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Do Low-risk Sexual Offenders Need Treatment?

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Abstract: The risk principle of offender rehabilitation states that the intensity of treatment should be proportional to the offender's risk. This article reviews the evidence base for the risk principle with sexual offenders, as well as identifying other arguments, in order to determine whether low-risk sexual offenders need treatment, and of what type and magnitude. We conclude that low-risk sexual offenders probably need no more than 100 hours of offence-focused treatment given their very low reconviction rates. Low-risk sexual offenders should be kept separate from higher-risk offenders, and treatment should not interfere with other activities that will enable a non-offending lifestyle.

Keywords: low risk; sexual offenders; risk principle

Sexual offending is a priority societal problem, which is typically addressed in part through the treatment and rehabilitation of sexual offenders in correctional settings. However, in current times of fiscal constraint it is becoming increasingly important to direct scarce resources to where they will most effectively bring a reduction in further sexual offending. Intensive treatment programmes should, therefore, be reserved for those offenders who will benefit most from them. This article examines whether treating low-risk male sexual offenders achieves any effect, and offers suggestions for appropriate allocation of resources within sex offender treatment programmes. One might argue that it is an improper use of public funds to provide treatment to sexual offenders where, at least in terms of being able to demonstrate a reduction in recidivism, the benefits are not apparent. Ideally, unless treatment was shown to be harmful, there would be no financial limitation in providing treatment for all sex offenders, regardless of their potential risk of further offending. However, in a time of global recession there may be a difficult balance to be struck between provision of appropriate offender rehabilitation programmes which reduce reoffending, and limited resources. Other factors, aside from funding, may also need consideration. For example, maintaining

experienced and skilled staff to work therapeutically with offenders can also be problematic; where prisons or probation offices are located in rural areas there may be a limited pool of staff who have the competencies to deliver treatment programmes. In such instances, these staff may be best reserved to deliver services to higher-risk offenders.

The risk, need and responsivity (RNR) principles of offender rehabilitation were introduced in the 1980s, formalised in the early 1990s (Andrews, Bonta and Hoge 1990), and have been further refined in more recent years (Andrews and Bonta 1998, 2006; Bonta and Andrews 2007; Ogloff and Davis 2004). The RNR premise is one of the most influential models guiding the assessment and treatment of offenders to date (Blanchette and Brown 2006; Ward, Messler and Yates 2007), providing a required focus to offender rehabilitation. The risk principle postulates that the degree of intervention provided to an individual should be proportional to the individual's level of risk for reoffending (Simourd and Hoge 2000); higher-risk offenders should receive a greater amount and intensity of treatment than lower-risk offenders should. An assertion of the risk principle is that criminal behaviour can be reliably and accurately predicted. There is now a variety of actuarial risk assessment tools, which use static, historical factors to place individuals into different categories according to their likelihood of reconviction. These actuarial tools have been shown to have good predictive validity and consistently outperform empirically-guided clinical judgment (for example, Bonta, Law and Hanson 1996; Hanson, Morton and Harris 2003; Hanson and Morton-Bourgon 2007; McNeil, Sandberg and Binder 1998).

The need principle states that in order to reduce recidivism, treatment should focus on 'criminogenic needs'. These criminogenic needs are psychologically meaningful, theoretically changeable factors that have an evidence base directly linking them to reoffending (see Mann, Hanson and Thornton 2010). Meta-analyses have identified a set of risk factors which are most related to sexual reoffending (for example, Hanson and Bussière 1998; Hanson and Morton-Bourgon 2005). Mann, Hanson and Thornton (2010) have summarised this literature in the form of lists of risk factors structured according to the strength of the evidence base. They proposed that treatment should be focused upon the strongly-supported risk factors (for example, sexual preoccupation, hostile beliefs, abuse-supportive attitudes, impulsivity) rather than non-criminogenic needs (such as anxiety and depression) which have demonstrated little relationship to criminal offending (Bourgon and Armstrong 2005).

Lastly, the responsivity principle examines factors which may affect, enhance or impede an individual's response to treatment. These factors include internal individual processes, such as learning style, intellectual functioning, and motivation, as well as external factors including therapeutic approach, environment and the programme content and delivery style (Ogloff and Davis 2004). This principle posits, for example, that treatment will be more effective if it uses cognitive-behavioural methods, and if it is matched to the offenders' learning style and abilities (Andrews and Bonta 2003; Wong 2000).

Many jurisdictions worldwide now adopt the RNR principles as a means of directing resources and allocating appropriate treatment pathways for offenders. In the next sections of this article, we discuss the evidence base for the RNR model (particularly the risk principle) in relation to general offenders and then, more specifically, in relation to sexual offenders.

Investigations of the Risk Principle with General Offenders

Treatment that adheres to the RNR principles has repeatedly been shown to be effective for general offenders (Andrews *et al*. 1990; Andrews and Bonta 2006; French and Gendreau 2006; Landenberger and Lipsey 2005). Andrews *et al*. (1990), for example, found that treatment allocated appropriately according to risk, need and responsivity, had a mean effect size of 0.30, but that treatment allocated inappropriately had a mean effect size of -0.06. Focusing on the risk principle specifically, a number of studies has shown that adherence to this principle has a strong relationship with a programme's ability to reduce recidivism (for example, Lowenkamp, Latessa and Holsinger 2006; Lowenkamp, Latessa and Smith 2006; Lowenkamp *et al*. 2006). Andrews and Bonta (1998) found the risk principle to have an effect size of 0.11. More recently, Landenberger and Lipsey (2005) conducted a large-scale meta-analysis, which found strong support for the risk principle (although there has been some criticism over the method used to classify risk levels in this study; Hanson *et al*. (2009)). Andrews and Bonta (2006) also conducted an extensive review of the general offender rehabilitation literature. They examined 273 studies, and found that treating high-risk offenders resulted in an 11% reduction in recidivism, but only a 3% reduction in low-risk offenders. The authors concluded that treatment services provided to low-risk offenders should be minimal (Andrews and Bonta 2006). Congruent with Andrews and Bonta's conclusions, a meta-analysis by Andrews and Dowden (2006) found that providing treatment to low-risk offenders was associated with a very mild effect (3% reduction in recidivism as opposed to 10% reduction in high-risk offenders).

Research has also examined the intensity of treatment given to low-risk offenders. A recent randomised controlled trial conducted by Barnes *et al*. (2010) observed no differences in recidivism amongst a group of low-risk offenders who either received standard or low-intensity supervision. Thus it appears that reducing contact with low-risk offenders does not increase reoffending rates. Additional studies have found that providing a greater intensity of treatment to low-risk offenders can actually *increase* recidivism in this group. Bonta, Wallace-Capretta and Rooney (2000) found that low-risk offenders who received *minimal* treatment had a 15% recidivism rate, whilst low-risk offenders who received *intensive* treatment had a recidivism rate of 32%. The same study found that the recidivism rate for high-risk offenders who received intensive treatment was significantly less than the recidivism rate for high-risk offenders who did not receive intensive treatment (32% *v*. 51% recidivism). That is, intensive treatment

markedly decreased reconviction rates for high-risk offenders, but markedly increased them for low-risk offenders. A series of other studies has similarly indicated that when intensive treatment is given to low-risk offenders, their likelihood of recidivism can increase (Andrews *et al*. 1990; Andrews and Dowden 2006; Lowenkamp and Latessa 2002; Lowenkamp, Latessa and Holsinger 2006). Lowenkamp and Latessa (2004) postulated two possible reasons for this effect. First, it could be that exposing lower-risk offenders to higher-risk offenders (if the risk groups were mixed in the treatment programme) enhances their anti-social attitudes and beliefs. Second, putting low-risk offenders through intensive treatment could disrupt other positive opportunities they may have, such as finding employment or developing pro-social networks. It could also be that requiring low-risk offenders to take part in offence-focused treatment enhances the salience of offending for them, or causes them to adopt deviant self-labels where they see themselves as more criminal than they really are and 'doomed to deviance' (Maruna 2001). Regardless of the reason, the evidence clearly indicates that with non-sexual offenders, intensive treatment should be reserved for high-risk offenders and low-risk offenders should only receive low-intensity treatment, if they are to be treated at all. But the question remains as to whether such an edict can also be generalised to *sexual* offenders?

Investigations of the Risk Principle with Sexual Offenders

Hanson and colleagues (2009) reviewed 23 sex offender treatment outcome evaluations to examine whether the RNR principles also apply to sexual offenders. They found that treated sexual offenders had lower recidivism rates than untreated sexual offenders (10.9% *v*. 19.2% for sexual recidivism), but also that the more treatment programmes adhered to the principles of RNR, the better they impacted on recidivism rates. Those programmes which adhered to all three of the RNR principles had a greater impact on recidivism than did programmes which adhered to none of the principles (whose effects were consistently low). The risk principle was found to have less impact on recidivism outcome than the other two principles. However, the strongest treatment effects were found for programmes provided only to higher-risk offenders. Hanson *et al*. (2009) concluded that: 'noticeable reductions in recidivism are not to be expected among the lowest risk offenders' (p.886).

An earlier study by Mailloux *et al*. (2003) examined the application of the risk principle to sexual offenders by looking at the allocation of sexual offenders to treatment. They found that higher-risk offenders were receiving more intense treatment than were lower-risk offenders. However, further investigations revealed that lower-risk sexual offenders received a similar amount of sex offender treatment as did moderate-risk offenders, and a similar amount of cognitive skills treatment as did the higher-risk offenders. The authors suggested that the lower-risk sexual offenders in their sample were receiving too much treatment, and (although not

directly measured) they implied that over-treatment may have negative effects on lower-risk sexual offenders.

More recently, Lovins, Lowenkamp and Latessa (2009) examined a sample of sexual offenders in a halfway house evaluation project (Lowenkamp and Latessa 2002) who either received intensive residential treatment or were released on parole with less intensive services. In their sample, residential sex offender treatment seemed to be effective for medium- and high-risk offenders, but not for low-risk offenders, who fared better when receiving less intensive interventions in the community. Additionally, higher-risk offenders who successfully completed residential treatment were less likely to reconvict than were those who received less-intensive services on parole. This study indicates that ignoring the risk principle may lead to a significant increase in recidivism for both low- and high-risk sexual offenders. However the sample size for this study was somewhat limited (n = 348), only two-year follow up data was available, and only general recidivism was examined (rather than sexual recidivism). Thus further research may be required to confirm these initial conclusions.

Friendship, Mann and Beech (2003) evaluated prison treatment for sexual offenders in England and Wales, and reported outcome by static risk category. This study found that low-risk sexual offenders (measured in this case by Static-99) did not significantly benefit from treatment, whereas medium-low- and medium-high-risk offenders did. The two-year sexual reconviction rate for the low-risk treated group was 1.1%, whereas the two-year sexual reconviction rate for the low-risk comparison group was 1.2%. This study clarified that low-risk sexual offenders in England and Wales have low base rates of reoffending, and indicated that treating low-risk sexual offenders may not reduce sexual recidivism. It also highlights that research into the effectiveness of treatment for low-risk sexual offenders is compounded by low base rates of recidivism. Barbaree (1997) pointed out that the base rates of recidivism have an important influence on the sensitivity of hypothesis testing, and may result in type II errors (concluding that treatment does not reduce recidivism when it does) in evaluation studies. With very low base rates it is often very difficult to establish programme efficacy when using recidivism as the outcome measure. Barbaree (1997) demonstrated this through a series of calculations showing that when base rates are high, treatment effects are more likely to be detected than they are when base rates are low. By definition, low-risk sexual offenders have significantly lower rates of recidivism than medium-, high- or very high-risk sexual offenders have; and the recidivism rates of low-risk sex offenders may, indeed, be negligible. For example, Barnett, Wakeling and Howard (2010) in a recent validation of the RM2000 static risk assessment tool, presented rates of recidivism by risk level. The low-risk sexual offenders had a four-year sexual recidivism rate of 0.7%, where the very high-risk sexual offenders had a rate of 27.3%. Other studies have found similar low recidivism rates for low-risk sexual offenders (Beech and Ford 2006; Friendship, Mann and Beech 2003; Hanson and Bussière 1998). It will, therefore, inevitably be difficult to

show significant reductions in reoffending in a group which already has very low rates of reoffending. But does this difficulty in showing a treatment effect for low-risk sexual offenders using recidivism as the outcome mean we should stop treating them? Further evidence would seem to suggest a move towards this position.

Alongside their low rates of recidivism, low-risk sexual offenders also have fewer criminogenic needs or dynamic risk factors than do higher-risk sexual offenders (for example, Underhill *et al*. 2008; Mann *et al*. 2007; Webster *et al*. 2007). Furthermore, sexual offenders with fewer risk factors, who are sometimes referred to as low deviancy (Beech 1998), reconvict at a significantly lower rate than do higher deviancy men (Beech, Fisher and Beckett 1998). When level of deviancy (or criminogenic need) is combined with static risk assessment, reconviction prediction is enhanced (for example, Beech *et al*. 2002; Thornton and Beech 2002). Thus, it follows that an examination of both risk and dynamic need is important in assessing the likelihood that an offender will reoffend. The fact that low-risk men tend to have lower deviancy than do high-risk men lends further support for the notion that low-risk sexual offenders may need less treatment than higher-risk offenders. Equally, this raises the issue that offenders who are low risk but have a high level of dynamic need may be more in need of treatment than a 'typical' low-risk sexual offender.

It is also relevant to examine studies of treatment change in sexual offenders. The function of cognitive-behavioural treatment is to produce positive changes in individual offenders' dynamic risk factors, which should lead to reductions in recidivism. There have been few studies which have examined the link between the changes in these dynamic variables that result from treatment, and subsequent reductions in recidivism (Douglas and Skeem 2005). Olver *et al*. (2007) found that therapeutic change scores as measured with the Violence Risk Scale–Sexual Offender version (VRS-SO; Wong *et al*. 2003) were significantly associated with reductions in sexual recidivism after controlling for static risk, amongst a sample of 321 treated sexual offenders. This change was significantly negatively associated with recidivism amongst high-risk offenders, but not amongst low-risk offenders. Two further studies by Olver and Wong (2009, 2011) have found a stronger link between therapeutic change and recidivism amongst higher-risk offenders, compared with lower-risk offenders.

Together these studies provide further indication that higher-risk offenders may stand to benefit more from treatment than might lower-risk offenders. It also appears that the changes that these high-risk offenders make are more prognostic of their outcome following treatment than are those for lower-risk offenders, who are less likely to show change (probably as a result of the low level of problems they have to start with).

Putting RNR into Practice for Low-risk Sexual Offenders

The studies described above indicate that the risk principle of the RNR model applies to sexual offenders. But how can we put this principle into

practice effectively? Does the risk principle mean that treatment should be provided *only* to high-risk offenders, or that the intensity of treatment should be proportionate to the risk level of the target group? Both Hollin (2001) and Bourgon and Armstrong (2005) identified an absence of guidance for treatment providers attempting to put the RNR principles into practice, and, in particular, defining how much treatment is enough.

We found just two studies that provided some specific information about treatment dose with offenders. First, Bourgon and Armstrong (2005) considered how well the RNR principles could be applied to general (not sex) offenders in a 'real world' prison setting. A sample of 620 offenders were assessed for static risk and screened for criminogenic needs using the Level of Service Inventory-Ontario Revised (LSI-OR: Andrews, Bonta and Wormith 1995) and other psychometric measures. Using the completed assessments, staff recommended a particular length treatment programme (100 hours, 200 hours, or 300 hours) for each offender, based on the RNR principles. Bourgon and Armstrong observed that recidivism was reduced for the whole treated group in comparison with the untreated group. When appropriately allocated to different treatment programmes, offenders who received treatment had a lower recidivism rate than the rate for those who did not receive treatment, but this difference was only significant for the 100-hour programme. Those who were inappropriately allocated treatment (that is, received a short programme when they were recommended a longer programme) had greater recidivism rates than had those who were appropriately allocated treatment. For low-risk offenders the 100-hour programme was enough to reduce recidivism, but for those with high risk and needs, it appeared that longer programmes were needed to reduce recidivism. This research supports the provision of different lengths of treatment to offenders, dependent on their levels of risk and need, and provides context for how jurisdictions might successfully put the RNR principles into practice.

Second, Beech, Fisher and Beckett (1998) examined the benefits of different doses of treatment for sexual offenders. Their study, of the English and Welsh prison-based Sex Offender Treatment Programme (SOTP), coincidentally took place at a time when the programme was being extended in length. This enabled the researchers to compare the impact of a shorter (80-hour) programme with a longer (160-hour) programme, while other variables such as context and therapeutic approach remained constant. Beech, Fisher and Beckett's study pre-dated the availability of static risk tools so they did not divide their sample into different risk groups, but instead, categorised their sample in terms of deviancy and denial. As 'high-deviancy' offenders had more sexual offence victims, were more likely to have a previous conviction for a sexual offence, and were more likely to have offended outside the family, it could be argued that the deviancy classification approximates a risk-based classification. Beech, Fisher and Beckett found that low-deviancy offenders, as long as they were also low in denial, fared as well in the 80-hour programme as in the 160-hour programme, in terms of showing improvement in pro-offending attitudes and overall change on psychometric measures. However, high-

deviancy offenders, and low-deviancy, high-denial offenders, showed significantly more progress in the 160-hour programme. This finding mirrors Bourgon and Armstrong's research in indicating that, generally, low-risk offenders need no more than 100 hours of treatment, unless they hold entrenched defensive views about the acceptability of sexual offending.

Some jurisdictions have applied the RNR principles by providing different levels of programming according to risk and need. For example, Mailloux and Serin (2001) reported on the determinants of sex offender treatment participation on a sample of incarcerated sexual offenders in the Ontario region of the Correctional Service of Canada. They found that higher-risk sexual offenders were more likely to take part in a greater number and variety of programmes than were lower-risk offenders. Since the 1990s, the Correctional Service of Canada has placed sexual offenders into low-, moderate- or high-intensity programmes based on an assessment of their risk and needs (Hanson *et al*. 2009). Similarly, in Her Majesty's Prison Service (HMPS) in England and Wales, although as many sexual offenders as possible are offered some form of treatment regardless of risk, lower-risk sexual offenders are channelled into a separate, less-intensive programme than are higher-risk sexual offenders, in line with the risk principle.

When jurisdictions have provided a different treatment route for low-risk offenders, that route is usually quicker, less intensive, and easier for the treatment provider to deliver. Clinical experience suggests that low-risk offenders are often more co-operative, less anti-social and motivated to comply with interventions than are high-risk offenders, making them, perhaps, a more desirable group to work with. But if a jurisdiction uses a performance target-based system whereby the number of offenders treated within a year is the performance measure, there is also a danger that the jurisdiction begins to focus increasingly on treating lower-risk offenders, since more offenders can be treated with the same resources. This tendency can be averted only if the target-based system specifies the performance target in terms of risk level. In the absence of such a stipulation, target-based systems create a discrepancy between application of the risk principle, and the pressures of getting offenders through treatment programmes in order to achieve targets. There remains a challenge to fully incorporate the RNR model into 'real life' settings, where often there are competing priorities, values and experiences.

Should Low-risk Sexual Offenders be Treated at All?

Given society's desire to reduce the rate of sexual offending, while operating in a time of severe financial restraint, it is important to debate the question of whether low-risk sexual offenders should be treated at all. Based on the outcome literature reviewed above, it seems permissible to conclude that appropriate allocation of limited resources would focus exclusively on high-risk sexual offenders. But there would be a number of issues to contend with should low-risk sexual offenders not be treated.

Decisions about treatment provision are not only governed by research evidence, but must also take into account public feelings and legal imperatives about sexual offending.

First, being low risk is a relative term; low risk does not necessarily imply no risk. Are low-risk sexual offenders still more likely to recidivate sexually than are non-sexual offenders or non-offenders? Research reviewed earlier indicates that 4- to 5-year recidivism rates for low-risk sexual offenders may be as low as less than 1% (Barnett, Wakeling and Howard 2010), although in non-routine samples (for example, samples already identified as needing treatment) the recidivism rate may rise to 10% (Thornton 2009). Therefore, some low-risk offenders still pose a raised risk to the public compared with a non-offender. Second, there is a need to consider the victims of sexual offences, many of whom have an interest in sanctions and treatment programmes for sexual offending, and who may be unhappy at the thought that a jurisdiction is choosing not to provide treatment. While jurisdictions cannot, and should not, provide services simply because the victims of crime think they should, some criminal justice systems have a statutory responsibility to take the views of victims into account. Such a responsibility means that a decision *not* to provide treatment to certain groups of offenders needs to be evidence-based and defensible against criticism.

Third, any jurisdiction that decides to exclude low-risk offenders from treatment will inevitably one day have to contend with a serious further offence from a low-risk offender. It is a reasonable argument that even a low probability of a high-harm reoffence justifies some unnecessary spending on a group where the majority need little or no professional intervention. Fourth, some (indeed, many) low-risk offenders (and/or their families) express concerns about their behaviour and actively seek treatment. A policy which denied treatment to those who request it could be seen as unethical and could attract strong criticism of a jurisdiction in this position. Fifth, a decision not to treat low-risk sexual offenders could also promote a view that some sexual crimes are not serious, because it implies that those who are assigned as low risk are not expected to address their behaviour. This is not a message that would be helpful to convey to the victims of sexual offences, the perpetrators responsible, or a public wanting to be reassured that criminal justice systems take their protection seriously.

Sixth, there is also the argument that risk tools are not validated for all types of sexual offenders. While there are clear and stable patterns concerning different rates of reconviction for different risk groups, there are greater controversies associated with applying recidivism prophesies to individuals. Most risk tools are particularly limited when it comes to subgroups of sexual offenders who would have been under-represented in validation studies. The most obvious example here is sexual killers, who may appear as low risk according to actuarial tools (if they are older and have no previous convictions before their homicide conviction), but may, indeed, pose a greater risk than the average low-risk sexual offender. Another relevant group is that of offenders convicted of viewing abusive

material over the Internet. While we now know that the reconviction rates for these offenders are low (Wakeling, Howard and Barnett 2011), this may not reflect actual reoffending, given that the crime of viewing abusive images, unlike most other sex offences, is a crime where the victim does not know that an offence is being committed and, therefore, offences are not reported to the police. It is, therefore, probable that reconvictions for these offenders do not represent the best measure of reoffending.

In conclusion, while an argument could be made not to treat low-risk sexual offenders at all, such a decision would have to carry a number of caveats (for example, it would probably need to exclude sexual killers and other high risk of harm offenders as well as high-deviance offenders), thereby making it difficult to operate in practice, and would be politically unappealing. The most appropriate alternative to no treatment is low-intensity treatment.

What Might Appropriate Treatment for Low-risk Sex Offenders Involve?

Research has indicated that if treatment is to be provided to low-risk offenders then steps should be taken to ensure that they are separated as much as possible from higher-risk offenders (Andrews and Bonta 2006) to prevent possible contamination effects, that is, exposing low-risk offenders to the possible negative influences of higher-risk offenders. Having separate treatment pathways also enables lower-risk offenders to receive shorter and less-intensive treatment than higher-risk offenders receive. This is defensible given that low-risk offenders often have mild pathologies which are less associated with their criminal behaviour and not specific to offending, such as anxiety, depression, distress and problems with self-esteem (Andrews and Bonta 2006). Andrews and Bonta (2003) have stated unequivocally that such well-being issues are not criminogenic, and, therefore, should *not* be the focus of offender rehabilitation programmes if those programmes intend to reduce reoffending. However, others might argue that these pathologies are worthy of treatment for other reasons. If so, these non-crimogenic needs could be better addressed through non-offence specific treatment such as cognitive skills programmes, or personal development programmes. Such needs could also be met in less restricted conditions than those which may be required for high-risk offenders. It may be less costly to provide treatment for low-risk sex offenders in a community setting, rather than within prison.

Low-intensity treatment should deliver some economies over high-intensity treatment, but there still need to be policies about what should be targeted, the level of training required for therapists to work with this group, and how treatment should be delivered. We suggest that open or rolling groups (see Ware, Mann and Wakeling 2009) provide more flexibility in terms of duration of intervention because the intensity of treatment can be varied according to need, with the facility available to discharge offenders from treatment as soon as they have met minimal conditions. In

terms of what should be targeted, establishing whether the strongly-supported risk factors summarised by Mann, Hanson and Thornton (2010) are most relevant to low-risk offenders would be a helpful next step.

Conclusion

Careful consideration of all of the literature concerning low-risk sexual offenders leads to the conclusion that the most appropriate policy is to focus resources on higher-risk offenders in terms of intensity and dose of treatment, and to offer a more limited treatment service to low-risk sexual offenders. The fact that recidivism studies with non-routine samples have found higher recidivism rates for low-risk groups (Thornton 2009) indicates that professional judgments (presumably based on some kind of identification or observation of dynamic risk factors) are able to identify more concerning low-risk offenders. We, therefore, concur with Mailloux *et al*.'s (2003) view that allocation of resources should be based on an assessment of both static risk and dynamic treatment need. In some jurisdictions, processes may need to change so that low-risk sexual offenders are not penalised if they do not receive intensive treatment. For example, a static risk assessment at the point of sentence would be helpful to ensure that low-risk offenders are not recommended for, or sentenced to, more intensive sex offender treatment than they need. At the same time, systems need to be flexible enough to increase treatment provision for a given individual low-risk offender, should the static risk level be deemed unrepresentative of actual risk posed.

To conclude, it seems unwarranted, possibly counterproductive, and certainly an inefficient use of scarce resources, to routinely provide intensive treatment (defined here as a treatment dose of more than 100 hours) to low-risk sexual offenders. Since public protection is the priority, it seems logical to prioritise high-risk sexual offenders, who are both more likely to recidivate and to benefit from treatment. Lower-risk offenders, who are less likely to recidivate and to benefit from intensive treatment, will usually require far less formal intervention. In order to be responsive to low-risk offenders who want to address their behaviour, to serve the needs of criminal justice systems and to maintain public confidence, we believe that low-risk offenders should receive low-intensity treatment solutions that focus on resettlement and that keep participants separate from their higher-risk counterparts.[1]

Note

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