A Recidivism Risk Measure as a Predictor of Sex Offender Treatment Completion

Donald S. Strassberg
Stephanie A. Reynolds
Department of Psychology
University of Utah
Salt Lake City, Utah

ABSTRACT

Short of imprisoning all known sex offenders indefinitely, the most effective means currently available to reduce their reoffending is to provide appropriate treatment. Yet many offenders who begin such treatment fail to complete it, representing a loss of very limited resources. Further, offenders who fail at treatment are also at relatively high risk for subsequent reoffending. Identifying those most at risk for failing to complete treatment as early as possible in the treatment process could help to increase treatment completion. This study examined 117 adult male sex offenders in residential treatment. The Minnesota Sex Offender Screening Tool (MnSOST-R), completed early in treatment, was predictive of treatment completion. Possible selection and treatment implications of these findings are discussed.

Introduction

Most men convicted of a sexual offense receive some treatment, either while incarcerated or as a condition of probation or parole. While the intensity and length of such treatment varies considerably, it is typically expensive and time consuming. Unfortunately, many sex offenders quit or are terminated from treatment programs prior to successful completion. For example, Shaw, Herkov, and Greer (1995) found that 86% of sex offenders admitted to a correctional treatment program would eventually be terminated because of lack of participation, unwillingness to do the work, or inappropriate behavior. Such premature termination from sex offender treatment represents a considerable loss of invested resources. Further, premature termination is also a significant predictor of reoffending following release to the community (Quinsey, Rice, & Harris, 1995). In fact, the rate of reoffending by treatment non-completers may be higher not only than that of those completing treatment, but also higher than that of those receiving no treatment at all (Marques, Miner, & Day, 1990).

The underlying nature of the relationship between treatment non-completion and recidivism has yet to be firmly established. Perhaps those who do not complete treatment are more likely to reoffend because they fail to receive a sufficient level (time and or intensity) of

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1 To whom correspondence should be addressed at Department of Psychology, 380 S. 1530 E., Room 502, University of Utah, Salt Lake City, Utah 84112; e-mail: strassberg@psych.utah.edu.
intervention. Alternatively, certain personality traits (e.g., low frustration tolerance, impulsivity, poor judgment, psychopathy) may predispose men to both treatment non-completion and eventual reoffending. Perhaps both mechanisms are involved.

Whatever the mechanism(s) underlying the association between treatment completion and recidivism, the existence of this robust relationship suggests that there may be significant clinical and financial value in attempting to identify likely non-completers as early as possible in the treatment process (Brown, Foreman, & Middleton, 1998; Geer, Becker, Gray, & Krauss, 2001). For example, if offenders likely to have difficulty completing treatment can be identified relatively early, they could then be targeted to receive more intense treatment or supervision to, perhaps, reduce this risk. The present study was the first in a series of projects from our group designed to address the prediction sex offender treatment completion.

The Minnesota Sex Offender Screening Tool (MnSOST-R; Epperson, Kaul, Huot, Goldman, & Alexander, 2003) is a well known and frequently utilized sex offender recidivism risk assessment tool, assessing both Static and Dynamic (institutional) risk factors (Bartosh, Garby, Lewis, and Gray, 2003; Hanlon & Larson, 1999; Langton, 2003). As this measure is already widely used in sex offender treatment programs, it seemed reasonable to explore for its possible value in predicting treatment completion. Given the known association between treatment completion and reoffending, we tested the hypothesis that MnSOST-R Static, Dynamic, and Total scores assessed early in treatment would be predictive of ultimate treatment completion, with non-completers scoring higher than completers.

Method

Participants

The present study examined a group of 117 men, ages of 20 to 77 (M = 38, SD = 12.4), involved in a 12- to 15-month residential (i.e., half-way house) treatment program for sex offenders. Treatment was cognitive-behavioral in orientation, with a strong relapse prevention focus. It consisted of weekly individual and group therapy sessions, as well as topic-specific weekly classes (e.g., anger management, sex education, empathy training). These men were in treatment as a condition of their parole or probation associated with conviction for a sexual offense, generally after having served jail or prison time for their crime. To be included, the offender had to have either graduated successfully from the program, or had an unsuccessful termination (i.e., been removed by program administrators). The number of offenders on whom MnSOST-R data was available was as follows, 95 (Total score), 96 (Dynamic score), and 117 (Static score). Of the 117 offenders, 48 completed and 69 failed to complete the program. Program completers and failures did not differ significantly on age (36.6 vs. 38.6 years, respectively).

Measures

The MnSOST-R, consisting of 16 items (each scored on a scale ranging from a low of from −3 to 0 to a high of from +1 to +4), yields scores for Static variables (12 items, possible summed range −10 to +22), Dynamic (Institutional) variables (4 items, possible summed range −4 to +9), and a combination of the two (i.e., Total score, possible summed range −14 to +31). The MnSOST-R was completed on each offender by either the director of the treatment program or by staff trained by her. The Dynamic (Institutional) scale items were based on the offenders’ discipline history while incarcerated prior to entering residential treatment, including their failure to
complete [prior] recommended sex offender and/or substance abuse treatment. A subset of completed MnSOST-Rs was regularly checked by a second rater to insure accuracy and to prevent rater drift. Unfortunately, no written record of the second ratings was made. Further, all data were provided to the researchers in a disguised form, making it impossible to identify specific offenders. As a result, it was not possible to formally evaluate the reliability of the MnSOST-R ratings.

For most offenders whose data was included in this study, the MnSOST-R was completed within one month of their arrival in the program. There were also a few offenders who were already in the program when the testing began. For these few individuals, their first testing may have occurred anywhere within their first six months of treatment.

Results

The MnSOST-R Static and Dynamic scores (which, for the group as a whole, were uncorrelated, $r = -.01$), and the MnSOST-R Total scores of treatment completers and non-completers were first compared via t-tests. All three analyses were statistically significant. As predicted, treatment completers scored significantly lower than treatment completers on all three measures; MnSOST-R Static ($M_s = 0.54$ vs. $2.45$; $t = 1.94$, $df = 109$, $p = .05$), Dynamic ($M_s = -0.37$ vs. $0.91$; $t = 2.83$, $df = 94$, $p < .01$), and Total ($M_s = -0.3$ vs. $0.9$; $t = 2.34$, $df = 93$, $p = .02$). To describe further the relationship between MnSOST-R scores and treatment completion, a-priori chi square analyses were conducted comparing treatment completers and non-completers on their MnSOST-R scores. The offenders were divided, as closely as possible, into three groups (lowest quartile, highest quartile, and middle 50%) based on each score. The distribution of treatment completers and failures was then compared across the three groups.

Treatment completion was significantly associated with MnSOST-R Static scores ($\chi^2 = 6.2$, $df = 2$, $p < .05$). Inspection (see Figure 1) revealed that those in the highest quartile of MnSOST-R Static scores (scores 6 through 15) had less than half the percentage of treatment completers (21.4%) than those (scores 2 through 5) in the middle fifty percent (47.5%) or the lowest (scores 10 through -3) quartile (46.7%), which had virtually identical outcomes.

Treatment completion was also significantly associated ($\chi^2 = 9.7$, $df = 2$, $p < .01$) with MnSOST-R Dynamic (Institutional) scores. As seen in Figure 1, those in the highest quartile of MnSOST-R Dynamic scores (scores 6 through 15) had a far lower percentage of treatment completers (17.2%) than those (scores 1 through 1) in the middle fifty percent (46.9%) or the (scores 2 through 7) lowest quartile (55.6%).

Finally, treatment completion was significantly associated ($\chi^2 = 6.3$, $df = 2$, $p < .05$) with MnSOST-R Total scores. Those in the highest quartile of MnSOST-R Total scores (scores 6 through 18) had less than half the percentage of treatment completers (19.2%) than those (scores 2 through 5) in the middle fifty percent (46.8%) or the (scores -12 through -3) lowest quartile (45.5%) (see Figure 1).
Discussion

Once they have begun treatment, sex offenders who fail to complete (i.e., are removed, escape, quit) represent not only a less than maximum use of limited resources, they are also at particularly high risk to reoffend once at large. For these reasons, it is potentially important to identify those most at risk for treatment failure as early as possible in the treatment process. The MnSOST-R, a well-known and frequently used instrument for predicting the likelihood sexual reoffending, was also found to be predictive of treatment completion.

When evaluated independently, the Static and Dynamic portions of the MnSOST-R, as well as the Total score, were found to be significantly associated with treatment completion. As is clear in Figure 1, most of this effect was associated with the highest scoring offenders. That is, while high scorers on all three indices were substantially (two to three times) and significantly less likely to complete treatment than those scoring lower on these measures, those with intermediate scores had completion rates that were not much different from those with low scores.

Further, the Dynamic (Institutional) scores appeared to be at least equally predictive of treatment completion as were the Static scores, even though there are three times as many Static than Dynamic items on the instrument. This is an interesting departure from the robust finding in the literature that static variables are far more predictive of recidivism among sex offenders than are dynamic variables. However, the effectiveness of the dynamic (actually more institutional than typically dynamic in nature) MnSOST-R items in predicting treatment completion makes sense given these included (a) discipline history while incarcerated and (b) failure to complete [prior] recommended sex offender and/or substance abuse treatment. Within the residential treatment program from which our offenders were drawn, multiple disciplinary infractions or failure to participate fully in treatment were common reasons why a resident might ultimately be terminated from the program.
The ability of the MnSOST-R to predict treatment completion months, on average, in advance of this outcome has several potentially important clinical implications. For example, those identified early as most at risk to fail to complete treatment might be allotted additional treatment resources (e.g., more hours of individual therapy, closer supervision) in the hope of increasing their chances for success. Alternatively, program resources might be disproportionately allotted to those at least risk for failure (i.e., “bet” on those most likely to “pay off”) or to those at some intermediate level of risk (on the assumption that otherwise these individuals are as likely as not to fail to complete treatment).

**Study Limitations**

The generalizability of our results is limited in several ways. Perhaps most importantly, all of the offenders we studied were in residential (i.e., half-way house) treatment. The relationships we observed between MsSOST-R scores and treatment completion may be limited to this type of setting; i.e., we have no way of knowing if they would hold true for other settings (e.g., prison-based treatment programs, outpatient programs). Further, the data evaluated in this study was, in one sense, retrospective in nature (i.e., the data were provided to us well after they were created). As a result, it was not possible for us to evaluate the reliability of the MnSOST-R ratings that were made. It would be important to replicate these findings based on MnSOST-R ratings with demonstrated inter-rater reliability.

Although offenders could have failed for any of several different reasons (e.g., halfway house rule violation, failure to participate in treatment), we had no information available regarding the specifics of any offender’s treatment failure. It may prove to be the case that the success of any predictor of treatment failure, including the MnSOST-R, will vary as a function of the specific reason for that failure. Wherever possible, this information should be included in future investigations of this kind.

Finally, the analyses available to us were restricted as a function of the number of offenders for whom we had data. A larger number of offenders would have allowed for an item-level analysis, perhaps identifying a subset of the MnSOST-R items most responsible for the test’s predictive success.

**Conclusion**

Treating sex offenders represents a substantial investment of time, money, and effort. Yet many of the offenders who begin this process never complete it, either because they chose to, or are asked to, leave treatment. Such premature terminations represent not only less than optimal resource allocation, but often appear to signal subsequent difficulties.

It is obviously more than coincidence that those starting, but failing to complete sex offender treatment are among those most at risk to ultimately reoffend. Recognizing that one has a problem and is in need of treatment, being willing and able to participate in such treatment, and choosing to follow the institutional rules surrounding the treatment are all necessary, if not sufficient, for both treatment success and ultimately a life other than as a sexual victimizer. Actuarial predictors of reoffense, such as the MnSOST-R, likely tap into many of these common features, and may be useful in both types of prediction.
References


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