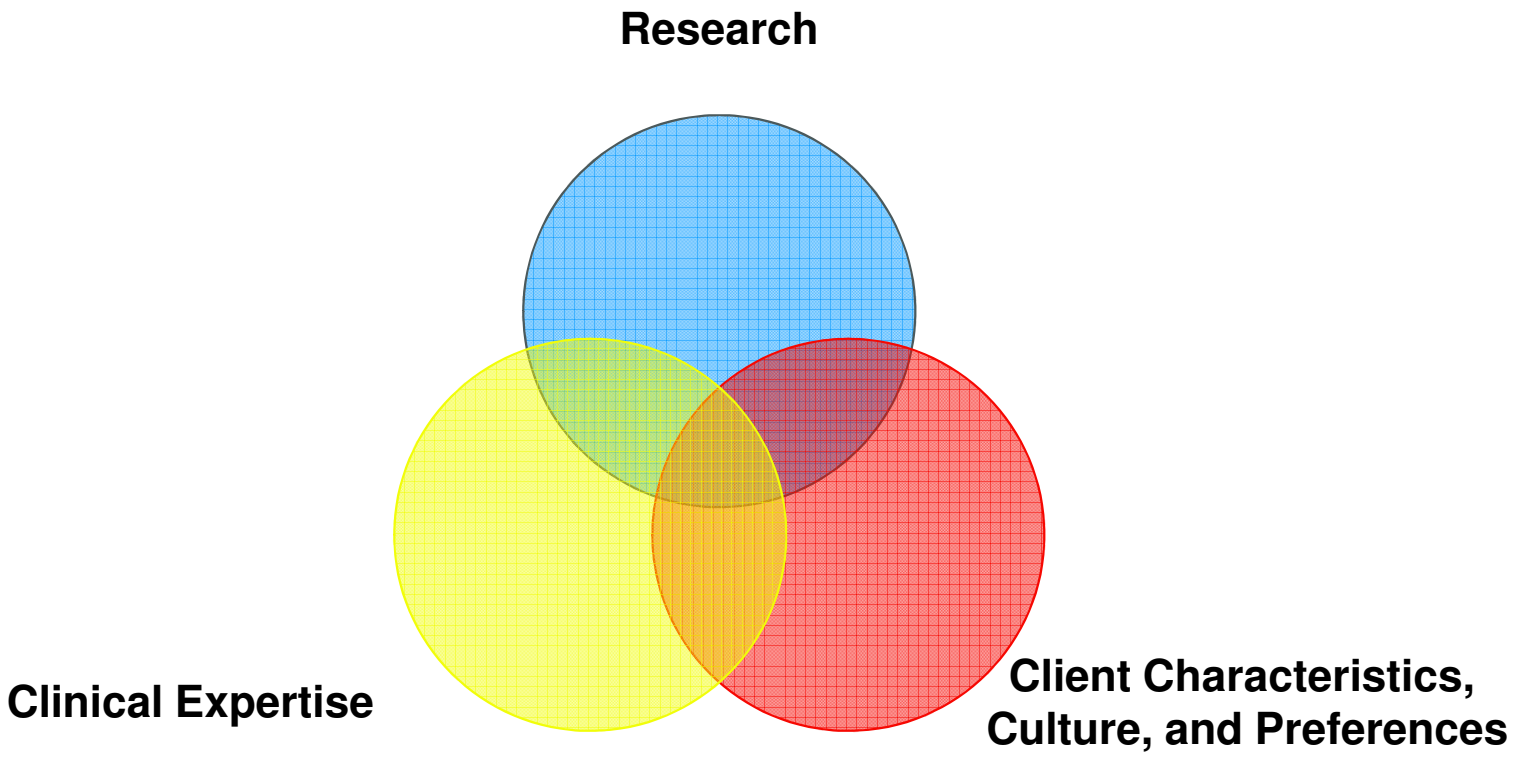
# EBP's - Background

American Psychological Association (APA):

Task Force on the Promotion and Dissemination of Psychological Procedures published its criteria for identifying empirically validated treatments for particular disorders (Chambless, et al., 1996).

The APA Task Force on EBPs has defined evidence-based practices as "…the integration of the best available research with clinical expertise in the context of patient characteristics, culture and preferences (APA, 2006)."

# Evidence-Based Practice Trinity



# EBPs – Goals and Scope

The goal of establishing EBPs in behavioral health is to apply them in clinical practice to improve client outcomes.

Scope of Application: EBPs could potentially comprise a wide variety of clinical activities with sexual abusers, including assessment and treatment interventions, but could also include activities relating to community support and supervision, and even public policy issues.

# First Leg of the EBP Stool - Evidence

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# First Leg of the EBP Stool: Establishing Evidence

The many methodological challenges associated with sexual abuser research have been well documented (heterogeneity of abusers, how to best measure Tx outcome, low base rates of recidivism, long follow-up periods, denial of offenses, treatment resistance)

As such, there is vigorous debate about how to manage these research challenges. Yet, the largest area of disagreement appears to relate to the amount of evidence necessary to deem our treatment interventions as effective or evidence based (Duggan, 2014).

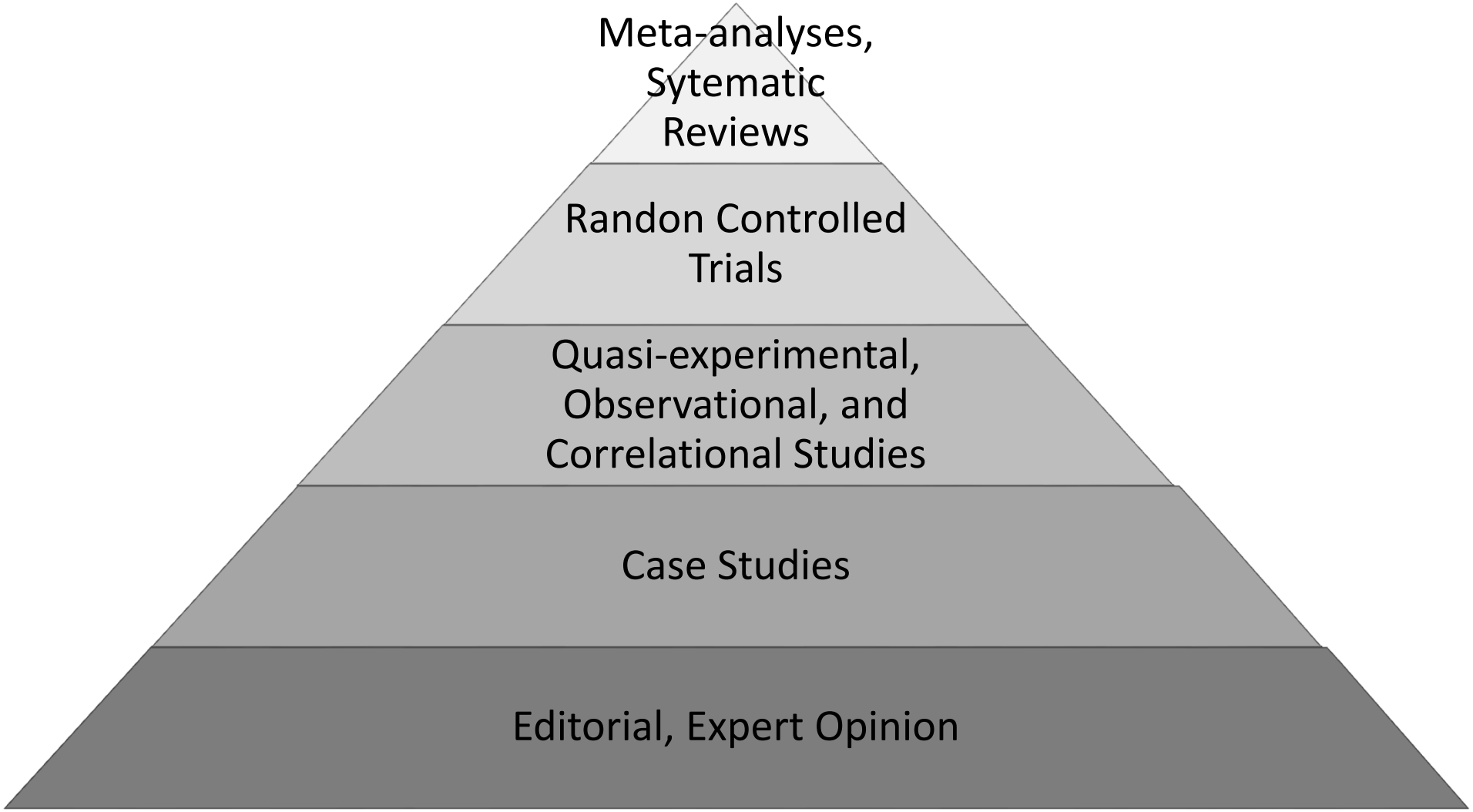
# First Leg of the EBP Stool: Establishing Evidence

What is *evidence*?

What amount (quantity) of research is sufficient to constitute as empirical "evidence" that a given clinical activity with sexual abusers is effective and should be considered an EBP?

How is the quality of research considered in the process of establishing "evidence"?

# Research Methods Pyramid Hierarchy



# Efforts to Establish Evidence in the Field of Sexual Abuser Treatment

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# Past and Ongoing Efforts to Establish EBPs with Sexual Abusers

Past and ongoing efforts at establishing EBPs with sexual abusers have primarily focused on the issue of treatment outcome (efficacy of treatment).

Early in this process, there was much criticism directed at the poor quality of the treatment outcome research.

Additionally, some argue (Marshall & Marshall, 2007) that RCTs are not well suited for evaluating sex offender treatment outcome, or involve ethical dilemmas that make them inappropriate.

# Randomized Controlled Trials

About 20 Random Controlled Trials have been conducted relating to treatment outcome (on both pharmacological and psychological treatments with sex offenders).

- Most were conducted more than 20 years ago, and many are of poor quality.
- Many did not measure recidivism/re-arrest as the outcome variable.
- Inconsistent and/or inconclusive outcomes.

(Duggan, 2014)

# Random Controlled Trials-Managing Research Challenges

- Seto and colleagues (2008) have suggested using random assignment to alternative treatment components.
- Hanson (1997) has suggested measuring in-treatment changes on dynamic risk factors that are known to be correlated with recidivism.
- Measuring intermediate treatment targets relating to dynamic risk factors while also waiting for actual recidivism data could improve the use of RCT designs in our field. Research using the Violence Risk Scale – Sex Offender Version, relating to risk and change, may be applicable in this regard (Lewis, et al., 2013; Olver, et al., 2007).

# Meta-Analyses

A substantial number of meta-analytic studies have been conducted relating to sexual abusers, many relating to treatment outcome.

- Early studies have been criticized for being of poor quality.
- Collaborative Outcome Data Committee (CODC) formed in 2002 (Hanson, Gordon, Harris, Marques, Murphy, Quinsey, & Seto, 2002).
- More recent studies have used CODC guidelines or guidelines from the Maryland Scientific Methods Scale and study quality has improved.

# Meta-Analyses of Sexual Abuser Tx Outcome

- Several, more recent, meta-analyses have shown significant differences in recidivism rates between treated and non-treated sexual offenders (Losel & Schmucker, 2005; MacKenzie, 2006; Hanson, R. K., Bourgon, G., Helmus, L., & Hodgson, S. 2009), demonstrating that cognitive-behavioral therapy and therapy approaches that incorporate the risk-need-responsivity principles are effective in reducing recidivism.

# Meta-Analysis "Other"

In addition to examining treatment outcome, meta-analyses have also been conducted on a variety of other clinical activities and research variables with sexual abusers, such as:

- Online sexual offenses (Babchishin, Hanson, & Hermann, 2011; Seto, Hanson, & Babchishin, 2011)

- Dynamic risk assessment (van den Berg, Smid, Schepers, Wever, van Beck, Jansen, & Gijs, 2017)

- Recidivism in female sexual abusers (Cortoni, Hanson, Coache, 2010)

- The neuropsychology of sexual abusers (Joyal, Beaulieu-Plante, & de Chanterac, 2014)

- Recidivism risk assessment tools (Hanson & Morton-Bourgon, 2009; Hanson, Sheahan, & Van Zuylen, 2013; Helmus, Babchishin, & Hanson, 2013; McGrath, Lasher, Cumming, Langton, & Hoke, 2014).

# Systematic Reviews of Sexual Abuser Tx Outcome

- At least 4 Cochrane Reviews have been conducted relating to sexual offender treatment outcome.
- None of these reviews were able to support the effectiveness of sexual offender treatment, citing the poor quality of the RCTs which were reviewed (White, Bradley, Ferriter, & Hatzipetrou, 1998; Kenworthy et al. 2003; Dennis et al. 2012; Khan, Ferriter, Huband, Powney, Dennis, & Duggan, 2015).

# Systematic Reviews of Sexual Abuser Tx Outcome

- Systematic Reviews Continued:
  - In addition to the Cochrane Reviews, 7 additional systematic reviews that have studied sex offender treatment outcome can be found in the literature.
  - 4 of these 7 studied both pharmacological treatments and psychological treatments. Three out of 4 of these studies found both pharmacological and psychological (cognitive-behavioral therapy) treatments to be effective in reducing recidivism (Aos, Miller, & Drake, 2006; Schmucker and Losel, 2008; Kim, 2016).

# Systematic Reviews of Sexual Abuser Tx Outcome

- Systematic Reviews Continued:
  - Three of the 7 systematic reviews looked exclusively at psychological interventions.
  - Polizzi, MacKenzie, Hickman (1999) reviewed 21 studies, 6 of which showed significant differences in recidivism between treatment and untreated sex offenders.
  - Brooks-Gorden, Bilby, and Wells (2006) reviewed 9 RCTs, showing lower recidivism at 1 year, but increases in re-arrest at 10 years
  - Netto, Carter, and Bonell (2014), reviewed 4 studies evaluating the Good Lives model, but found no eligible studies of sufficient quality.

# Program Accreditation

Correctional Services Canada Accreditation Criteria (Hanson et. al., 2004):

1. Theory of program effectiveness supported by research.
2. Treatment program targets problems linked with offending.
3. Methods used to deliver programs have demonstrated effectiveness.
4. Those methods involve teaching offenders new skills.
5. Effective programs fit the learning styles/abilities of offenders.
6. Programs are of sufficient intensity/duration to address problems of typical offender.
7. Program includes provisions for follow-up care in the community.
8. Programs are monitored and evaluated to ensure integrity.

(Closely modeled after HMPPS criteria, which were based on meta-analytic reviews of “what works” in correctional treatment for general offenders (Lipton, et. al., 2000)

# The Status of EBPs with Sexual Abusers

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# The Absence of EBPs with Sexual Abusers

While there has been much effort in our field to provide empirical support for our treatment approaches, there is yet no consensus within the field regarding any given approach that meets the threshold as an evidence-based practice.

The American Psychological Association's Society of Clinical Psychology (Division 12)

- Website on research-supported psychological treatments (PsychologicalTreatments.org):
  - No research supported treatments relating to sexual offending, sexually illegal, or sexually unhealthy behavior listed on website.

# Trends That Have Slowed Our Use of EBPs

1. Within our field, there is no agreed upon threshold for what constitutes sufficient “evidence” to establish an approach as an EBP.
2. Since the 1980’s, the field has seen a continuous process of importing of approaches from other areas of mental health into the field of sexual abuser treatment.
3. Lack of education/training within the field on the importance of EBPs, and on the processes for their development and implementation.

# 1st Trend: No Established Threshold for "Evidence" Within our Field

Our field has not yet embraced a system or set of criteria for making decisions about an evidence threshold.

- What quantity and quality of research is necessary to establish an approach or intervention as an EBP?

- Should the evidence threshold decision be dichotomous (e.g., sufficient evidence versus insufficient evidence as an EBP)

- Or…should nominal categories be created and used to denote a relative level of evidence (e.g., strong, modest, weak)?

# 1st Trend: No Established Threshold for "Evidence" Within our Field

The Promising Practices Network (PPN) was developed in 1997, by the not for profit RAND Corporation.

- The PPN website lists "evidence criteria" that are used to rate programs as either "proven" or "promising".
- These criteria include considerations of research sample size, effect size, level of statistical significance, and whether or not a comparison group was used.
- The PPN does not require research to have been published in a peer reviewed journal or to have been replicated to be listed as either proven or promising.
- We could find no programs or practices on their website that relate to youthful or adult sexual abusers. The PPN was discontinued in 2014.

# 1st Trend: No Established Threshold for "Evidence" Within our Field

The California Evidence Based Clearinghouse for Child Welfare (CEBC) Scientific Rating Scale (CEBC, 2017).

- Requires the clinical practice being rated to have a written manual that describes how its interventions are administered and to have outcome studies that have been published in a peer reviewed journal.

- Based upon the number of RCTs showing a practice to be superior to a comparison group, and showing demonstrated clinical effectiveness over time, practices are rated as "Well Supported by Research Evidence", "Supported by Research Evidence", or "Promising Research Evidence".

- The CEBC has rated Multisystemic Therapy for Youth with Problematic Sexual Behaviors as "Well Supported".

# 2nd Trend: Importing of Approaches From Mental Health

During the past 30 years there has been an ongoing practice of integrating and importing of clinical approaches, initially used with other mental health populations, into the field of sexual abuser treatment, without sufficient evidence of efficacy with sexual abusers.

- Modifying cognitive distortions (Murphy, 1990)
- Relapse prevention (Laws, 1989)
- Motivational interviewing (Prescott & Porter, 2011)
- Dialectic behavior therapy (Shingler, 2004)
- Humanistic and experiential therapies (Bauman & Kopp, 2004; Longo, 2004)
- Trauma informed care (Levenson, 2014).

# 2nd Trend: Use of New Approaches Prior to Establishing Efficacy with Sexual Abusers

Also, “new” or “original” models of sexual abuser treatment and supervision have been advanced:

- Containment Approach (English, 2003)
- Self-Regulation (Ward & Hudson, 2000)
- Good Lives (Ward, 2002)

Despite little initial empirical evidence or systematic evaluation of their effectiveness, many were widely embraced by treatment providers almost immediately after their emergence in the literature (McGrath et al., 2010)

# A herd mentality in the field of sexual abuser treatment?

# 2nd Trend: Use of Imported and New Approaches Without Establishing Efficacy

Imported approaches and new models of treatment that are seen, intuitively, as theoretically meaningful and clinically needed have had the greatest impact on clinical practice and program content.

2 factors may explain our use of these models……..

# 2nd Trend: Use of Imported and New Approaches without Establishing Efficacy

1. The normal and natural tendency for paradigm shifts to occur, in theoretical and clinical approaches, during the growth and development of a new field (in behavioral health).
2. The second is the pressure our clinicians experience to deliver effective treatment services to prevent sexual abuse and protect the community. This, coupled with the need to remain current with the most recent and most progressive treatment approaches, appears to result in a willingness to adopt clinical activities without proper empirical vetting prior to their wide-scale use.

# 3rd Trend: Lack of Training re EBPs

- There is a need for information sharing and education in the field of sexual abuser treatment about what "evidence-based" or EBP really means, including training relating to the processes necessary for establishing and implementing EBPs.

- This is exemplified by the general lack of training on the topic of EBPs with sexual abusers at national and international conferences, and by the paucity of published articles in our field that discuss concepts such as EBPs, best practices, empirically supported treatments, and related issues.

# 3rd Trend: Lack of Training re EBPs

- When the topic of EBPs with sexual abusers does appear in the literature, it is sometimes used to suggest that clinical activities and interventions with sexual abusers are evidence-based where no basis for this assertion is provided or currently exists (titles of books and journal articles, and occasionally in conference workshops).

- Titles may contain the wording “evidence-based” or “evidence-based practice”, but no definition of “evidence-based” is provided in the text. In some cases references are made to specific research studies relating to the topic being discussed in the article, but without a meaningful evaluation of the validity, volume, and the overall strength of the larger pool of research on that topic.

# A Model for Establishing EBPs with Sexual Abusers

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# The First Leg of the EBP Stool - Revisited

- The current process being used within our field, of attempting to infer "evidence" based upon the results of meta-analyses and systematic reviews of treatment outcome studies without establishing evidence thresholds, has shown to be insufficient and ineffective.
- Given the wide variety of topics upon which sexual abusers are being researched, and the diversity of methodologies being used to conduct this research, a formal evidence-based review process is a necessary step toward advancing a true EBP model with sexual abusers.

# The First Leg of the EBP Stool - Revisited

A model for conducting formal evidence-based reviews of the sexual abuser literature:

1. Synthesis of all relevant research on a specific topic
2. A valid and reliable tool for scoring research
3. Individuals that can score research
4. Nominal categories (thresholds) for communicating the level of evidence on given clinical activities.

# The First Leg of the EBP Stool - Revisited

Scoring Tool - A valid and reliable scoring tool that can rate the strength and quality of individual research studies is required.

- This tool should be capable of scoring the wide variety of research methods and analyses that exist in sexual abuser research, including but not limited to true experiments, quasi-experimental designs, correlational studies, and systematic reviews/meta-analyses.

- This tool should also provide detailed scoring criteria, across multiple indices of research design and statistical analysis, which allow for clear and objective scoring of the research.

# The First Leg of the EBP Stool - Revisited

- Several systems for scoring and rating research studies of diverse designs and methodologies have been developed and described (Chambless & Hollen, 1998; Kratochwill & Stoiber, 2002; West, King, Carey, Lohr, McKoy, Sutton, Lux, 2002; Sirriyeh, Lawton, Gardner, & Armitage, 2012).

-As mentioned above, quality guidelines for researchers designing new studies specific to sexual abuser treatment outcome, and reviewers critically examining research, were developed by the Collaborative Outcome Data Committee (CODC) (Hanson et al., 2002; Beech, et al., 2007). Since the initial development of these guidelines, several researchers have utilized them to address the issue of research quality in conducting treatment outcome studies on sexual abusers. However, there has been no use of these guidelines as a tool for synthesizing and evaluating studies as part of a formal evidence-based review process.

# The First Leg of the EBP Stool - Revisited

- Deming, Yates, and Barbaree (2016), as part of their ongoing work with the International Project for Evidence-Based Practices with Sexual Abusers (IPEPSA), have developed a scoring tool for use with research relating to sexual abusers.

- The IPEPSA tool, adapted from a system described by Sirriyeh, Lawton, Gardner, & Armitage (2012), has shown very good inter-rater reliability in initial testing, and is being used as part of a broader effort to evaluate the empirical strength of clinical activities currently being used with sexual abusers and to determine their standing as evidence-based practices.

# 2nd Leg of the EBP Stool: Clinical Expertise

- Ethical and practice guidelines for helping to determine whether a person has sufficient training to provide sexual abuser treatment currently do exist, and are helpful in clarifying the EBP concept of expertise.

- For example, the Association for the Treatment of Sexual Abusers (ATSA, 2014) provides recommended qualifications (in the areas of education, training, and experience) to its members that provide clinical services to sexual abusers.

# 2nd Leg of the EBP Stool: Clinical Expertise

- Yet, additional clarification by the field relating to what defines expertise seems warranted.

- What are the key clinical skill sets that need to be mastered by a therapist treating sexual abusers before certain interventions or approaches can be said to be established competencies?

- For example, some research has indicated that therapist qualities such as warmth, respect, and empathy are positively associated with treatment progress and outcome in sexual abusers (Marshall, Serran, Moulden, Mulloy, Fernandez, Mann, & Thornton, 2002).

# 2nd Leg of the EBP Stool: Clinical Expertise

- If findings by Marshall et al., 2005 are shown to hold true, then we should be asking how training and continuing education of therapists can be best structured to assist treatment providers in developing these skill, and how to assess when these skills have been mastered.

- Similarly, if interventions specific to any of the models that have been advanced for the treatment of sexual abusers are found to be evidence-based (e.g., relapse prevention, risk-need-responsivity, Good Lives, etc.), then training that teaches and assesses competencies in utilizing these treatment methods would be vital to developing clinical expertise in sexual abuser treatment providers as part of larger approach to the use of EBPs by sexual abuser treatment programs.

# 3rd Leg of the EBP Stool

Client Characteristics, Culture, and Preferences

- Actually comprised of three distinct concepts, “client characteristics, culture, and preferences”. These concepts, individually and as a whole, speak to the significance of two fundamental ideas in the application of EBPs.

- The first is the importance of considering idiographic factors in the delivery of clinical services. Individuals have unique histories and needs which should be addressed and incorporated into their treatment.

- The second idea concerns the role of the client in decision making about their own care. Individuals should have sufficient information and education to choose their preferences in accordance with their own values and beliefs.

# 3rd Leg of the EBP Stool

- There is an increasing awareness in the field of sexual abuser treatment of the importance of assessing and considering client characteristics, and several models of treatment that have been advanced for use with sexual abusers also give consideration to client characteristics and needs (e.g., Good Lives, Risk-Need-Responsivity).

# 3rd Leg of the EBP Stool

- The idea of shared decision making, although present in some approaches with sexual abusers (e.g., Good Lives model of treatment, motivational interviewing), is a concept that has not been fully explored or realized in the field.

- As Spring (2007) has indicated, the role of shared decision making in EBPs is a complex process that requires a departure away from paternalistic models of care toward one that is more culturally informed.

# 3rd Leg of the EBP Stool

-This requires clients to have information that allows them to weigh the risk and benefits associated with difficult decisions.

- In the field of sexual abuser treatment, these decisions often have significant legal and social risks to the client, such as the decision to acknowledge unreported sexual offenses, to register oneself as a “sexual offender”, or where to live in the community when local ordinances or parole stipulations restrict the best and/or healthiest options.

# Implementation of EBPs

- Even with an established base of empirical evidence regarding clinical activities with sexual abusers, and a firm understanding of how clinical expertise and client characteristics influence outcomes, the implementation of EBPs within the treatment and supervision systems where sexual abusers receive services will be no small task.

# Implementation of EBPs

- Effectively implementing EBP's with sexual abusers will require coordination and communication across the various levels, and within the variety of systems, within which clinical services are delivered.

- Toward this end, empirical research evidence related to the three legs of the EBP stool must get accurately communicated to program administrators, training of end-users (e.g., clinicians, parole officers) will be needed, and fidelity to the EBP model should be evaluated on an ongoing basis to ensure proper use and effectiveness.

# Recommendations

1. The use of evidence-based reviews, with a research scoring tool, and the development of evidence thresholds to communicate nominal categories of empirical evidence in treatment, assessment, community support/supervision, and public policy with sexual abusers.

2. Imported and new/original models of treatment should be properly vetted and researched prior to their wide-scale clinical implementation.

# Recommendations

3. Additional theory and research are needed relating to the second (clinical expertise) and third (client characteristics, culture, and preferences) legs of the EBP stool as they relate to sexual abusers.

4. Increased training and literature relating to the development and implementation of EBPs with sexual abusers, and other related concepts (best practices, standards of care, etc.).

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