Measuring Treatment Needs and Progress: The SOTIPS

Sponsored by DAIL
Middlebury, Vermont
April 6, 2012

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Workshop Outline

1. What are evidence-based assessment practices?
2. What is the SOTIPS?
3. How does the SOTIPS perform?
4. How do I score the SOTIPS?
5. How can the SOTIPS be used in practice?

1. What are evidenced-base risk and needs assessment practices?

Where Are We Now?

Four Generations of
Sex Offender Risk Assessment

1st – Unstructured professional judgment

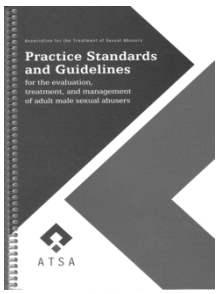
2nd – Structured risk instruments (mostly static risk factors)

3rd – Structured risk-needs instruments (static & dynamic)

4th – Structured risk-needs instruments; ongoing planning

Association for the Treatment of Sexual Abusers (ATSA)

"Practice Standards and Guidelines" (2005)



27.01 – evaluate client's risk and clinical needs before beginning treatment

31.00 – periodically re-evaluate client's treatment progress

Principles of Effective Services "RNR"

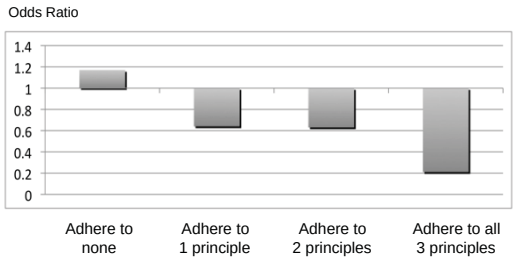
1. Risk Principle – Who to treat?
- Assess offenders'risk to reoffend.
- Focus treatment on offenders at moderate risk or higher.

2. Need Principle – What to treat?
- Assess offenders' treatment needs.
- Focus treatment on offenders' criminogenic needs.

3. Responsivity Principle – How to treat?
- Assess offenders' learning styles.
- Match services to offenders' learning styles.

Programs that adhere to RNR principles have lower rates of sexual recidivism than those that do not.

23 sex offender treatment outcome studies (Hanson et al., 2009)



2. What is the SOTIPS?

The SOTIPS is 16-item dynamic updated version of the 22-item TPS and 25-item TIPS-ID.

SOTIPS

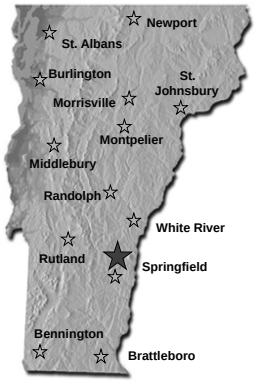
16 Dynamic Risk Items			
1.	Offense Responsibility	9.	Treatment Cooperation
2.	Sexual Interests	10.	Supervision Cooperation
3.	Sexual Attitudes	11.	Emotion Management
4.	Sexual Behavior	12.	Problem Solving
5.	Risk Management	13.	Impulsivity
6.	Criminal Attitudes	14.	Employment
7.	Criminal Behavior	15.	Residence
8.	Stage of Change	16.	Social Influences

SOTIPS Risk Levels and Scores

Risk Level	Score
Low	0 - 10
Moderate	11 - 20
High	21 - 48

SOTIPS & Vermont DOC Treatment Programs
(2001 to 2012)

We collected and analyzed 3-year reoffense data on 759 adult male sex offenders to develop and norm the SOTIPS



SOTIPS

- McGrath, R. J., Lasher, M. P., & Cumming, G. F. (2012). *The Sex Offender Treatment Intervention and Progress Scale (SOTIPS) Manual.* Middlebury, VT: Author.
- McGrath, R. J., Lasher, M. P., & Cumming, G. F. (2011). *A model of static and dynamic risk assessment.* Final grant report to the National Institute of Justice. Award Number 2008-DD-BX-0013.https:// www.ncjrs.gov/pdffiles1/nij/grants/236217.pdf
- McGrath, R. J., Lasher, M. P., & Cumming, G. F. (in press). The Sex Offender Treatment Intervention and Progress Scale (SOTIPS): Psychometric properties and incremental predictive validity with Static-99R. *Sexual Abuse: A Journal of Research and Treatment.*

3. How does the SOTIPS perform?

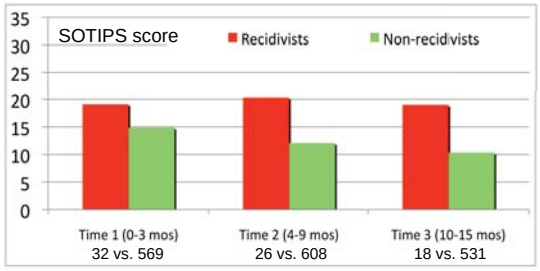
We know more about risk assessment among the general sex offender population than among individuals with developmental disabilities. However, risk factors for each group appear to be very similar.

Reliability
(320 cases scored by 17 treatment providers & 24 POs)

	ICC_1	ICC_2
Total score	.77	.87
F1 – Sexual deviance	.68	.81
F2 – Criminality	.76	.86
F3 – Social stability and supports	.69	.82
Standard error of measurement (68% CI)	3.45	2.59
Cronbach's alpha	.87	
Gutman split-half reliability	.87	

SOTIPS Scores and Sexual Recidivism

Recidivists (red) start with high SOTIPS scores and stay high.
Non-recidivists (green) start with lower scores which go down over time.



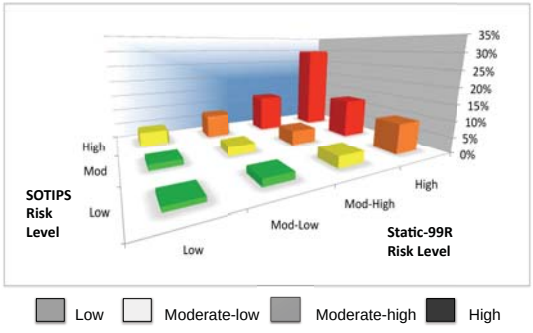
SOTIPS can be used with static risk instruments such as the VASOR-2

VASOR-2 12 Static Risk Items			
1.	Age at community placement	7.	Relationship to victims
2.	Prior sex offense convictions	8.	Sexual fixation
3.	Prior sentencing dates	9.	Substance abuse past 5 yrs
4.	Violations of release	10.	Address changes past year
5.	Any non-contact convictions	11.	Time employed past year
6.	Any male victims	12.	Treatment failure or recidivist

VASOR-2 and SOTIPS Relative Risk Levels

VASOR-2		SOTIPS Low (0 to 10)	SOTIPS Moderate (11 to 20)	SOTIPS High (21 to 48)
Low	(0 to 5)	low	low	moderate-low
Moderate-Low	(6 to 8)	low	moderate-low	moderate-high
Moderate-High	(9 to 11)	moderate-low	moderate-high	high
High	(12 to 22)	moderate-high	high	high

Sexual Recidivism Rates at 3 Years by Combined VASOR-2 and SOTIPS GEE Risk Levels



Combined VASOR-2 and SOTIPS

3 Year Predicted Sexual Recidivism Rates

759 adult male sex offenders
placed in the community in Vermont 2001-2007

Risk category	Percent of offenders	Predicted percent sexual recidivism rate	95% confidence interval
Low	52.0	**1.0**	0.4 – 2.7
Moderate-low	22.7	**4.7**	2.4 – 9.1
Moderate-high	15.9	**9.7**	5.7 – 16.5
High	9.5	**16.5**	9.6 – 28.5
	100.0	**4.3**	1.1 – 14.9

4. How do I score the SOTIPS?

Who Scores the SOTIPS?

- Single Scorers
  - Clinician
  - Case manager
  - Probation/parole officer
- Multiple scorers*
  - Two or more members of the team
- Qualifications
  - Expertise in the area of sex offenders
  - Understand principles of assessment

When do I score the SOTIPS?

- Initial
  - during first month of treatment/supervision
- During treatment/supervision
  - Once a year
- End of treatment/supervision

What information can I use to score the SOTIPS?

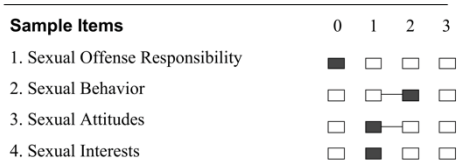
- Interview
- Observation
- Consumer self-reports
- Collateral reports
  - home providers
  - probation and parole officers
  - family
  - support persons

"Anchors" for scoring SOTIPS Items

Scoring Window: 6-month window or current status

0	1	2	3
minimal or no need for improvement	some need for improvement	considerable need for improvement	very considerable need for improvement

How is it Scored?



Sliders: If unsure how to score some items (0 or 1; 1 or 2, 2 or 3),score about half higher and half lower

Using the SOTIPS

- Individual items
  - Structured method of identifying and describing specific intervention targets and progress
- Total Score
  - Method of identifying overall level of treatment and supervision need
  - Combines with static risk measures to improve predictive validity
  - Absent local norms, focus on relative risk

See SOTIPS Scoring Manual

1. Sexual Offense Responsibility

1. I didn't do it, and I don't remember. ____
2. I knew it was wrong but I went ahead and did it anyway. I know I have trouble controlling myself. ____
3. It was 100% my fault because I am the adult. But, she wanted to as much as I did. She never said no. She used to hug me close. I never would have forced her to do anything. ____
4. It was mostly my fault. I knew she might be young, but she told me she was 17. I had no idea she was only 13. ____

2. Sexual Behavior

1. He is "suspected" by staff of engaging in consensual sex with his housemate . ____
2. He was recently caught engaging in consensual sex with his housemate against house rules. ____
3. He reports masturbating 2-3 times a day. ____
4. When staff are not looking, he pulls his wheel chair up alongside other residents and fondles their thighs and groin areas. ____

3. Sexual Attitudes

1. He says T.V. shows and magazines involving children sometimes trigger fleeting inappropriate sexual thoughts. He said he catches himself and uses self-talk successfully to avoid or get himself out of these situations. Staff confirm he avoids these stimuli. ____
2. In group, he often says there are two types of women – "good girls" and "bad girls." Bad girls are just out to use men and deserve what they get (e.g. abused or used themselves). He won't budge from this view. ____
3. He said he sometimes sees little girls he thinks are "sexy." He knows this is "old me" thinking, has some difficult using "ne me" thinking but usually is successful. ____

4. Sexual Interests

1. He molested two 10-year-old boys who were not his relatives and continues to cut out pictures of young boys from magazines. He has one sexual experiences with and adult female which was unsatisfying. He says his sexual interests are exclusively towards adult females. ____
2. He molested three females when they were between the ages of 13 and 15. On PPG, his arousal is 75% towards adult females, 30% towards adolescent females, and below 20% to other stimuli. ____
3. He has a history of multiple short and long-term sexual relationships with adult females and one conviction for a coercive date rape type offense. He said all his sexual interests concern consensual sexual activity. ____

5. Sexual Risk Management

1. He says T.V. shows and magazines involving children trigger his inappropriate sexual thoughts. He said he uses self-talk interventions successfully to avoid or extricate himself from these situations. House staff confirm he avoids these stimuli. ____
2. He is able to describe his risk factors and appropriate intervention strategies in detail. However, during a recent team meeting, he admitted to using sexual fantasies of minor females whenever he masturbates. ____
3. He plans to live with his parents and they continue to think he is innocent. He is frightened and somewhat resistant to telling them about his sexual offending history but says he is willing to do so. ____

6. Criminal and Rule-Breaking Behavior

1. He recently physically assaulted his housemate. ___
2. Over the last 6 months, he has one major house rule violation. He refused to go to his room when asked to do after having a temper tantrum. ____
3. He was found to have food in his room and has received several warnings about this and other rule breaking behavior during the last 6 months. ____
4. On a rare occasion he is argumentative when asked to do household chores but then cooperates . ____

7. Criminal and Rule-Breaking Attitudes

1. He does not have a non-sexual criminal history and he follows and supports program and house rules without problems. ____
2. In group he often complains that the house rules are unfair so he and other men in the program should not have to follow them. He is not open to examining these views. ____
3. Treatment notes and his home work indicate that he is able to recognize and describe how he challenges the thoughts that support his rule-breaking behavior. However, he has been broken multiple minor house rules during the last 6 months. ____

8. Stage of Change

1. He has been in his own apartment for two years and has continued to do very well. He recognizes and manages his risks and has developed a healthy social support system. His new lifestyle is incompatible with sexual offending. ____
2. He has been actively working the program for the past year, has no disciplinary problems, and is being transitioned to a less restrictive setting in the next few weeks. ____
3. He vacillates between admitting he has a sexual offending problem for which he needs treatment and saying that if he simply stays away from the “wrong people” he will never reoffend. ____
4. He said he does not have a problem with sexual offending, knows he will never reoffend, but is willing to do the program if that is what is required of him. ____

9. Cooperation with Treatment

1. He usually pays attention in group but rarely participates unless prompted, sometime misses group, and often does not have his homework ____
2. He always seems to have an excuse about why he is late for group. He is late by about 10 minutes about one-third of the time. He has been given a written warning indicating concerns about this behavior. ____
3. Staff decided that he would not benefit from going to sex offender treatment so he is not in treatment ____
4. He is prepared for group with his written home work assignments about 85% of the time. ____

10. Cooperation with Supervision

1. He attends meetings with his case manager on time, knows the court ordered rules he must follow, and follows these rules. ____
2. During the past few months, he has failed to follow his release conditions while awaiting resolution of his ACT 248 court case and staff have reported this to the court. ____
3. His case manager has asked him to meet with her more frequently because he has been engaging in risk behaviors. ____

11. Emotion Management

1. Anger was his predominant precursive emotional state when he has sexually offended. He is sensitive to criticism. He often lashes out verbally in anger when he perceives he is being "put down." He is typically able to talk himself down when staff intervene. ____
2. Seeking emotional closeness was a motivating factor in his sexual offending. When under stress he will sometimes isolate himself in his room but he has done this less during the last 6 months. He increasingly will seek out other people to talk with during stressful times in his life. ____

12. Problem Solving

1. He has trouble learning from his past mistakes and repeats the same problems over and over. He has difficulty taking feedback from others and examining how he could have handled situations differently. ____
2. The program has a process for resolving disputes among housemates. However, he complains to his guardian before attempting to address perceived wrongs at a lower level. ____
3. He gets flustered when the normal house scheduled is changed, but will talk through his concerns with other residents or staff and adjust relatively quickly. ____

13. Impulsivity

1. He can't sit still in group and frequently blurts out irrelevant comments. Therapists have moderate success redirecting him in group. He is generally able to control his behavior enough to not get asked to leave group. ___
2. He is very self controlled, rigid, and deliberate in his actions. ___
3. He says that he occasionally lets other people egg him on to play practical jokes on others. He says he usually regrets it afterwards and says, "I really need to 'think' before I act." His practical jokes have never been particularly serious. ___

14. Employment

1. Records from the house where he resided prior to meeting with you for his initial evaluation indicate that he worked in a print shop. He said he didn't like the work much but needed the money. ____
2. He refuses to work. He says household chores such as cleaning toilets or sweeping floors is beneath him. ___
3. He works as a janitor 20 hours a week with one-on-one supports. He enjoys his work and is very proud of his work accomplishments. ___

15. Residence

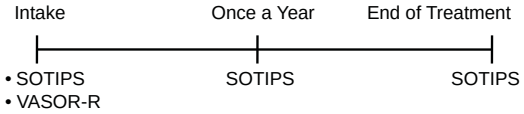
1. In the 6 months prior to his current placement a few weeks ago, he had no permanent residence. He would crash at several friends' apartments for a few weeks at a time. ____
2. He had lived with his aunt in the same apartment for 3 years. He likes living there. ____
3. He recently had to be moved to a more restrictive group home because of ongoing failure to follow house rules in a less restrictive setting. ____

16. Social Influences

1. He lives with his parents but has refused to tell them about his sexual offending history. They continue to believe he is innocent. The friends with whom he are not involved in substance abuse and other rule breaking activity. ____
2. Of his two other roommates in his home, he avoids the one who is disruptive and hangs out with the one who follows house rules and is very prosocial. ____
3. He spends most of his time with care providers and has little opportunity to interact with peers. ____

5. How can the SOTIPS be used in practice?

Assessment Schedule



We use results for treatment
and case management planning.

Summary

- Best practice involves assessing risk and needs
- Use the SOTIPS to help:
  - Provide a “structure” for assessing risk and needs
  - Inform treatment and supervision decisions
  - Reassess and recalibrate services at regular intervals
  - Measure treatment progress
  - Inform placement and treatment completion decisions