Adviescollege Verloftoetsing TBS
Ministerie van Justitie

Recent developments in risk assessment & treatment efficiency in forensic psychiatry

Verslag

Seminar 24 april 2009

Recent developments in risk assessment & treatment efficiency in forensic psychiatry

Verslag

Seminar 24 april 2009

Inhoudsopgave

Hoofdstuk 1
Algemene inleiding

Sinds 1 januari 2008 toetst het Adviescollege Verloftoetsing TBS alle door de Forensisch Psychiatrische Centra ingediende aanvragen voor verlof van tbs-gestelden. Het adviescollege brengt hierover advies uit aan de minister van Justitie. De belangrijkste vraag die het adviescollege dient te beantwoorden, is of het toekennen van verlof aan een tbs-gestelde verantwoord is.

Tijdens de tbs behandeling en bij het aanvragen van verlof is het taxeren van risico's voor zowel het adviescollege als het tbs veld een hoofdthema. Een net zo belangrijk thema is de effectiviteit van de behandeling.
Om een bijdrage te leveren aan de 'lerende verlofpraktijk' organiseerde het Adviescollege Verloftoetsing TBS op 24 april 2009 te Utrecht een seminar met als titel 'Recent developments in risk assessment & treatment efficiency in forensic psychiatry.'

Voor het ochtendprogramma van het seminar werden psychiaters, psychologen, juristen, onderzoekers en overige belangstellenden uit het tbs-veld uitgenodigd. Het middagprogramma vond in een kleiner verband plaats en was alleen voor de leden van het adviescollege bedoeld.

Dr. R. Karl Hanson (Canada) trad op als spreker van het seminar. Hij verzorgde twee lezingen over de genoemde onderwerpen. Dr. Hanson is één van de meest gerenommeerde onderzoekers op het gebied van risicotaxatie. Hij heeft meegewerkt aan de ontwikkeling van diverse internationaal bekend geworden risicotaxatie-instrumenten en heeft internationaal faam verworven door belangwekkende meta-studies over (seksuele)recidive bij zedendelinquenten. Dr. Hanson heeft een indrukwekkende reeks van publicaties op zijn naam en treedt op diverse toonaangevende congressen op als een graag geziene spreker die een zeer grote autoriteit bezit op zijn onderzoeksgebied.

Deze publicatie omhelst een verslag van het seminar. Van het ochtendprogramma is het welkomstwoord van de voorzitter van het adviescollege, mr J.W.P. Verheugt, opgenomen. Daarnaast zijn de lezingen van dr. Hanson integraal opgenomen, inclusief de gebezigde Powerpoint presentaties. Voorts treft u een overzicht van de meest relevante publicaties op het gebied van risicotaxatie en behandeleffectiviteit aan. Tijdens het middagdeel van het seminar heeft dr. Hanson diverse vragen van de leden van het adviescollege beantwoord en een nadere toelichting op het systeem in Canada gegeven. Ook hiervan treft u in het kort de verslaglegging aan.

Het adviescollege kijkt met deze publicatie terug op een geslaagde dag, met een inspirerende spreker, nieuwe inzichten en - wellicht nog wel het belangrijkste - bijgewoond door veel collega's uit het tbs-veld. Met dit seminar is hopelijk een goed begin gemaakt met het voornemen van het adviescollege om jaarlijks een inhoudelijke dag voor het tbs-veld te organiseren.

Hoofdstuk 2
Programma

Programma ochtenddeel seminar

09.30 - 10.00 uur	Ontvangst met koffie en thee in de Geertekerk te Utrecht
10.00 - 10.05 uur	Opening door mr J.W.P. Verheugt, voorzitter van het Adviescollege Verloftoetsing TBS
10.05 - 11.00 uur	Presentatie over risicotaxatie door dr. R. Karl Hanson, gevolgd door discussie
11.00 - 11.15 uur	Pauze met koffie en thee
11.15 - 12.15 uur	Presentatie over behandeleffectiviteit door dr. R. Karl Hanson, gevolgd door discussie
12.15 - 12.20 uur	Slotwoord door mr J.W.P. Verheugt, voorzitter van het Adviescollege Verloftoetsing TBS
12.30 - 13.15 uur	Lunch
13.15 uur	Einde seminar

Hoofdstuk 3
Welkomstwoord mr J.W.P. Verheugt, voorzitter AVT

Dames en Heren,

Ik heet u namens het Adviescollege Verloftoetsing TBS graag van harte welkom op dit ochtendseminar.

Het doet mij een groot genoegen dat wij dr. Karl Hanson bereid hebben gevonden vanochtend over een tweetal onderwerpen een lezing met aansluitend discussie te houden. Dr. Karl Hanson is - zo heb ik begrepen - een vermaarde en gewaardeerde deskundige in de forensische psychiatrie, met een bijzondere expertise op het gebied van risicotaxatie, recidive en behandeling bij seksuele delinquenten. Voor een eenvoudig jurist als ik, die zo goed als geen verstand heeft van deze materie, is het internet in een geval als dit beslist een uitkomst. Want wie daar zoekt op dr. Karl Hanson, die zal vinden! Ik keek er slechts een half uurtje rond en trof meer dan honderd vermeldingen van artikelen, lezingen, symposia en dergelijke, met zijn naam. Juridisch geldt dit dan wel niet als bewijs, maar indrukwekkend waren de resultaten van mijn onderzoekje wel.

Ja, dames en heren, het is niet anders, de rest van de ochtend gaat in het Engels. Ik ga daar dus naar overschakelen. Maar voordat ik dat doe, meld ik u nog dat het Verlofadviescollege - volgens de beste vertaling die we konden krijgen - in het Engels als volgt heet: The Advisory Board on review of leave from detention under a hospital order. Ik vond en vind Adviescollege Verloftoetsing TBS al een flinke mond vol, maar hier kan echt niemand tegenop. Ik stel voor dat we het de rest van de ochtend eenvoudig houden op: The Advisory Board of - nog simpeler - The Board.

En nu verder in het Engels.

Dear mr Hanson,

The Advisory Board is very pleased to welcome you here. We are honoured with your presence as far as from Canada and your willingness to inform us on recent developments in two main issues in modern forensic psychiatry and psychology.

About the first issue, one thing is for sure: Risk assessment is the core business in the advisory task of the Board. In the relatively short time the Board exists, we discussed as members of the Board that it is important to keep ourselves - so to say - up to date in our knowledge: knowledge on all topics in forensic psychiatry and psychology that we need to fulfil our responsible task at a level of best practice. That aim is not only necessary and obvious from an internal, strict professional point of view. It is also necessary from the view of the government, politicians and the general public. They are right to expect that the Board functions at - to put it very short - a level of top quality. One of the instruments to keep and sustain that quality is to gather information that is state of the art. And one of the methods to reach that target - as we decided in the Board - is to organize seminars on a regular basis to keep us as best informed as possible. This seminar is the first in - I hope - a long series.

Your lectures this morning are held not only for members of the Board. We invited professionals in forensic psychiatry and psychology who - in one way or another - deal with risk assessment and treatment in forensic psychiatry. It is important that all professionals involved, share their knowledge, and with this invitation we

hope to have contributed to that purpose. It is a pleasure to see so many of them here assembled.

Our task - not only in the Board, but also in the whole field - is to facilitate for our patients a safe return into society. Safe for society, safe for them. In that long and often difficult journey risk assessment and efficient treatment are organic and essential elements.

Now it is time to change roles: I look forward to listen to you today!

Hoofdstuk 4
Lezing dr. R. Karl Hanson over risicotaxatie

Risk Assessment[1]

The first question is: what should risk assessment look like as opposed to what risk assessment currently is?

First of all we want a risk assessment that is understandable, so that we know what it is we are working with. So that we are able to identify the core features and explain them. You can do risk assessment on a purely empirical basis. You take certain factors and see if they predict. That is important to do, but you want more than that. You want to understand why a factor is predicting or not. You want to identify the factors that are clinically useful; the things that you can do something about. You may know what the number of prior offences predicts, but more so you would want to know about the propensities that those prior offences indicate or identify. And if you are able to identify those propensities, then you would be able to intervene, change or manage those propensities in some way.

You want precise estimates of recidivism risk. In many cases you are making a decision about the probability of a certain negative outcome, so that offenders would be expected to reoffend at 10%, 50% or 70%. These are hard numbers to get, but ideally you would want to know these numbers. Not just that somebody is higher risk than somebody else, but you would want to know how their risk relates to some threshold. It is important to think about what thresholds you care about and if the offender is above or below that threshold. You want to consider all relevant risk factors. We should inform treatment targets and interventions and allow the assessment of both long term and short term. One of the distinctions I frequently make is between stable enduring traits or characteristics which predict recidivism and what I call acute risk factors. These are the factors that happen just before somebody reoffends. In research there is some evidence that the acute factors and the stable factors are not necessarily the same. In some cases they are the same, but something like negative mood or emotional collapse is a much better acute factor than a stable long term risk factor.

You also want the ideal risk assessment. We spend a lot of time asking what is wrong with people. And the people that end up in our system have a lot of problems. We spend a lot of time thinking and talking about those problems. We should do that, but the people that come in have a lot of strengths as well. There are many things in their live that they do well. They may play music well, dress well, they may have a good sense of humour or are physically strong. We neglect these things just by habit because we are concerned about what they do wrong. You can look at protective factors for a couple of reasons. One reason is in terms of risk assessment. If you look at risk assessment as balancing the risk factors with the protective factors as a model of risk assessment, then understanding the protective factors is important. It is also important to look at protective factors as a way of engaging the offenders in the assessment and treatment progress. You can do risk assessment with offenders against their will, but the risk assessment works best if you have the cooperation of the offender; if they are interested in talking to you and tell you what really is going on. And if they are concerned about self management. If you talk to them about them as a full person, not just a problem but somebody with strengths, then it increases

[1] Dr. Hanson heeft deze lezing gegeven naar aanleiding van een powerpointpresentatie, welke presentatie als bijlage 1 in deze publicatie is gevoegd.

your chances that they will see this engagement with you as something worth while.
In terms of risk assessment you want something that can be done by ordinary people. You do not want a risk assessment to only be done by a small number of select experts. Ideally you want a risk assessment that is trainable. You can train other people, it is objective, and you can do it in a cost effective way. One of the reasons I focus on cost effectiveness and implementation is that we have done a number of studies looking at implementing risk assessment protocols in our correctional system and in the mental health system as well, and what we find is that there are huge differences in how well something works in the community or in real live versus how well it works in research. In research it works really well, people can do it well and we have predictability and accuracy. If everybody (all the probation officers and all psychiatrists) has to use this method, it doesn't work. What you find is that people don't implement it. They don't care and it doesn't work. So if you go and do the reviews of what they have been doing, you end up with stuff which is of very limited value. You don't have predictability and accuracy. What I found is that the simpler the system you have for risk assessment, the more likely it is to be implemented well. If you ask people just to count the number of prior offences, usually they are able to do it. If you ask them to evaluate if they have deviant sexual interests or not, it's more problematic. You need strong professional training and supervision for those type of questions. There is an advantage in keeping it simple.

What is a risk factor?
A risk factor in the simplest definition is something that is empirically associated with the outcome. And it needs to be established empirically. I used to think that I had some special insight in what made offenders reoffend. Years ago I used to do risk assessments in the community and people would bring me offenders and ask if they were high risk or low risk. I would always say something, but if you ask me about the bases on which I was making these decisions: some of the things I was basing my decisions on were correct, but many were not. There were many things that I thought were valid risk factors, but once the research was done it turned out not to be the case. And that is humbling. You can hypothesize or guess, and I think you have to guess what the risk factors are, but you always have to check. There is no guarantee that what you think is a risk factor is actually going to be the case. One of my consistent messages and motivators for why I am standing here and do the work I do, is that we need evidence. We can not just go on saying stuff. We do need evidence to justify what we do.
More than just being a risk factor, you want something that is changeable or what we call criminogenic needs or dynamic risk factors. To determine a criminogenic risk factor it involves identifying a factor that is theoretically plausible. Things like lifestyle impulsivity, sexual preoccupation and substance abuse are things that have theoretical plausibility. You need to change these factors and see if changes on these factors are related to changes in recidivism rates. There has been a lot of research on this for general offenders, less so for certain specialty groups.

What I am going to cover now are some meta-analyses looking at risk factors. What we are looking at is: does it predict? In general the same types of factors predict different kinds of outcome, with a few exceptions. We are looking at general recidivism, violent recidivism and sexual recidivism.
Looking at age, as you get older you are less likely to reoffend. If most of these things are similar across the groups, you will find a few exceptions. Minority and race are related to general and violent recidivism, but not much to sexual recidivism. Criminal history is a pretty good predictor. Juvenile and adult are pretty consistent. The degree of violence in the index offence has little or no relationship to reoffending. If somebody comes in who has killed somebody, they are not necessarily higher risk than somebody who has fondled a child. One of the bigger predictors for general recidivism is who you hang out with, your peer associates. It also predicts for sexual recidivism. Sex offenders know other sex offenders and they hang out with them. It is not as big a predictor, but it is there.
Substance abuse predicts, but it is not a big risk factor. Antisocial personality disorder and psychopathy sort of predict. Personal distress, such as anxiety and depression, have relatively little relation to long term recidivism. This surprises many people, particularly those who are trained in a mental health background where there is such a focus on subjective distress and internalising disorders as the cause of all things that are bad. It has not much relationship to criminal behaviour.
Psychoses also have a very small relationship. There are a few specific risk factors for specific groups. Deviant sexual interests apply for sex offenders, but not much for the other offenders. There is actually a bit of a reverse effect. The rates of violent recidivism are slightly lower among people who have more deviant sexual interests.

Criminogenic needs for offenders in general.
One of the basic criminogenic needs is antisocial personality. The definition I use is adventurous pleasure seeking, restlessly aggressive and callous disregard for others. Other main criminogenic needs are grievance/hostility, bad friends, thinking that crime is ok, low attachment to family and lovers, low engagement in school or work, aimless use of leisure time and substance abuse.
Things that have relatively little relationship to general recidivism are personal distress, major mental disorder, self-esteem and low physical activity. In Canada and the US you see programs like boot camps or wilderness adventure trips, where we are teaching people to be more active and physically independent, but that is not the offenders problem.
Other non-criminogenic needs are:

- Physical living conditions. The physical state of where they live doesn't matter that much, it is who they spend time with that does matter.
- Low conventional ambition. There is a whole series of intervention which have encouraged people to want to get ahead, to succeed in live, but offenders want the same things. They don't lack that. They don't do the things they do because they don't want to succeed in society. Increasing this actually increases their engagement in crime. It works against you.
- Insufficient fear of official punishment. Offenders don't think they get caught. That is not what is inhabiting them.

If you look at sex offenders specifically then you see some differences. Criminogenic needs for sexual recidivism are deviant sexual interests especially for children, sexualized violence and multiple paraphilias. Multiple paraphilias are especially important for the higher risk group, where they are interested in many different, unusual, odd, illegal, sexual behaviours. And often these interests change. They may be interested in exhibitionism for a while or they may be interested in children for a while. They switch. It is a sort of sexual preoccupation with these deviant types of sexual behaviour. This is an important factor. The factors of multiple paraphilias and sexual preoccupations go together. The factor of antisocial orientation is essentially the same as you see with general offenders. Sexual offenders are offenders and you get a lot of the same offending type of predictors. The factor of intimacy deficits, you find with child molesters. They have emotional congruence with children. Especially pedophiles sexually interested in boys, feel comfortable with children. It is not that they just have sexual interest in children, they like playing with them, they like kid games. And that emotional immaturity is a risk factor and it is an interesting treatment target as well.

Then there are some factors that have some evidence, but are less strongly established. Some are quite interesting. For instance the sexualized coping. If things go wrong and we feel bad, we try to do things that will make us feel better. Sometimes we do things that in the long run are not that good for us at all. Some people start drinking too much, others get stuck to overeating. One thing that some sex offenders do, is that they are sexually overactive in their thinking and behaviour.

Factors that are unrelated to sexual recidivism are victim empathy, denial of their offences, lack of motivation for treatment and internalizing psychological problems. Being sexually abused as a child increases the risk of becoming a sex offender, but it doesn't increase the risk of them going on. That is not a specific risk factor. Low sex knowledge is also an unrelated factor. They often know enough about sex. That is not what is getting them into trouble. Dating skills and hallucinations and delusions are also not a major factor.

If you look at the major risk scales, they work fairly similar for the different outcomes. If you look at the Psychopathy Checklist-Revised (PCL-R), you see it is not a bad predictor for general and violent recidivism. There is some relation to sexual recidivism, but more to violence. Many of the other risk scales do as well or better. The LSI is commonly used for general offenders. It does just a little bit better then the psychopathy checklist. SIR Scale is a criminal history based scale that is used in Canada. The VRAG is a violent risk appraisal guide which includes the psychopathy checklist as an item. Many of these different scales do pretty much the same. As long as you are sampling reasonably good risk predictors, how you add them up doesn't seem to make much difference. You can even take random items from scales and make a new scale from random items and it does as well as any one of the scales.

If you look at risk assessment you have the relative risk and an absolute recidivism risk. What is puzzling us currently is that the risk assessment scales are relatively stable at ranking relative risk, but we have base rates differences across different settings.

With all the scales that we have examined, there are differences based on features that are not part of the scales. These can include things such as unmeasured risk factors, but also what the criminal justice system does with it, the quality of the treatment and the quality of the police work. They can all effect the recidivism base rates. That makes it hard to predict absolute recidivism rates across settings. We haven't fully resolved what to do with this.

How do risk factors cause recidivism?

There are three general ways you can think about it. One is the linear theory, where you basically add them up. That is how most of the risk scales have been created, by just adding the features together. You can also think of dimensional theory and more sophisticated psychological theories. If you look for example at violent recidivism, then factors as the number of traffic accidents a person has had in their history and the number of different jobs and the willingness to defend honour are all empirical predictors of violent recidivism. You can add these factors as a linear combination, but you can also organise them in a more dimensional way. Then the number of traffic accidents and the number of jobs have to do with lifestyle impulsivity and the willingness to defend honour has to do with the attitudes tolerant of violence. Then you get these dimensions that are important.

Part of risk assessment is that you try to infer what these dimensions are from the items that you are using to assess risk. There are also other ways of combining the items. You can use the theory of planned behaviour, which works with attitude, norms, perceived control and actual control. Attitude means: if you think about it, does it seem like a good thing to do. Norms means: what do the people that you know and like, think about what you are going to do. Perceived control means: if you would want to do it, would you be able to. Actual control means: can you do it. If you think about intention to commit a child molesting offence, paedophilic interest would increase the risk and emotionally closeness to kids would increase the risk. But they may have attitudes that view it as wrong, which may decrease the risk. Or they may have a stake in conformity. They may believe they lose their job or their wife. In terms of norms they may have bad friends and they may have good friends. In terms of perceived control they may have knowledge of offending, something that many offenders do and something we unfortunately teach offenders in our treatment programs as well. Self efficacy is an example of normally a good thing. You want people to feel in control of their life, able to make decisions and do things. But here is a way that actually increases the risk, because they are able to effectively commit crimes or engage in criminal behaviour. Actual control involves things that we do that can potentially control what they do, such as access to victims and surveillance.

Age and violence

I like to say a couple of things about age and violence. In general young men are more violent than old women. In violence you see a general linear decline from twenty onwards. And you see very low levels of violence in those aged over sixty. If you take very high risk people at age twenty, the number of them who are violent at age sixty is one or two percent.

In Canadian statistics you see the biggest peak in violence at the early teenage years. That is when most people are at risk for violence. There is a second peak in the thirties. If you go over sixty then there are a few, but not very many. If you look at age distribution of sexual offenders, rapists tend to be in their twenties, extra familial

child molesters tend to be in their thirties and incest offenders tend to be slightly older, which is not surprising because it takes you a few years to have children and to be around children. Again the numbers that are over sixty are very small.
If we look at the recidivism rates of individuals by the age of release, we find with sex offenders that there is a general linear decline but with some variation. With the rapists it goes pretty straight down with age. The incest offenders tend to be low risk overall, except for the very young guys (incest offenders under the age of twenty five).

Why is age a predictor?
There are a couple of reasons. One reason is that age is highly correlated with criminogenic factors. Young people tend to be unattached, have aimless use of leisure time, are impulsive, have substance abuse and a low stake in conformity. Another reason is independent contribution of age. There are a couple of things that we know. One is declining testosterone levels, particularly for sex offending. That is a relevant factor. Another is declining physical energy and strength, especially for violent offending. It actually takes work to rob somebody or wrestle somebody or beat them up. Another factor is increased emotional self-regulation. When people get older they are better able to manage their emotions. This applies to everybody.
If you look at the testosterone levels of healthy males, you see a pretty steady decline from the thirties onward. From the mid thirties onward there is a general decline. Testosterone has as we know a relation to sexual interest and motivation. It also has a pretty strong relationship with the capacity of ones body to rebuild itself and develop muscle strength. There is a gradual decline in physical strength over time. Age is a risk factor and an effective marker. Most of the existing actuarial risk tools do not fully capture the contribution of advanced age. If you look at things such as the VRAG and Static-99, they are not bad at distinguishing the early ages (20 to 35), but none of them really looks at the over fifties and sixties. Age is an effective marker, but it is an unsatisfying explanation. There is not much you can do about it.

Offenders with traditional mental illness
Compared to other offenders, mentally disordered offenders are the same or lower risk for general recidivism. Compared to non-offenders, major mental disorder increases the risk of violence substantially. The risk factors for general and violent recidivism among mentally disordered offenders are the same as those for general offenders. Individuals with major mental disorders have more criminogenic needs than “normal” non-offenders. Major mental illness by itself is not the predictor, it is how it effects the criminogenic needs. Mental disorder is unlikely to be a major causal risk factor for sexual recidivism. But mentally disordered sexual offenders have lots of criminogenic needs. The standard risk scales work fairly well with mentally disordered sexual offenders.

Outstanding challenges and questions
In terms of outstanding challenges or questions for risk assessment, we need better theories. Linear combinations of risk factors work quite well, but they are not much useful for intervention. We need better theories of what is going on and we need to test them and to determine the validity of the different theories.
We need to do better at communicating risk. The terms that we use to describe low, medium and high for example, mean different things to different people. And often mean different things to different people in the same system. We have to be very careful about that.
We have done relatively little work at evaluating change in high risk offenders. We know that high risk offenders do change and if we let them out, the longer they stay offence free in the community their recidivism rate goes down. After about five to ten years their recidivism rates are in the low risk range. But who do you let out? We have got some evidence of what those are, but we need much more evidence on that area.
The other thing is that multiple risk scales work and I encourage to use them, but the trouble is that different risk scales give different results. And then you have the trouble of how you interpret the results of different risk scales. That is an outstanding challenge.

General recommendations
My general recommendations for risk assessment are:

- Focus on factors that have been empirically established to predict risk. You should be asking yourself all the time: what is it that I am looking at and what is the evidence that this is relevant. Not just “I think so or my boss thinks so”. You have to look for evidence that the factors you are considering matter.
- We should routinely use structured methods for combining risk factors.
- We need to anchor our risk communication in non-arbitrary metrics.
- We have to be conscientious about quality control. We have to make sure that if we are using risk factors or risk scales, that we are doing it in a consistent way and that we have some common understanding what this means.
- We also need to be humble and remember that people are not fully predictable.

End of presentation

Questions:

You say that recidivism rates are dependent of many factors, but you see in the literature that they widely vary. In your meta-analysis of 2005 you say that recidivism rates are about 13%, while at the same time you see in other studies that there are really much higher. Your low rate is frequently used to say that the risk of recidivism is not as high for sexual offenders as we think it is. I think it is dangerous to draw this conclusion because there are dark numbers and they vary widely across settings and between kind of offenders.

In terms of the observed recidivism rates we do have reasonably small numbers after the follow up periods of time that we have. If you do research in this area you have to wait to get the numbers. The difficult question has to do with how good the observed recidivism rates are as indicators of the real rates. We know that most sex offences are not reported and with those reported, most don’t end up in any sort of criminal justice sanction. What we don’t know is the extent to which offenders who are reoffending get caught eventually. So if you do a lot of offences, even if the risk of doing one offence and getting caught is quit small, and you do fifty of them you eventually get caught. Whereas if you do one, two or three offences, you may not get caught. There are certain types of offences where you are more likely to get caught than others. In Canada and the US if you rape a stranger using overt physical force, your chances of getting caught are pretty high. If you molest a family friend, your chances of getting caught are pretty low.

We don't know the answer and the field is divided. The evidence we need has largely to do with the frequency of reoffending among known offenders, which is a figure that we don't know. If we knew that figure, the distribution of offending among known offenders, then we would be able to make a better estimate. The rate of 13% is probably double or triple. The short term rates are worse than the long term rates. The twenty year rates are up around 30%. The real rate is maybe like 40%. Whereas the short term rates of 15% are maybe more like 30 to 35%. But it is still guessing.

The outcome of risk assessment is a chance number and that number is characteristic of the group. And we attach this number to the individual. One of my first lessons in statistics was that you can't do that. The reason for that is that in an individual case the number is zero, somebody does it or not.
I totally disagree with your position. This is an argument that goes back and forth. The reason I think you are wrong is that there is a confusion in fundamental thinking about probablelistic determinations. If you are looking at something like diagnoses of brain disorder or brain problems and you use a diagnostic tool to identify a probability that giving this score this person has a brain tumour, that score is either wrong of right because there is a true state of affairs that is known that the person either does or doesn't have a brain tumour. You have a probablelistic statement about an outcome and the outcome here is a brain tumour. He does or doesn't have it at a metaphysical level. When we are doing risk assessment we are not talking about something that has happened or is happening, but we are talking about something that is going to happen. At some metaphysical level you could make some sort of theory of mind or theory of deterministic world where the future is actually determined. It is fixed, it is true or false. But we don't know it. That is metaphysics. You can also have a metaphysics where the future is not determined and that is the one I subscribe to. We are not exactly sure what is going to happen, but more than that whatever happens is not determined. If you start with a metaphysical distinction that the future is not determined, then inherently what you are identifying is probabilities. And I think that that is the best model for human nature. We don't know and will never know the exact mechanism by which people decide if they are going to have a cheese sandwich for lunch, let alone if they are going to reoffend. So given that the future is undetermined, the best that we can do and should do is to give probablelistic statements and to verify those statements based on generalisations of group data. I don't think we have a choice.

Is it not dangerous to conclude in studies that a specific risk factor is not important, as you did for major mental disorder or for empathy. Because it is so depending on the group that you are studying and especially the group you are comparing it with. It is also dependent on the outcome you are looking at or the follow up time you are looking at. Doesn't it give the wrong message that these factors are not important, when maybe in a different setting they are very important.
At this point, given the weight of evidence, I think it is incumbent of people who want to believe that major mental disorder is an important risk factor, to provide the empirical evidence that that is true. I think that we have got enough evidence now that it has very little relationship in most samples and that the weight of the argument has now switched so that people who want to justify it will need to provide convincing evidence that this is a factor. I am not saying you shouldn't treat it, but in terms of if you do your risk assessment, give me the evidence that you should give high weight to it. I just can't see it. I don't think we can do risk assessment without evidence.

Hoofdstuk 5
Lezing dr. R. Karl Hanson over behandeleffectiviteit

Treatment Efficacy[2]

Looking at the history of offender treatment, in the fifties, sixties and seventies there were lots of studies and lots of variability. There is Martinson's famous article in 1974 on what works in corrections and his conclusion was; nothing works. This had a major impact on North American correctional practise and English practise. It shut down correctional interventions. Since the eighties and really since the nineties there has been a huge resurgent in offender treatment due to the 'what works' literature. Don Andrews and his colleagues have really led the charge and have substantially reformed correctional practise in Canada and largely in de States as well. What they have found generally is the effect that if you provide human service interventions, you can reduce recidivism about 12%. If you just provide sanctions, greater supervision, greater punishment, you end up with slight increases in recidivism rates. More importantly they have identified three ingredients of effective correctional treatments or interventions, which are referred to as the principals of risk, need and responsivity.
The first principal is to treat only offenders who are likely to reoffend (moderate risk or higher). If you look at much of the correctional treatment literature they take people whose expected recidivism rates are less then 10%. If you are going to show effectiveness, put your resources into people who are likely to reoffend.
The next principal is to target criminogenic needs. Offenders have a lot of problems. Not all of those problems are related to committing crime. Low self esteem is a problem, but increasing self esteem is not going to change your recidivism rates. In fact, if you change self esteem and you don't change criminal attitudes, you actually increase the recidivism rates. So target things which are related to offending.
The third principal is responsivity, which is to match your treatment to the offenders learning styles and cultures. Speak their language and engage them. Do interventions that they are likely to benefit from. If an offender has trouble reading, don't give him pages of things to read. If the person is from a Muslim background, have some Muslim or Islamic components in the whole treatment program. Treatments that follow these three principals do well and those who don't, don't do well. And the same results are found in randomised clinical trials and non-random assignment studies, except those with obvious biases. So it is not a function of different methodologies. There are a lot of good quality studies which justify these principals and they have been replicated by independent groups using meta-analysis of existing studies.
If you focus on the criminogenic needs you will make a difference, if you focus on the non-criminogenic needs you will not. It doesn't mean you don't have to treat some of the non-criminogenic needs. You have to address things like self efficacy, low self esteem and mental disorder, you can't avoid them, but don't think you are changing criminal behaviour if that is all you are doing. Your recidivism rates are not going to be different then if you didn't spend time on these things. They may be happier or less mentally ill, but they are still going to reoffend. If you spend time on the criminogenic needs, they are less likely to be involved in crime. For sex offenders specifically you have to spend time on deviant sexual interests, sexual preoccupa-

[2] Dr. Hanson heeft deze lezing gegeven naar aanleiding van een powerpointpresentatie, welke presentatie als bijlage 2 in deze publicatie is gevoegd

tions and emotional identification with children.
If we look at the results in difference in recidivism rate of the treated group compared to the recidivism rate of the untreated group: if we look at the studies that followed none of the principals, we find that 124 studies averaged a slight increase in recidivism rates. If you only had one of the elements (risk or responsivity or needs) it didn't seem to make a difference either. If you had two of the elements, we start seeing something. You start seeing result. If you have all three of the elements, we see results that are fairly strong and meaningful. These results are based on a large number of studies.
Examples of the types of programs that have been the most studied for general offenders are:

- Multisystemic therapy. This is a family systems therapy largely directed towards adolescent offenders. Systems therapy has been used in Holland for a long period of time. This is an example of an effective therapy for adolescent offenders.
- Moral reconation therapy for general offenders. This is a form of structured cognitive behavioural therapy for offenders gearing towards their criminogenic cognitions.
- Reasoning and rehabilitation. This focuses on criminogenic thinking, more specifically on impulsive thinking. What are the consequences of your behaviour and think before you act. It does not specifically target criminogenic thinking, but more generally lifestyle impulsivity. A large number of studies have looked at it and have gotten positive results.

If you look specifically at sex offenders, you essentially find the same pattern. The studies that don't follow the principals of risk, responsivity and needs, show no effect or a slightly negative effect. With those that do, you find meaningful differences in the recidivism rates. The sample sizes are only much smaller.
It is only since 1980 that there are treatments that show real effectiveness for sex offenders. The nineties are the era that the principals of risk, need and responsivity started to become generally known in North America.

Implementation
Implementation is difficult. In demonstration projects where you are trying to set it up and you are concerned about the fidelity and get keen people involved, you get a pretty orderly increase in effectiveness based on adherence. In the real projects, after you have demonstrated that it works, what you find is that you get effects but that they are much smaller. The question is how you implement programs. A couple of keys to effective implementation are:

- Select staff for relationship skills. It is possible to train staff in the program, but don't expect staff to instantly be able to have good connections with the offenders. The characteristics that make good therapists are pretty stable personality characteristics. They are changeable, but don't expect to change your staff just by telling them to be better. Start with good staff that you select in the appropriate characteristics.
- Programs that have manuals or make explicit what they should be doing, do much better then those who don't. Don't just trust your staff to do what they should be doing. You have to have manuals, you have to train the staff and you have to monitor them.
- Another mistake which is made very commonly is that you see demonstrations projects which have big effects and then they want to implement it and roll it out across large jurisdictions. But it is better to start small. Choose people, train them and create the culture where there is an expectation of what people are supposed to do as therapists. Until you have that established, you are not going to have a sustainable intervention system. Creating a culture in which good interventions are expected is necessary. In programs that have selected staff on relationship skills, you find a substantial reduction in recidivism rates. If you have explicit manuals, it also does much better.

What are characteristics of effective therapists?
First of all they are able to form meaningful relationships with offenders. They are warm, accurate empathy and rewarding.
The second skill is that they have to provide pro social direction. They don't just listen to the offenders. They intervene and they intervene in a particular way by supporting their strengths in their pro socials. Particularly they teach skills, they help problem solving and they demonstrate pro social values.
There are a large number of studies that look at the characteristics of interveners with offenders and consistently positive effects are found from therapists, probation officers, correctional officers and friends who are pro social and socially skilled. They are people that they want to connect with. If you are pro social without the social skills you have no effect. If you have social skills but are not pro social, you make them worse.

How does it go wrong?
One of the things that commonly happens, is that you set up the same program and give it to everybody regardless of risk level. Often this is a resource issue, because you have a limited number of staff and a limited number of offenders. One of the problems with this is that you introduce low risk offenders to high risk offenders. The other thing that happens is that the high risk offenders don't get the treatment. Programs reject them or the offender is not engaged and gets kicked out or quits. High risk offenders are trouble. These are the guys that don't do anything well and you don't want them around. You need a certain level of patience to work with these guys and it needs to be backed up by intellectual understanding that it is worth working with these difficult guys. If you are able to hang in there with them, you are probably going to make more difference than with the guys that you find easy.
Another problem is if you focus on non criminogenic needs.
A very important problem is that often offenders feel judged or rejected. They are only going to listen to you if you matter to them. The offenders have spend a lot of their life being rejected by others. They have probably had levels of punishment that are well beyond anything that you could inflict on them. The way you are going to make a difference is that you as a therapist have to become an important person in their lives. You have to matter to them. Once you are able to do that, they may listen or at least be willing to hear something. That is a continuous back and forth. You loose them and bring them back.
Another way that it goes wrong, especially in the early stages of therapy, is that criminal thinking is rewarded by either blind acceptance of "alternative" subcultu-

res or rewarding candour. When offenders come in we want them to talk about their offending and their offences. We want them to tell what they have done and how they have hurt people. We don't tend to judge but just listen for a long period of time. The offenders will tell these stories and we tell them to tell more. We want them to talk about the things that they have done wrong. And this is in fact reinforcing deviant values and attitudes. And we often get into bonds or relationships. Many of these offenders have a certain amount of personal power and once you have made a connection with somebody, some of these guys have enough power that they drag you somewhere. That is the advantage of working with groups and in teams and have other people observe. Because pulling a whole team is more difficult than pulling an individual. If you get involved with these guys, just be aware of that.

Another problem is that we punish pro social acts. Offenders make criminal decisions and pro social decisions. The high risk offenders are usually very practised in making criminal decisions, such as manipulating, cheating, playing power games and deliberately hurting other people. If they try to do things such as cooperate, be kind or help, they may be not so good at it. What often happens is that when they make little baby steps in the right direction, they do it really badly. So it doesn't work and is rejected in their environment and we also may punish them for that. To recognise that this is a sincere effort to do something right, even if it looks wrong, is important.

Another issue that I want to raise is that involuntary clients are hard to change. With the really coerced clients you don't see treatment effects, even for good programs. On average if you get individuals that don't want to be there and are only there because they are forced to, it is really hard to make a difference. You have to have some engagement of the offenders. That is a continuous struggle in the type of programs that the Advisory Board in Holland is concerned about.

Offender programs in the correctional service of Canada

In Canada a treatment for high risk offenders is divided into two distinct systems. We have a federal system, which is a correctional system (for people who have committed a crime and have a mental disorder and who follow a mental health route within the correctional system) and we also have thirteen different provincial systems (for people who are not guilty by reason of insanity or not criminally responsible by reason of mental disorder). Each of the provincial systems is different and very considerably at that. Some of them are quite sophisticated and some of them are non functional.

The programs within the correctional service of Canada have an explicit adherence to risk, need and responsivity at a systems level. What that means is that there is little or no treatment for the low risk offenders and there are increasing levels of intervention as the risk goes up. The programs are always changing, but I will give you a description of what they are roughly like. In general you have multiple programs. They are structured and most people would get something like basic cognitive behaviour therapy, as well as some education and employment interventions. For the moderate and high risk guys we have specialized programs to do with things like violence, domestic violence, substance abuse and sexual offending. They are all separate programs and there is some emphasis on integrating them.

The programs are accredited according to the following criteria:

- They need to have an explicit, empirically-based model of change.
- It has to target criminogenic needs.
- It needs to use effective methods.
- It has to be skills oriented.
- It must have evidence of responsivity.
- There has to be evidence of program intensity as appropriate to the risk level.
- There has to be a continuity of care. So that when the offender finishes the program, there is the expectation of follow up in the community or in other programs within the institution.
- There has to be some level of monitoring and evaluation. It is not just enough to set up a program and have it run, but there need to be mechanics to make sure that it is still running and that it is doing the things that you want it to do.

There is a supervised release in our system. There is an expectation that a third of the sentence will be served in the community. How much treatment is needed or more to the point how much treatment do we give them? We have regional assessment centers where we divide people up according to risk and need. With sex offenders we look at the history of crimes, deviant sexual interests, antisocial orientation, attitudes tolerant of sexual offending, problems in emotional management and motivation to change. Motivation to change is not a risk factor, but it is a responsivity factor. Engaging people in treatment requires them to be motivated. We use explicit risk assessment tools, such as Static-99, STABLE-2007 and the VPS sex offender version. All three of them are used for sex offenders.

We have moderate security institutions. These are the places which are not continuously locked down. There is free association amongst the offenders. They can meet in groups. The treatment is approximately ten hours a week for about four or five months. The high intensity treatments are about eight to nine months of intervention, typically followed up by further interventions in less secured settings. And special needs patients, like the tbs population in Holland, have about twelve months of daily intervention. These are people who have limited cognitive ability or a significant psychiatric overlay that would make it difficult for them to pick up the materials. We do provide low intensity treatments, just because we have to, but we don't believe it does much. We provide maintenance for all sex offenders of about one to four times per month. The high intensity treatment is a manualized group treatment. It is cognitive behavioural. We have separate systems for dealing directly with mental health needs. We divide our programming into two separate streams of programming. There is a mental health programming, that deals with things such as psychosis, manic depression, suicide risk and severe personality disorder of the borderline and narcissistic types. We have also programming which deals with criminogenic needs. These would be things such as antisocial personality disorder and criminogenic risk factors. They are treated separately, some times in the same institution, but they are considered as separate programs for the offenders.

General recommendations for treatment of mentally disordered offenders

- Distinguish the criminogenic from the non-criminogenic needs.
- Address the non-criminogenic needs for intrinsic value (relief of suffering), but also as mediators of criminogenic needs. You need to address the mental illness component in order to make the changes on the criminogenic needs. It is a sort of staged process.
- The next step, after you have addressed the mental health needs and somebody is basically functional, is to address the criminogenic needs.

End of presentation

Questions:

The cognitive distortions are coming back as an important issue in treatment. What happened to the cognitive distortions in the STABLE-2007, because we are basically left without a way to measure them?

In an evaluation that I have recently done, we thought of a method of assessing cognitive distortions and we implemented it but it didn't work. That specific procedure was insufficient to identify the type of things that matter. My current thinking is that the cognitive distortions matter in a couple of senses. One is at the deeper schema level. For example pervasive grievance, which we know is a risk factor for all sort of crimes, is usually motivated by a generalized perception that people are out to get you. And it is that deeper perceptual level which matters. The other sense that we are exploring has to do with the theory of planned behaviour, a different way of assessing attitudes. In the theory of planned behaviour attitudes have to do with attitudes supportive and attitudes contrary. I think that we have just been looking at the attitudes that are supportive of crime, without looking at the attitudes contrary. Asking questions like 'if you committed a sex offence, what would be the good things that come of it' and 'if you didn't commit a sex offence, what would be the good things'. I think we can get more nuanced ways of asking the questions. With the STABLE-2007 we have just re-analyzed the datasets with attitudes, separating out the context. We divided the risk assessments in ones that assess attitudes in an adversarial context (such as probation and conditional release assessments) and ones that do them in a voluntary context (a treatment context). And what you find is that in the volunteer context, attitude predicts pretty well. In the adversarial context the outcome is zero. They are not going to tell you and it is really hard to get it in adversarial context.

How long does the treatment of patients in Canada take?

With the high risk offenders it is largely organized by dosage as opposed to by calendar years. A typical high risk offender would spend a year or two in pretty active treatment. High risk offenders probably get daily treatment for close to a year plus some. If you look at their sentence length they are spending about four to six years in the system. The first couple of years they are typically just learning how to live in the institution and then they are probably given treatment programming for a year to two years and then there is a release follow up after that.

In Holland the clinics take the patients at random, regardless of their decease or the offence that they have committed. What do you think about that?

We haven't worked that way. There is some movement now in our system to spend less time with specialized treatments and more time with generic treatments. The reason for that is that the core correctional needs are pretty similar. There is a fair overlap. You do have some population management issues with mixes of that nature and often they are at very different stages. So we haven't done it, but there is some interest in having a more integrated program with less differentiation, for cost efficiency methods primarily.

Hoofdstuk 6
Verslag middagdeel seminar

Tijdens het middagdeel van het seminar heeft dr. R. Karl Hanson het kantoor van het Adviescollege Verloftoetsing TBS bezocht en aldaar met de leden van het college gesproken. Hanson heeft een nadere toelichting gegeven op het systeem in Canada en diverse vragen van de leden van het adviescollege over risicotaxatie en behandeleffectiviteit beantwoord. De belangrijkste uitkomsten van dit onderhoud zijn hieronder opgenomen.

Canada
Canada heeft 30 miljoen inwoners. Er zitten in Canada 17.000 veroordeelden in het federale systeem die zijn veroordeeld op basis van *not guilty because of reasons of insanity* of *not fit to stand trial*. Twintig procent van die veroordeelden zijn hoog risico daders. Dat zijn er in totaal derhalve ruim 3.000. Er zijn in Canada verschillende niveaus van beveiliging. In de zogenaamde *provincial institutions* zitten 200 à 300 personen per instelling. De meeste patiënten zitten echter in het normale gevangeniswezen.

Er zijn in Canada zogenaamde *review boards*, waarin twee medewerkers uit de gezondheidszorg zitten alsmede twee andere leden. Eén van deze twee andere leden is een lid uit de gemeenschap, die uit professioneel oogpunt bij de materie betrokken is. Sommige van deze leden uit de gemeenschap zijn advocaten van slachtoffers. De *review boards* nemen geen beslissingen op microniveau zoals het adviescollege, maar nemen meer beslissingen op hoofdlijnen, bijvoorbeeld of een patiënt naar een half open inrichting kan. Ze laten zich niet uit over individueel verlof. De *review boards* zijn onafhankelijk en ondervinden in Canada geen oppositie.
Ten aanzien van de vraag hoe men in Canada omgaat met de berichtgeving van de pers op het moment dat er een recidive plaatsvindt, geeft Hanson aan dat er in Canada de politieke wil is om een dergelijke storm te doorstaan. Je moet een simpele reactie richting de politiek geven, namelijk dat je moet leven met de realiteit. In Canada is er voorts de zogenaamde John Howard society. Dit is een christelijke vrijwilligersorganisatie voor de rehabilitatie van forensische patiënten en zij zijn een belangrijke stem geworden in het debat. Je hebt dergelijke organisaties nodig als niveau c.q. stem tussen de politiek en de maatschappij. In Canada nemen de gemeenschappen voorts de verantwoordelijkheid voor de re-integratie van hoog risico patiënten die vrij komen. Zij begeleiden de patiënten na hun vrijlating nog jaren. Deze begeleiding wordt gedaan door groepen vrijwilligers van slachtofferorganisaties. Zij zijn een krachtige spreekbuis voor succesvolle resocialisatie. Er is één aangewezen official die de vrijwilligers selecteert.

Naar ervaring doen personen met een antisociale persoonlijkheidsstoornis het in Canada beter in het normale gevangeniswezen dan in psychiatrische instellingen. Als er een grote groep van dergelijke patiënten in een psychiatrische instelling zit, dan leert de ervaring dat zij daar leidend worden. Ze functioneren beter tussen ‘normale’ criminelen. Het is daarbij belangrijk dat de specifieke *criminogenic needs* worden behandeld.

Wat betreft de effectiviteit van de behandeling is er volgens Hanson momenteel geen noodzaak voor betere programma’s of meer onderzoek, maar wel voor een beter management. Het personeel kent de regels vaak niet waaronder zij werken. Je kunt een goede praktijk niet opleggen. Dat is een organisch proces met het geven en

ontvangen van feedback en het opdoen van ervaring. Er moet een atmosfeer worden gecreëerd waarin mensen graag willen werken en waarin patiënten behandeld willen worden. Daar zijn geen speciale opleidingen voor. Dat moet al doende geleerd worden in de instelling. Goede training en goed management zijn daarbij van belang.

Wat betreft de opbouw van databases heeft Canada verschillende systemen:

- *National criminal records;* deze zijn goed te gebruiken voor onderzoek, maar zijn niet gelinkt aan de psychiatrische zorg.
- *Mental health records* in de provincies; het nadeel is dat deze verdwijnen op het moment dat je verhuist naar een andere provincie.
- De regering kan iemand in het systeem oormerken als een hoog risico dader, zelfs als de laatste delicten geen lange gevangenisstraf rechtvaardigen. Het oormerk wordt gebaseerd op het volledige dossier.

Behandelduur

De behandelduur in Nederland van gemiddeld acht jaar is lang te noemen. Je hebt een goede wetenschap nodig om te kunnen bepalen of de behandeling heeft gewerkt. Je moet het kunnen verantwoorden als je hoog risico daders eerder vrij laat. De enige indicatie dat het risico is verminderd, is om een graduele vrijlating te creëren zodat kan worden beoordeeld of de behandeling heeft gewerkt.

Welke patiënten zijn het moeilijkst te taxeren en wat kan daarbij worden gedaan?

Hanson raadt het gebruik van actuele risicotaxatieinstrumenten aan, zoals de HCR-20, VRAG, Static 99 en STABLE. Je moet het instrument kiezen dat het beste bij de setting past. Zelden zullen alle instrumenten dezelfde uitkomsten vertonen. Je moet de verschillende resultaten trachten te interpreteren. Het is lastig om te bepalen wat de resultaten precies betekenen. Je begint met het bewijs en gaat van daaruit verder. Je moet daarbij naar de *individual propensities* van de patiënt kijken.

Moeilijke gevallen zijn die zaken waarin je risicofactoren ziet, maar waar er geen bewijs voor aanwezig is. Hanson geeft aan het meest moeite te hebben met intelligente, oneerlijke patiënten. Bij die patiënten moet je bepaalde gedragsindicatoren creëren. Je moet manieren vinden om ze te verleiden tot deviant gedrag.

De leugendetector wordt in Canada gebruikt als onderdeel van de behandeling. De manier waarop de leugendetector wordt opgezet, maakt het verschil. Als je op een goede manier naar de test toewerkt en de sfeer opbouwt, dan krijg je al vrij snel informatie. Als je het goed opbouwt, vindt er al veel substantiële openheid plaats voordat de daadwerkelijke test plaatsvindt. Je moet de patiënten vragen naar hun risicogedrag. De helft van de seksuele delinquenten vertelt dan al onmiddellijk wat ze hebben gedaan of wat hun voorkeuren zijn.

Een PBG-test is goed voor patiënten met interesse in kinderen. In de meeste gevallen heb je het echter niet nodig, omdat het verleden van de patiënt duidelijk is en de patiënt bekend heeft. Als ze de delicten ontkennen, dan leren de patiënten door middel van de test veel over hun eigen gedrag en interesses. Ze zijn zelf vaak verbaasd hoe ze reageren op foto's van kinderen.

Het is belangrijk om te onthouden dat mensen nooit compleet veranderen. Ze blijven bepaalde gewoontes houden. Het drinken van alcohol is bijvoorbeeld nooit het probleem. Het drinken is alleen een *facilitator* voor het delict.

Psychopathie is een dimensie en zelf geen risicofactor. Factor 2 voorspelt, maar factor 1 niet. De zogenaamde *acturial results* zijn niet perfect, maar ze zijn alles wat er is. Met het principe van *evidence based* wordt het steeds beter. Dat heeft een belangrijk effect op het beter maken van de behandeling. Het gaat om een accumulatie van kennis, gebaseerd op een groep data. De huidige instrumenten werken redelijk goed bij het bepalen van de risicofactoren. Niet bekend is of het risico in de behandelsetting is veranderd.

Na het bereiken van een bepaalde leeftijd zie je bij hoog risico daders een teruggang in het aantal recidives. Dus ze veranderen wel als ze ouder worden. Hoog risico vrouwen zijn gelijk aan medium risico mannen. Mensen met een verstandelijke beperking hebben veel meer *criminogenic needs* dan mensen zonder beperking. Mensen met een lage intelligentie lijken meer hoog risico te zijn en in sommige gevallen zijn ze dat ook. Een hoge intelligentie is een beschermende factor.

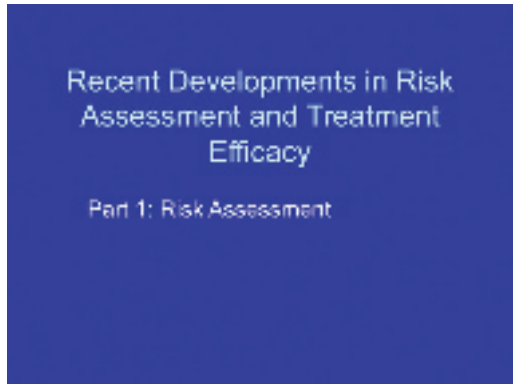
Libidoremmers

Libidoremmende medicatie wordt in Canada gebruikt in een bepaalde selectie zaken. Er is niet echt een goed onderzoek naar de effectiviteit van de medicatie. Het testosteron vermindert met leeftijd. Als je dat proces kan versnellen, dan is dat positief. Je moet de patiënt daarbij aan jouw kant krijgen. Ze moeten denken dat het in hun eigen belang is om de medicatie te nemen.

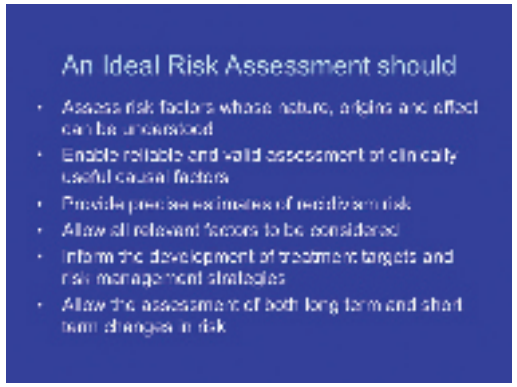
Bijlage 1

Presentatie Risk assessment, dr. R. Karl Hanson

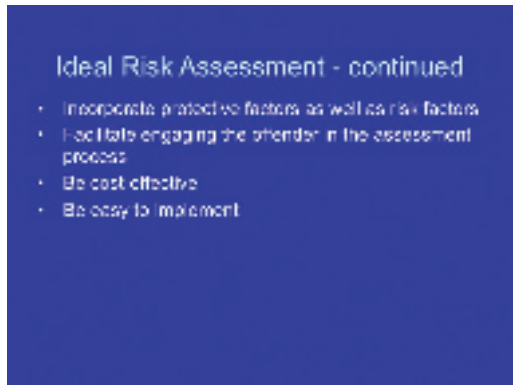
Slide 1/40



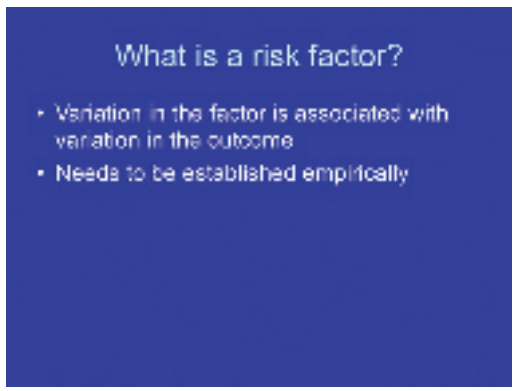
Slide 2/40



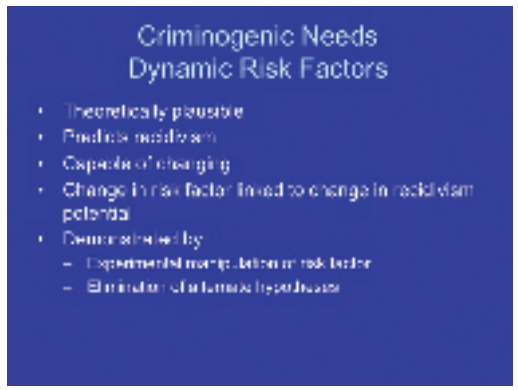
Slide 3/40



Slide 4/40



Slide 5/40



Slide 6/40

Risk Factor Meta-Analyses

- Bonta, Law & Hanson, 1998
- Gendreau, French & Gendreau, in press
- Gendreau, Goggin & Smith, 2002
- Gendreau, Little & Goggin, 1996
- Hanson & Bussiere, 1998
- Hanson & Morton-Bourgon, 2004, 2005
- Hanson & Morton-Bourgon, 2009

Slide 7/40

Variable	Adult Corrections Any Recid.	MDO Violent Recidivism	Sex Offenders Sexual
Age	-.11	-.16	-.13
Minority	.17	.12	.03
Prior Offences			
Juvenile	.13	.27	.12
Adult	.17	.19	.13
Violent index		.00	.04

Slide 8/40

Variable	Adult Corrections Any Recid.	MDO Violent Recidivism	Sex Offenders Sexual
Bad Friends	.21		.13
Substance Abuse	.10	.06	.03
Antisocial PD	.18	.18	.14
Personal Distress	.05	.01	-.01
Psychosis	.03	-.04	-.01
Deviant Sexual Interests			.15

Slide 9/40

Andrews & Bonta's (2006) Criminogenic Needs

- Antisocial Personality
  - Impulsive, adventurous pleasure seeking, restlessly aggressive, callous disregard for others
- Grievance/hostility
- Antisocial associates
- Antisocial cognitions
- Low attachment to Family/Lovers
- Low engagement in School/Work
- Aimless use of leisure time
- Substance Abuse

Slide 10/40

Non-criminogenic needs (general recidivism)

- Personal distress
- Major mental disorder
- Low self-esteem
- Low physical activity
- Poor physical living conditions
- Low conventional ambition
- Insufficient fear of official punishment

Slide 11/40

Criminogenic Needs for Sexual Recidivism A-list (3+ Prediction Studies)

- Deviant sexual interests
  - Children
  - Sexualized Violence
  - Multiple Paraphilias
- Sexual preoccupations
- Antisocial orientation
  - Lifestyle instability
  - Unstable employment
  - Resistance to rules and supervision
  - Antisocial Personality Disorder

Slide 12/40

Criminogenic Needs for Sexual Recidivism A-list (3+ Studies)

- Offence-Supportive Attitudes
- Intimacy deficits
  - Emotional congruence with children
  - Lack of stable love relationships
  - Conflicts in intimate relationships
- Negative Social Influences
- Poor Cognitive Problem-Solving
- Grievance/Hostility

Slide 13/40

Criminogenic Needs for Sexual Recidivism B-list (at least one prediction study)

- Sexualized coping
- Callousness/Lack of concern for others
- Poor emotional control
- Hostile beliefs about women
- Adversarial sexual orientation
- Machiavellianism

Slide 14/40

Factors Unrelated to Sexual Recidivism

- Victim empathy
- Denial/minimization of sexual offence
- Lack of motivation for treatment
- Internalizing psychological problems
  - Anxiety, depression, low self-esteem?
- Sexually abused as a child
- Low sex knowledge
- Poor dating skills/Social skills deficits
- Hallucinations/delusions

Slide 15/40

Variable	Any Recidivism	Violent Recidivism	Sexual Recidivism
HCR-20		.22	.19
LSI/LSI-R	.10	.27	.22
PCL/PCL-R	.27	.26	.14
SIR Scale	.42	.22	.24
VRAG		.31	.25

Slide 16/40

Variable	Any Recidivism	Violent Recidivism	Sexual Recidivism
Static-99	.27	.25	.31
Static-2002	.31	.32	.34
SVR-20	.18	.28	.32
MnSOST-R	.21	.16	.36
SORAG	.10	.36	.30

Slide 17/40

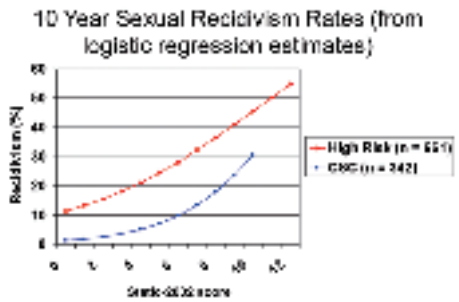
Actuarial – Empirical (Sex Recidivism)

	d (95% CI)	N (k)
Static 99	.67 (.62-.72)	20,010 (33)
RRASOR	.60 (.54-.65)	11,031 (34)
Static-2002	.70 (.59-.81)	3,330 (8)
MnSOST-R	.76 (.65-.87)	4,672 (12)
Risk Matrix –2000	.67 (.56-.77)	2,755 (13)

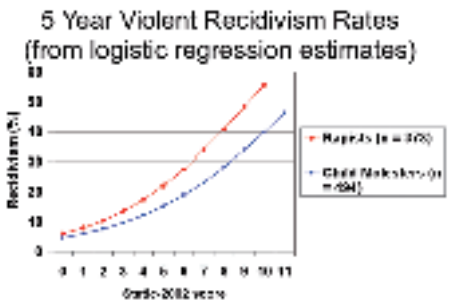
Slide 18/40

- Relative Risk
  - Higher/lower than another offender
- Absolute risk
  - E.g., 45% violent recidivism rate after 10 years.

Slide 19/40



Slide 20/40



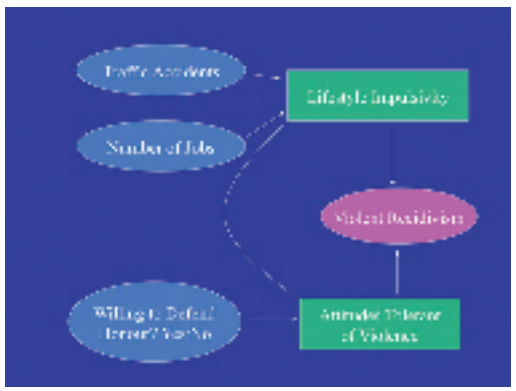
Slide 21/40

How do risk factors cause recidivism?

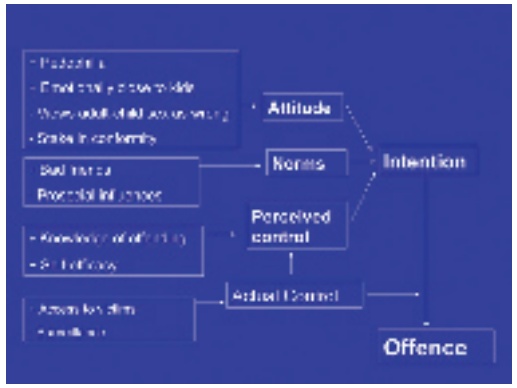
- Linear Theory
- Dimensional Theory
- Psychological Theory
  - E.g., Theory of Planned Behaviour (Ajzen)

Slide 22/40

Slide 23/40



Slide 24/40

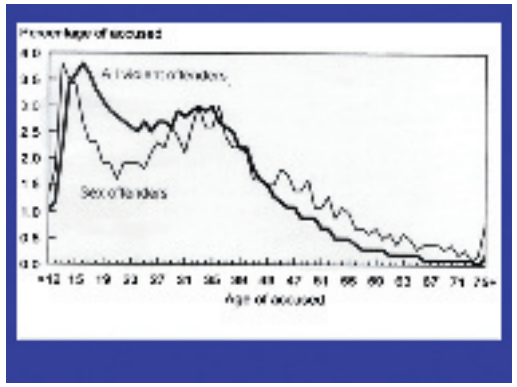


Slide 25/40

Age and Violence

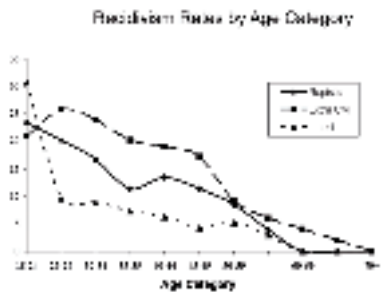
- Young men are more violent than old women (universal and cross-cultural)
- Gradual linear decline from mid 20s onward
- Very low levels in those aged 60+

Slide 26/40



Slide 27/40

Slide 28/40

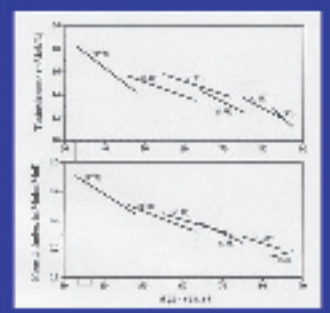


Slide 29/40

Why is age a predictor?

- Age is highly correlated with criminogenic factors
  - E.g., unemployed, aimless use of leisure time, impulsive, substance abuse, low stake in conformity
- Independent contribution of age?
  - Declining testosterone levels
  - Declining physical energy and strength
  - Increased emotional self-regulation

Slide 30/40



Slide 31/40

Age as risk factor

- Effective marker
- Most of the existing actuarial risk tools do not fully capture the contribution of advanced age (> 50)
- Unsatisfying explanation

Slide 32/40

Offenders with Traditional Mental Illness

Slide 33/40

Risk for General and Violent Recidivism among Mentally Disorder Offenders

- Compared to other offenders, MDO are the same or lower risk for general recidivism
- Compared to non offenders, major mental disorder increases the risk of violence
- Risk factors for general and violent recidivism among MDOs are the same as those for general offenders (Bonta et al., 1998)
- Individuals with major mental disorders have more criminogenic needs than "normal" non-offenders (Mullen, 2008)

Slide 34/40

Is Major Mental Disorder a Risk Factor for Sexual Recidivism?

	d (95% CI)	N (k)
Severe psychiatrical disorder	-.03 (-.18, .12)	1,266 (8)
With outlier	.24 (.11, .38)	2,783 (8)

Slide 35/40

DSP – Hanson et al.

- Sexual offenders on community supervision in Canada and 2 states
- 108 of 991 had "Ever spent a night in a psychiatric hospital"
- Higher rates of sexual (13.8% vs 6.2%) and violent recidivism (21.5% vs 12.5%)

Slide 36/40

Accuracy of Static-99 and Static-2002 for Sexual Offenders with a history of psychiatric hospitalization (d)

	Static 99	Static 2002
Sexual Recidivism	.95	.77
Sexual or Violent	.95	.94
Sample Size	108	76

Slide 37/40

Risk Assessment with Mentally Disordered Sex Offenders

- Mental disorder is unlikely to be a major causal risk factor for sexual recidivism
- Mentally disordered sexual offenders have lots of criminogenic needs
- Standard risk scales rank order the risk of mentally disordered sexual offenders with high accuracy

Slide 38/40

Challenges/Questions

- Need better theories of recidivism risk
- Consistency of risk communication
  - E.g., meaning of "high", "moderate", "low"
- Evaluation of change in high risk offenders
- Interpreting multiple risk scales

Slide 39/40

Recommendations for Risk Assessment

- Focus risk assessment on empirically validated risk factors
- Routinely use structured methods for combining risk factors
- Anchor risk communication in non-arbitrary metrics (e.g., recidivism rates, percentiles, risk ratios)
- Be conscientious (methods for quality control)
- Remember that people are not fully predictable

Slide 40/40

Bijlage 2
Presentatie Treatment efficacy, dr. R. Karl Hanson

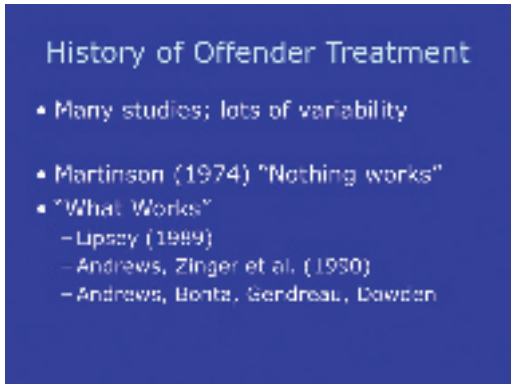
Slide 1/36

Slide 2/36

Slide 3/36

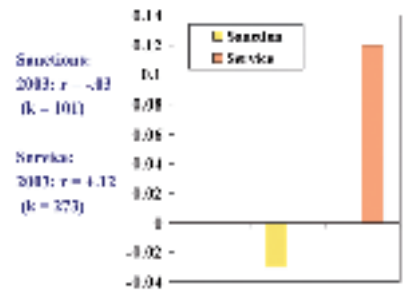
Slide 4/36

Slide 5/36



Slide 6/36

Sanctions or Service?



Slide 7/36

Effective Correctional Interventions

- Risk
  - Treat only offenders who are likely to reoffend (moderate risk or higher)
- Need
  - Target criminogenic needs
- Responsivity
  - Match treatment to offenders' learning styles and culture

Slide 8/36

Results Stable Across Studies

- Same results found in randomized clinical trials and non-random assignment studies (except those with obvious biases)
- Meta-analytic findings replicated by independent groups

Slide 9/36

Criminogenic Needs

- Antisocial Personality
  - Impulsive, adventurous pleasure seeking, restlessly aggressive, callous disregard for others
- Grievance/hostility
- Antisocial associates
- Antisocial cognitions
- Low attachment to Family/Lovers
- Low engagement in School/Work
- Aimless use of leisure time
- Substance Abuse

Slide 10/36

Non-criminogenic needs (general recidivism)

- Personal distress
- Major mental disorder
- Low self-esteem
- Low physical activity
- Poor physical living conditions
- Low conventional ambition
- Insufficient fear of official punishment

Slide 11/36

Criminogenic Needs for Sexual Offenders

- Deviant sexual interests
  - Children; Paraphilias
- Sexual preoccupations
- Antisocial orientation
  - Lifestyle instability, rule violation, APD
- Attitudes tolerant of sexual assault
- Intimacy deficits
  - Emotional identification with children
  - Lack of stable love relationships

Slide 12/36

Adherence to Risk/Need/Responsivity

	r (k)
Not at all	.02 (174)
One element	.03 (106)
Two elements	.17 (84)
All three	.25 (60)

Slide 13/36

Effective Programs

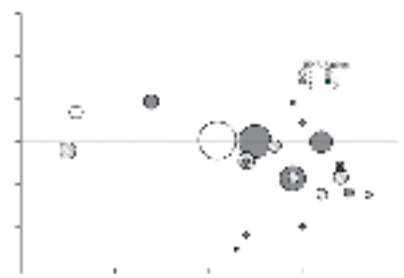
Program	d (k)	Meta analysis
Multisystemic Treatment	.50 (7)	Curtis et al. (2004)
Moral Reconation Therapy	.36 (6)	Wilson et al. (2005)
Reasoning & Rehabilitation	.07 (25)	Tong & Farrington (2006)

Slide 14/36

Risk/Need/Responsivity and reductions in sexual recidivism for sex offenders

	r (k)
Not at all	.05 (3)
One element	.13 (7)
Two elements	.14 (9)
All three	.43 (3)

Slide 15/36



Slide 16/36

Implementation is Difficult

Adherence to R/N/R	Demonstration r (k)	Real r (k)
Not at all	.01 (1)	-.02 (93)
One element	.07 (7)	.04 (71)
Two elements	.31 (10)	.09 (16)
All three	.34 (23)	.15 (10)

Slide 16/36

Keys to Effective Implementation

- Screen staff for relationship skills
- Print/tape manuals
- Train staff
- Start small

Slide /36

	No	Yes
	r (k)	r (k)
Staff selected for relationship skills	.07 (361)	.34 (13)
Printed/taped manuals	.05 (303)	.20 (71)

Slide 21/36

Characteristics of Effective Therapists with Offenders

- Able to form meaningful relationships with offenders
  - Warm, accurate empathy, rewarding
- Provide prosocial direction
  - Skills, problem-solving, values

Slide 20/36

How it goes wrong

- Risk
  - Same program for all, regardless of risk/need
  - Low risk offenders introduced to high risk offenders
  - High risk cases excluded from treatment (by self and program)
- Focus on non-criminogenic needs

Slide 21/36

How it goes wrong

- Offender feels judged/rejected
- Criminal thinking rewarded
  - Blind acceptance of "alternative" subcultures
  - Rewarding candour
  - Procriminal attitudes of staff
  - Bonding/collusion with offenders
- Punishing Prosocial Acts
  - Prosocial incompetence

Slide 22/36

How it goes wrong

- Difficulty changing involuntary clients
  - Farhar et al., 2008

Slide 23/36

Offender Programs in the Correctional Service of Canada

- Explicit adherence to Risk/Need/Responsivity at a systems level
- Little or no treatment to low risk offenders
- Multiple programs
  - Cognitive skills
  - Education/employment
- Moderate/High Intensity Treatment
  - Violence
  - Domestic Violence
  - Substance Abuse
  - Sexual Offending

Slide 24/36

Accreditation Criteria for the Correctional Service of Canada

- Explicit, empirically-based mode of change
- Targeting criminogenic needs
- Effective methods
- Skills oriented
- Responsivity
- Program Intensity
- Continuity of Care
- Ongoing monitoring and evaluation

Slide 25/36

Community Follow-up

- Supervised release
- Expectation that 1/3 of sentence will be served in the community
- Long-term offenders (up to 10 years)

Slide 26/36

How Much Treatment is Needed?

Slide 27/36

Criteria for Treatment Intensity Sexual Offenders

- History of sexual crimes
- Deviant sexual interests
- Antisocial orientation
- Attitudes tolerant of sexual offending
- Problems in emotional management
- Motivation to change

Slide 28/36

Sexual Offender Assessment

- Static-99 (Harris et al., 2003)
- STABLE-2007 (Hanson et al., 2007)
- VPS-SO (Olver et al., 2007)

Slide 29/36

Recommended Treatment Intensity for Sexual Offenders

20 % High

58 % Moderate

22 % Low

Slide 30/36

Moderate Intensity

- Moderate security institutions
- 10 hours per week for group meetings
- 4-6 months

Slide 31/36

High Intensity

- Specialized Unit (one per region)
- Daily sessions
- 15 hours per week for group meetings
- Additional individual sessions
- 6-9 months

Special needs (cognitive, psychiatric)

- Up to 12 months

Slide 32/36

Low Intensity

- In community (4 – 8 months)
- In institution (2 – 4 months)
- 2- 5 hours per week for group meetings

Maintenance

- All treated sexual offenders
- 1- 4 contacts per month

Slide 33/36

High Intensity Treatment

- Residential
- Specialized Settings
- Manualized group treatment
  - Cognitive behavioural
  - 6-8 months – daily
- Mental health needs are distinguished from criminogenic needs (separate services)

Slide 34/36

CSC High Intensity Treatment

- Treatment readiness (motivational interviewing)
- Attitudes – thinking affects behaviour
- Emotional self-management
- Explicit focus on criminogenic needs
- Offence chain/relapse prevention
- Release planning

Slide 35/36

Recommendations for Treatment of Mentally Disordered Offenders

- Distinguish criminogenic from non-criminogenic needs
- Address non-criminogenic needs
  - Intrinsic value (relief of suffering)
  - As mediators of criminogenic needs
- Address criminogenic needs to reduce crime and violence

Slide 36/36

Bijlage 3
References and recommended readings

Risk assessment - General

- Andrews, D.A. & Bonta, J.S. (2006). The psychology of criminal conduct (4th ed). Cincinnati, OH: Anderson.

- Andrews, D.A., Bonta, J., & Wormith, J.S. (2006). The recent past and near future of risk and/or need assessment. Crime and Delinquency, 52, 7-27.

- Bonta, J. (1996). Risk-needs assessment and treatment. In A.T. Harland (Ed.), Choosing correctional options that work: Defining the demand and evaluating the supply (pp. 18-32). Thousand Oaks, CA: Sage.

- Bonta, J., Bogue, B., Crowley, M., & Motiuk, L. (2001). Implementing offender classification systems: Lessons learned. In G. A. Bernfeld, D.P. Farrington, & A.W. Leschied (Eds.), Offender rehabilitation in practice (pp. 227-245). Chichester, NY: Wiley.

- Bonta, J., & Wormith, J. (2008). Risk and need assessment. In G. Mclvor & R. Raynor (Eds.). Developments in social work with offenders (pp. 131-152). London, England: Jessica Kingsley Publishers.

- Hanson, R.K. (1998). What do we know about sexual offender risk assessment? Psychology, Public Policy and Law, 4, 50-72.

- Hanson, R.K. (2005). Twenty years of progress in violence risk assessment. Journal of Interpersonal Violence, 20(2), 212-217.

- Hanson, R.K. (in press). The psychological assessment of risk for crime and violence. Canadian Psychology/Psychologie canadienne.

- Hilton, N.Z., Carter, A.M., Harris, G.T., Sharpe, A.J.B. (2008). Does using nonnumerical terms to describe risk aid violence risk communication: Clinician agreement and decision making. Journal of Interpersonal Violence, 23, 171-188.

- Jackson, R.L., & Hess, D. T. (2007). Evaluation for civil commitment of sex offenders: A survey of experts. Sexual Abuse: A Journal of Research and Treatment, 19, 409-448.

- Kraemer, H.C., Kazdin, A.E., Offord, D.R., Kessier, R.C., Jensen, P.S., & Kupler, D.J. (1997). Coming to terms with the terms of risk. Archives of General Psychiatry, 54, 337-343.

Risk Assessment Measures

- Andrews, D.A., Bonta, J., & Wormith, J.S. (2008). Level of Service/Case Management Inventory (LS/CMI). Toronto: Multi-Health Systems.

- Banks, S., Robbins, P.C., Silver, E., Vesselinov, R., Steadman, H.J., Monahan, J., Mulvey, E.P., Appelbaum, P.S., Grisso, T., & Roth, L.H. (2004). A multiple-models approach to violence risk assessment among people with mental disorder. Criminal Justice and Behavior, 31, 324-340.

- Boer, D.P., Hart, S.D., Kropp, P.R., & Webster, C.D. (1997). Manual for the Sexual Violence Risk - 20: Professional guidelines for assessing risk of sexual violence. Vancouver, British Columbia: The British Columbia Institute Against Family Violence.

- Borum, R., Bartel, P., & Forth, A. (2006). SAVRY: Structured Assessment of Violence Risk in Youth: Professional manual. Lutz, FL: Psychological Assessment Resources.

- Douglas, K.S., Guy, L.S., & Weir, J. (2006). HCR-20 violence risk assessment scheme: Overview and annotated bibliography. Retrieved January 15, 2009, from http://www.sfu. ca/psyc/faculty/hart/resources.htm

- Epperson, D.L., Kaul, J.D., Huot, S.J., Goldman, R., & Alexander, W. (2003). Minnesota Sex Offender Screening Tool — Revised (MnSOST-R) technical paper: Development, validation and recommended risk level cut scores. Retrieved January 23, 2009 from http:/www.psychology.iastate.edu/faculty/epperson/TechUpdatePaper12-03. pdf

- Hanson, R.K., Harris, A.J.R., Scott, T., & Helmus, L. (2007). Assessing the risk of sexual offenders on community supervision: The Dynamic Supervision Project. Corrections User Report No 2007-05. Ottawa: Public Safety Canada.

- Hanson, R.K., Helmus, L., & Thornton, D. (in press). Predicting recidivism among sexual offenders: a multi-site study of Static-2002. Law and Human Behavior.

- Hanson, R.K., & Thornton. D. (2000). Improving risk assessments for sex offenders: A comparison of three actuarial scales. Law and Human Behavior, 24, 119-136.

- Hare, R.D. (2003). Manual for the Psychopathy Checklist — Revised (2nd ed.). Toronto, Ontario: Multi-Health Systems.

- Harris, A., Phenix, A., Hanson, R.K., & Thornton, D. (2003). Static-99 coding rules: Revised 2003. Ottawa: Department of the Solicitor General of Canada. www.publicsafety.gc.ca

- Hilton, N.Z., Harris, G.T., Rice, M.E., Lang, C., Cormier, C.A., & Lines, K.J. (2004). A brief actuarial assessment for the prediction of wife assault recidivism: The Ontario Domestic Assault Risk Assessment. Psychological Assessment, 16, 267-275.

- Olver, M.E., Wong, S.C.P., Nicholaichuk, T., & Gordon, A. (2007). The validity and reliability of the Violence Risk Scale — Sexual Offender Version: Assessing sex offender risk and evaluating therapeutic change. Psychological Assessment, 19, 318-329.

- Otto, R.K. & Douglas, K. (Eds.). (in press). Handbook of violence risk assessment tools. Milton Park, UK: Routledge.

- Quinsey, V.L., Harris, G.T., Rice, M.E., & Cormier, C.A. (2006). Violent offenders: Appraising and managing risk (2nd Ed.). Washington, DC: American Psychological Association.

- Worling, J.R., & Curwen, T. (2001). The ERASOR: Estimate of risk of adolescent sexual offense recidivism (Version 2.0). Toronto, Ontario: SAFE-T Program, Thistletown Regional Centre.

Risk Prediction Meta-Analyses

- Bonta, J., Law, M., & Hanson, R.K. (1998). The prediction of criminal and violent recidivism among mentally disordered offenders: A meta-analysis. Psychological Bulletin, 123(2), 123-142.

- Campbell, M.A., French, S., & Gendreau, P. (in press). The prediction of violence in adult offenders: A meta-analytic comparison of instruments and methods of assessment. Criminal Justice and Behavior.

- Gendreau, P., Goggin, C., & Smith, P. (2002). Is the PCL-R really the “unparalleled” measure of offender risk? Criminal Justice and Behavior, 29, 397-426.

- Gendreau, P., Little, T., & Goggin, C. (1996). A meta-analysis of the predictors of adult offender recidivism: What works! Criminology, 34, 575-607.

- Hanson, R.K., & Bussière, M.T. (1998). Predicting relapse: A meta-analysis of sexual offender recidivism studies. Journal of Consulting and Clinical Psychology, 66(2), 348-362.

- Hanson, R.K., & Morton-Bourgon, K. (2004). Predictors of sexual recidivism : An updated meta analysis. Corrections User Report No. 2004-02: Public Safety and Emergency Preparedness Canada. www.publicsafety.gc.ca

- Hanson, R.K., & Morton-Bourgon, K.E. (2005). The characteristics of persistent sexual offenders: A meta-analysis of recidivism studies. Journal of Consulting and Clinical Psychology, 73, 1154-1163.

- Hanson, R.K., & Morton-Bourgon, K.E. (2009). The accuracy of recidivism risk assessments for sexual offenders: A meta-analysis of 118 prediction studies. Psychological Assessment, 21, 1-21.

Treatment outcome

- Bonta, J., & Andrews, D. A. (2007). Risk-need-responsivity model for offender assessment and rehabilitation (Corrections Research User Report No. 2007-06). Ottawa, ON: Public Safety Canada. www.publicsafety.gc.ca

- Bourgon, G., & Armstrong, B. (2005). Transferring the principles of effective treatment into a real world prison setting. Criminal Justice and Behavior, 32, 3-25.

- French, S.A., & Gendreau, P. (2006). Reducing prison misconducts: What works! Criminal Justice and Behavior, 33, 185-218.

- Hanson, R.K., Bourgon, G., Helmus, L., & Hodgson, S. (2009). A meta-analysis of the effectiveness of treatment for sexual offenders : Risk, need and responsivity. Corrections User Report 2009-01. Ottawa: Public Safety Canada. www.publicsafety.gc.ca

- Hanson, R.K., Bourgon, G., Helmus, L., & Hodgson, S. (in press). The principles of effective correctional treatment also apply to sexual offenders : A meta-analysis. Criminal Justice and Behavior.

- Hanson, R.K., Gordon, A., Harris, A.J.R., Marques, J.K., Murphy, W., Quinsey, V.L., & Seto, M.C. (2002). First report of the Collaborative Outcome Data Project on the effectiveness of psychological treatment for sexual offenders. Sexual Abuse: A Journal of Research and Treatment, 14(2), 169-194.

- Landenberger, N.A., & Lipsey, M.W. (2005). The positive effects of cognitive-behavioral programs for offenders: A meta-analysis of factors associated with effective treatment. Journal of Experimental Criminology, 1, 451-476.

- Lipsey, M.W., & Cullen, F.T. (2007). The effectiveness of correctional rehabilitation: A review of systematic reviews. Annual Review of Law and Social Science, 3, 297-320.

- Lösel, F., & Schmucker, M. (2005). The effectiveness of treatment for sexual offenders: A comprehensive meta-analysis. Journal of Experimental Criminology, 1, 117-146.

- Lowenkamp, C.T., Latessa, E.J., & Smith, P. (2006). Does correctional program quality really matter? The impact of adhering to the principles of effective intervention. Criminology & Public Policy, 5, 575-594.

- Parhar, K.K., Wormith, J.S., Derkzen, D.M., & Beauregard, A.M. (2008). Offender coercion in treatment: A meta-analysis of effectiveness. Criminal Justice and Behavior, 35, 1109-1135.

- Tong, L.S.J., & Farrington, D.P. (2006). How effective is the “Reasoning and Rehabilitation” programme in reducing reoffending? A meta-analysis of evaluations in four countries. Psychology, Crime & Law, 12, 3-24.

- Wilson, D.B., Bouffard, L.A., & Mackenzie, D.L. (2005). A quantitative review of structured, group-oriented, cognitive-behavioral programs for offenders. Criminal Justice and Behavior, 32, 172-204.

Age and recidivism

- Barbaree, H.E., & Blanchard, R. (2008). Sexual deviance over the lifespan: Reductions in deviant sexual behaviour in the aging sex offender. In D.R. Laws & W.T. O’Donohue (Eds.), Sexual deviance: Theory, assessment, and treatment (2nd ed.). New York: Guilford.

- Gottfredson, M.R., & Hirschi, T. (1990). A general theory of crime. Stanford, CA: Stanford University Press.

- Hanson, R.K. (2002). Recidivism and age: Follow-up data on 4,673 sexual offenders. Journal of Interpersonal Violence, 17, 1046-1062.

- Hanson, R.K. (2006). Does Static-99 predict recidivism among older sexual offenders? Sexual Abuse: A Journal of Research and Treatment, 18, 343-355.

- Harman, S.M., Metter, E.J., Tobin, J.D., Pearson, J., & Blackman, M.R. (2001). Longitudinal effects of aging on serum total and free testosterone levels in healthy men. Journal of Clinical Endocrinology and Metabolism, 86, 724-731.

- Sampson, R.J., & Laub, J.H. (2003). Life-course desisters? Trajectories of crime among delinquent boys followed to age 70. Criminology, 41, 555-592.

Mental Illness as a risk factor

- Elbogen, E.B., & Johnson, S.C. (2009). The intricate link between violence and mental disorder. Archives of General Psychiatry, 66, 152-161.
- Lamberti, J.S. (2007). Understanding and preventing criminal recidivism among adults with psychotic disorders. Psychiatric Services, 58, 773-781.

- Mullen, P.E. (2006). Schizophrenia and violence: from correlations to preventive strategies. Advances in Psychiatric Treatment, 12, 239-248.

Theory of Planned Behaviour

- Ajzen, I. (2005). Attitudes, personality, and behavior (2 ed.). Milton-Keynes, England: Open University Press. See also http://www.people.umass.edu/aizen/tpb.html

Het Adviescollege Verloftoetsing TBS toetst verlofaanvragen van tbs-gestelden en brengt daarover onafhankelijk advies uit aan de minister. Het beoordeelt verlofaanvragen primair vanuit veiligheidsoogpunt voor de samenleving.

Colofon
Dit verslag is een uitgave van:
Adviescollege Verloftoetsing TBS
Postbus 24019 | 3502 MA Utrecht
T 0880 713 900
secretariaat@avt.minjus.nl
www.verlofadviescollege.nl

Publicatie-nr. 0908 14112