Sex offender risk assessment in the Netherlands: Towards a risk need responsivity oriented approach
Smid, W.

Citation for published version (APA):

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CHAPTER 1
INTRODUCTION
Sexual offending in the Netherlands
High profile sexual offending cases in the media seem to cause more uproar and intense indignation than any other crime. Indeed, sexual offending is arguably regarded as the most reprehensible behavior in western society today. At stark odds with the strong condemnation of these crimes is the scant level of empirical knowledge on the topic. Accordingly, policies run the risk of becoming based on emotions rather than empirical data, which may not produce optimal results. There is no doubt as to what these optimal results should be: a minimum number of victims of sexual crimes. The objective of this thesis is to add to the body of evidence on the topic of sexual offending behavior, and more specifically, on risk assessment in sex offenders, along with its clinical and policy implications. The empirical approach and dispassionate stance of this thesis by no means equals indifference to the topic of sexual offending behavior, let alone its victims. It is the firm belief of the author, however, that a pragmatic, open, and transparent approach to this subject will be most helpful to decrease the number of victims.

The introduction to this thesis provides a rather broad context on the sexual offending in general. The first paragraph describes and presents legal definitions of sexual offending. The next paragraph reports on prevalence estimates of sexual offenses in the Netherlands. The following three paragraphs elaborate on the perpetrators: who are the people who have committed a sexual offense? How likely are they to reoffend, and what can we do to prevent this? The last paragraph describes common policies regarding sex offenders in The Netherlands and introduces the research question underlying this thesis.

Definitions and Penal Codes
‘Contact’ sexual offending (sexual assault, rape, abuse) is generally defined as involving actual sexual interactions with a person who did not give informed consent or who is deemed incapable of giving informed consent. The latter category usually involves children under the ‘age of consent’. Age of consent varies from country to country; in the Netherlands and UK it is defined at 16 years old, in Spain at 13 years old, in Germany at 14 years old, and in large parts of the US at 18 years old. Accordingly, what sexual offending behavior entails exactly varies from country to country. Other reasons why a person may be deemed unable to give informed consent include mental disability, unconsciousness during the sexual interaction, or being in a dependent relationship with the offender, such as a doctor-patient relationship.

Contact sexual offending behavior is contained in the Dutch Penal Code in Articles 242-249 (see Table 1). The criminal sexual conduct is subdivided based on three
characteristics: a) use of physical force (or threat), b) penetration of the victim’s body, and c) age of victim(s). If (threat of) physical force was used in the perpetration of a sexual offense, the Dutch Penal Code refers to the offense as rape or sexual assault, regardless of the age of the victim. When there was penetration, the Penal Code defines the offense as rape, when not the Penal Code defines the offense as sexual assault. If no (threat of) physical force was used, but a victim incapable of informed consent was involved, the offense is referred to as lewd and lascivious behavior (sexual abuse). The Dutch law includes separate Penal Codes for lewd and lascivious behavior with-, and without penetration. Previously, the term penetration referred only to vaginal or anal penetration by the penis. In recent years the definition of penetration has been broadened and also includes oral penetration and digital penetration. The designation of an enforced French kiss as penetration (and therefore rape) was recently reversed on appeal (Van Dorst, De Hullu, Splinter-van Kan, Groos & Jörg, 2013). Finally, the Dutch Penal Code distinguishes age categories. First, there is the distinction between children over and under the age of consent (which in The Netherlands is set at sixteen years old). Second, there is a distinction between children over-, and under the age of 12, as offenses against the latter are considered extra heinous and carry the possibility for longer sentences. Finally, there is a separate Penal Code to indicate the category of victims who were entrusted into the care of the perpetrator (e.g. father/child, teacher/student, doctor/patient). This Code is applicable to both victims under and above the age of consent.

Up to 2002, cases involving victims of 12 years or older could only result in prosecution if the victim or their primary caregivers pressed charges. Since 2002, the public prosecutor has the power to single-handedly decide to prosecute but is obliged to provide the victim with the opportunity to make their views on the prosecution known (Kool, 2007).

In addition to these punishable actual sexual acts, the law also penalizes some sexual behaviors that do not involve direct physical contact with a victim, such as (child) pornography offenses and sexual exposure. These ‘non-contact’ sexual offenses are included in the Penal Code Articles 239 and 240. It is prohibited to expose one’s genitals (exhibitionism) or present pornographic images to people who have not explicitly requested this, or to children under the age of 16. In recent years there have especially been major developments in the Legal Code regarding pornographic material depicting children, i.e. child pornography (CP) (see Table 2). The production of CP material usually includes contact offending and as such has been punishable for many years.
### TABLE 1  BRIEF DESCRIPTION OF RELEVANT ACTS FROM THE DUTCH PENAL CODE CONSIDERING SEXUAL OFFENDING

<table>
<thead>
<tr>
<th>Act</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>239</td>
<td>Exposing of genitals in public places or to children under 16</td>
</tr>
<tr>
<td>240</td>
<td>Unsolicited presenting of pornographic material or in public places</td>
</tr>
<tr>
<td>240a</td>
<td>Presenting of pornographic material to children under 16</td>
</tr>
<tr>
<td>240b</td>
<td>Possession of pornographic material involving children under 18</td>
</tr>
<tr>
<td>242</td>
<td>Rape: penetration of victim with use of force or threat</td>
</tr>
<tr>
<td>243</td>
<td>Abuse: penetration of a victim incapable of consent</td>
</tr>
<tr>
<td>244</td>
<td>Abuse: penetration of a victim under 12</td>
</tr>
<tr>
<td>245</td>
<td>Abuse: penetration of a victim under 16</td>
</tr>
<tr>
<td>246</td>
<td>Sexual assault: lewd acts with use of force or threat, no penetration</td>
</tr>
<tr>
<td>247</td>
<td>Lewd acts with a victim incapable of consent</td>
</tr>
<tr>
<td>248.1</td>
<td>Penalty increase for two or more collaborating offenders</td>
</tr>
<tr>
<td>248.2</td>
<td>Penalty increase for a victim who was entrusted to the care of the offender</td>
</tr>
<tr>
<td>248.3</td>
<td>Penalty increase for severe injury of the victim</td>
</tr>
<tr>
<td>248.4</td>
<td>Penalty increase for death of the victim</td>
</tr>
<tr>
<td>248a</td>
<td>Alluring children under 18 to lewd acts (e.g. offering money)</td>
</tr>
<tr>
<td>248b</td>
<td>Make use of the services of a prostitute under 18</td>
</tr>
</tbody>
</table>

*Note: Italic acts are of relatively recent date (2002 to 2011).*

### TABLE 2  HISTORY OF LEGISLATION CONSIDERING CHILD PORNOGRAPHY OFFENSES

<table>
<thead>
<tr>
<th>Year</th>
<th>Legislation</th>
</tr>
</thead>
<tbody>
<tr>
<td>1886:</td>
<td>Ban on the production of ‘obscene material’</td>
</tr>
<tr>
<td>1911:</td>
<td>Ban on presenting pornography to children under 16</td>
</tr>
<tr>
<td>1986:</td>
<td>Ban on the production, stocking and distribution of pornographic material involving children under 16</td>
</tr>
<tr>
<td>1996:</td>
<td>Ban on the possession of any pornographic image involving children under 16</td>
</tr>
<tr>
<td>2002:</td>
<td>Ban on the possession of any pornographic image involving children under 18</td>
</tr>
<tr>
<td>2010:</td>
<td>Deleted files are allowed as evidence</td>
</tr>
<tr>
<td>2011:</td>
<td>Online sexual acts are equated with contact offenses to allow for higher penalties</td>
</tr>
<tr>
<td></td>
<td>Ban on online grooming of children under 16 with the intent to commit abuse or produce CP</td>
</tr>
</tbody>
</table>
In 1986 the stocking and distribution of CP material (i.e. involving children under 16) became illegal as well, but private possession remained legal. This law was passed specifically to facilitate the prosecution of CP producers and to ward CP (‘teen sex’) magazines off the shelves of shops and gas stations, where they were widely available at the time. The emergence of the Internet provided another boost to the availability of pornography, as it made the production, storage and distribution of audiovisual material easier and cheaper than ever before. Along with pornography in general, the availability of child pornography (CP) has also increased (Wortley & Smallbone, 2006).

In 2006 an estimated 100,000 websites were offering CP material (Ropelato, 2006). This evoked the disconcerting, yet never empirically supported fear that the increased distribution of CP material would automatically lead to an increase in contact child abuse. This increase would partly be induced to ‘serve the market’ and partly because the consumption of CP was supposed to more or less automatically lead to contact offending (Quayle & Taylor, 2003). As a result all possession of CP material was prohibited in 1996. In 2002 the age limit was raised from 16 to 18 years, or more precisely: “anyone who apparently has not reached the age of 18”, (Dutch Penal Code, § 240b, 2002) thus including 18 year olds who (were made to) look younger. Especially this raised age limit increased the number of cases dramatically between 2002 and 2005. In 2010 it became possible to use erased computer files as evidence in CP cases. All in all, the current policy makes it punishable to ever have been in the possession of any sexual images involving anyone looking younger than 18. This age limit is two years above the age of consent in The Netherlands, creating the remarkable situation in which it is legal to have sex with a 16 or 17 year old, but illegal to watch a picture of it. Finally, it should be noted that in 2011, online sexual act involving minors (e.g. ‘sexting’, sexual chatting, webcam sex) have been classified as contact offenses to enable longer sentences. Also, the Netherlands is the first country to penalize grooming, i.e., the process of roping the victim in (which sometimes precedes actual sexual offending behaviors).

**Prevalence**

In the Netherlands, between 2005 and 2010, each year roughly 200,000 people reported having been confronted with unwanted sexual contact (Kalindien, De Heer-De Lange & Van Rosmalen, 2011); women almost five times as often as men (2.4 percent versus 0.5 percent). The majority of these incidents was experienced as ‘unpleasant behavior’ (e.g. sexual harassment, inappropriate comments). About 15 percent of the cases (± 30,000 cases per year) concerned some form of sexual assault or (attempted) rape (Frenken, 2002). Judicial statistics only reflect a small portion of these incidents.
The vast majority of sexual assaults and rapes remain unreported (87% in Kalindien et al., 2011; 83% in Mumsnet Rape and Sexual Assault Survey, 2012) and the vast majority of reported sexual offenses do not lead to a conviction of the perpetrator (90%, Kalindien et al., 2011). Between 2005 and 2010 an average of 12 percent of the total number of incidents was reported to the police.

A substantial minority of the registered suspects (17%) is under 18 years old. Women are a small minority of the suspects. The Dutch registration makes it hard to assess the exact number of women, but international research showed that about 5% of sex offenses are perpetrated by women, usually as co-perpetrators of men (Cortoni, Hanson en Coache, 2010), although some authors have suggested that sexual offenses committed by women may be even more underreported than those committed by men (e.g. Gannon & Rose, 2008).

The possession of CP was penalized in 1996, which inherently resulted in an increase of cases. Raising of the age limit in 2002 from 16 to 18 years old resulted in another large increase of cases. Since 2005, the number of registered CP cases has been relatively stable around an average of 432 cases per year (Dettmeijer-Vermeulen, 2011). The capture of CP downloaders and other online offenders mostly requires active police searching on the Internet. Such searches produce many new leads in relatively short time periods (Algemeen Nederlands Persbureau, 2013a). Accordingly, the stabilizing number of CP cases over the past years is widely assumed to reflect the maximum number the judicial system can process rather than the actual number of men involved in online CP consumption (Jewkes & Andrews, 2005). In other words: if the number of specialized CP detectives is increased over the coming years, the number of prosecuted CP cases is likely to increase as well. The recent penalization of grooming has also naturally resulted in an increase of cases. However, it is becoming clear that the investigation of these offenses consumes a lot of police time and the burden of proof remains problematic. The Minister of Justice is therefore currently investigating the possibility to allow the use of decoy, i.e. police officers posing as children online, in this type of investigations (Algemeen Nederlands Persbureau, 2013b).

The number of registered contact sex offenses declined from 12,699 in 2005 to 9,088 in 2010. The slow but steady decline of registered contact sex offenses falls in line with international data (Finkelhor & Jones, 2004). The declining numbers do not seem to reflect a decrease in the willingness to report sex offenses, since the estimated percentage of unreported cases has remained the same or even slightly decreased over the same time period (Kalindien et al., 2011). These developments may therefore point to an actual decline in the number of contact sex offenses. Possible reasons for this decline have been put forward, but to date none of the explanations have been
generally accepted. The increase in possession of CP and other Internet offending did not seem to have had the feared worsening effect on contact sexual offending. There are even some studies that suggest that the increasing availability of CP may have helped channeling pedophilic desires and contributed to a decrease of contact offending against children (Diamond, Jozífková & Weiss, 2010); this theory too lacks convincing evidence (Kingston en Malamuth, 2011).

### Sexual Deviance

Popular belief often equates sexual offending behavior with sexual disorder: i.e., child molesters are equated with pedophiles and rapists are presumed to be sexual sadists. Likewise, in the theoretical literature, deviant sexual interests have long served as the mono-causal theoretical explanation for sexual offending: offenders were assumed to have a deviant preference for the offending behavior whereas those who did not offend were assumed to have no deviant interests at all. However, reality has turned out to be much more complicated. Sex offenders form a very heterogeneous group of offenders, varying widely in motivation, modus operandi, and choice of victims (e.g. Bickley & Beech, 2001; Poloschek, 2003; Woessner, 2010). Accumulating evidence has indicated that sexual offending behavior does not automatically imply the presence of a (sexual) disorder or sexual deviance; nor does the presence of a sexual disorder or sexual deviance imply the inevitability of sexual offending behavior.

There is an essential difference between interest in unusual sexual interactions and interest in illegal sexual interactions. On the one hand, there is a large number of unusual stimuli that are considered sexually arousing by any number of people: e.g., diapers, stuffed animals, popping balloons, the crushing of insects, etc. No consistent figures on the prevalence of these paraphilic interests are available (Thibaut, De la Barra, Gordon, Cosyns, Bradford, & the WFSBP Task Force on Sexual Disorders, 2010), although most are probably relatively rare. Most of these interests, however, are not illegal as long as the practitioners do not violate the rights of others.

On the other hand, interest in illegal sexual interactions (without informed consent) may not be particularly rare. Studies in normal populations find approximately 20 percent of adult males to have at least some sexual interest in children (Brière & Runtz, 1989; Green, 2002; Pithers, Becker, Kafka, Morentz, Schaln, & Leombruno, 1995; Seto, 2008). Ahlers et al. (2011) reported that 10 percent of their non-offender subjects engaged in sexual fantasies involving children under the age of 14. Psycho-physiological research showed that sexual arousal resulting from exposure to stimuli involving children from ages 13 and older was fairly common (Lalumière, Harris & Quinsey, 2005). And even though sexual arousal and sexual interest are not entirely
equivalent, one can be seen as a reflection of the other. It should be noted however, that most subjects included in the study mentioned above clearly showed more sexual arousal in reaction to stimuli involving adults. The percentage of men engaging in actual sexual contact with a minor is suggested to be less than 5% (Seto, 2008). Of men born in England and Wales in 1953, by the age of 40 years old, seven in 1000 had a conviction for a sexual offence against a child (Marshall 1997).

What applies to sexual stimuli involving underage children, also applies to sexual stimuli involving coercion. Malamuth (1981) found that more than half of the men in his non-offender sample deemed themselves capable of sexual coercion. Forty percent of the non-offender males in another sample (Pithers et al., 1995) reported sexual fantasies of rape. More recent research in South Africa, where the probability of detection and legal consequences for perpetrators of rape are virtually nil, indicated that more than a quarter of men admitted to have forced a woman to have sex (Bijl & Rumney, 2009). Psychophysiological research found sexual response to sexual stimuli involving coercion to be very common although non-offender samples clearly showed greater sexual arousal to stimuli depicting consensual sex (Lalumière, 2009).

In sum, a certain level of interest in illegal sexual interactions (involving children or coercion) appears to be relatively common, and is held by far more people than those who resort to sexual offending behavior. Hence, the deviant interests cannot be the sole determining factor in sexual offending behavior. The degree of arousal to illegal stimuli, often interpreted as a reflection of the level of sexual interest, varies widely between individuals. This relative level of deviant sexual interest is far more important in the prediction of sexual offending than the mere presence or absence of any illegal interest. More specifically, (exclusive) illegal preferences provoke sexual offending to a larger extent than low-level non-preferential interest. Not all child sexual abusers show a clear sexual preference for children however, (e.g. 35%; Seto, Cantor, & Blanchard, 2006) and a only small minority reports an exclusive preference for children (7%; Hall & Hal, 2007). Besides sexual deviance, antisocial-impulsive traits are important determinants for the risk of sexual offending behavior (Hanson & Morton-Bourgon, 2005). The propensity to disregard social convention and violate the rights of others for the benefit of one’ s personal satisfaction fails to inhibit offenders to commit illegal behaviors. In that respect, sex offenders are largely comparable to other offenders (Andrews & Bonta, 2010).

Risk Assessment
Contrary to popular belief, sex offenders as a group are not notorious recidivists. In a recent meta-analysis, including 45,398 sex offenders from 110 published and
unpublished studies, carried out between 1972 and 2008 in 16 different countries, Hanson and Morton-Bourgon (2009) found a sexual recidivism rate of 15 percent, and a combined recidivism rate for violent (including sexual) crimes of 28 percent with an average follow-up time of 70 months. In other words: within a period of six years, 15 percent of the offenders were charged or convicted of a new sexual offense. Mindful of the extensive underreporting of sexual offenses, research into recidivism generally uses long follow-up periods (10 years or more) and includes charges as well as convictions. The resulting percentages of recidivism, however, carry the possibility of underestimation. Still, within the heterogeneous group of sex offenders, strong differences in recidivism rates per subgroup exist. Research has shown, for instance, that incest offenders tend to recidivate at lower than average rates, while extra-familial child abusers with male victims tend to recidivate at higher than average rates (Harris & Hanson, 2004). The determination of the risk of recidivism for an individual offender is what is generally referred to as risk assessment.

Up to the 90s, unstructured clinical judgment was the most widely used method to assess the risk of recidivism. This judgment was based on the factors present in an individual case, aggregated and weighted by clinical expert(s). Numerous studies have shown that the predictive value of this unstructured clinical judgment is at, or even below chance level (e.g., Hanson, Morton & Harris, 2003). The limitations of clinical judgments with respect to predictive value are not a recent finding and are not limited to clinical judgments in the forensic field (Dawes, Faust & Meehl, 1989). Unstructured clinical judgments are mostly burdened by a very low statistical reliability: no two individual experts reach the same clinical verdict. Reliability and validity of clinical judgment are open for improvement by consensus between several clinicians, preferably multidisciplinary. In other words: when multiple judges evaluating various angles of the treatment process reach agreement on a case, their judgment is usually more reliable and valid than the assessment of a single person (Huss & Zeiss, 2004).

The counterpart of relying on clinical judgment is the use of structured actuarial risk assessment instruments. These instruments contain items that were empirically assessed to be related to recidivism: i.e., they describe characteristics that have been found to be more (or less) common among recidivists than among non-recidivists. For every characteristic that applies to an individual sex offender, his score and recidivism risk increases. Of course, risk assessment provides an indication of the risk level of an individual sex offender but does not provide certainty as to whether a specific offender is going to recidivate or not.

Since the start of this century, structured actuarial risk assessment for sex offenders has become the norm for practice in Canada, the US, and the UK. A number of rather
similar, alternative tools have been developed for this purpose. The most commonly used risk assessment tools for sex offenders are the STATIC-99 (Hanson & Thornton, 2000) or the revised STATIC-99R, which includes a more elaborate weighing of the offender’s age (Helmus, Thornton, Hanson, & Babchishin, 2012). The items of the STATIC-99R all relate to factual information and the instrument is relatively simple and reliable to score. The scores on the items lead to a total score that corresponds to a certain risk category and associated estimates of recidivism risk.

The STATIC-99R (Hanson & Thornton, 2000; Helmus et al., 2012) is an example of a so-called actuarial, static, and a-theoretical risk assessment instrument. Actuarial means that the score is determined by a set algorithm. Static refers to the factual, unlikely-to-change-over-treatment type of information that forms the input for the score of these instruments. A-theoretical refers to the fact that the items, although empirically related to recidivism, have an unknown causal relationship to sexual offending behavior. For example, research has shown that child molesters with male victims recidivate at higher rates, but no theoretical rationale has been established for this effect. The actuarial character of the instruments evokes resistance from clinical practitioners because it leaves no room for the inclusion of case-specific considerations of risk- and protective factors deemed important by the experts. However, research has shown that inclusion of these clinical adjustments to the total score does not improve the prediction of recidivism risk (De Vogel, De Ruiter, Van Beek & Mead, 2004); in fact, it seems to make the assessment less accurate (Dempster, 1998; Morton, 2003; Michel et al., 2013; Wormith, Hogg & Guzzo, 2012; Quinsey, Harris, Rice, & Cormier, 2004). Especially when assessing basic risk levels, i.e., before intervention, structured actuarial risk assessment may well be the most appropriate strategy.

Most of the available instruments are tailored to adult male sex offenders and cannot be applied to adolescent or female sex offenders. Specific instruments for adolescent sex offenders have been developed, such as ERASOR (Worling & Curwen, 2001) or J-SOAP (Prentky & Righthand, 2003). The overall recidivism rate of juvenile sex offenders is significantly lower than seen in adult sex offenders, and (accordingly) harder to predict (Caldwell, 2010). As noted before, there are relatively few female sex offenders and their overall recidivism rate is very low (Cortoni et al., 2010). No specific risk assessment instruments for female sex offenders have been developed yet. With regards to the relatively new group of child pornography offenders, research has shown (Eke & Seto, 2011) that it is important to make a distinction between CP-only offenders and mixed offenders (those who have also committed contact offenses). Mixed offenders with a current charge for CP possession, but a contact offense in the past, can be assessed with the standard instruments for contact offenders. For CP-only offenders no risk assessment instruments are available yet.
Research to date indicates the risk of future contact offending to be very low for CP-only offenders. Graf and Dittmann (2011) found that, after an average follow up time of 5 years, 2.9% of their 4,658 Swiss CP-only offenders had been charged for a new CP offense and 0.3% had been charged for a contact sexual offense.

In sum, not all sex offenders are at high risk to recidivate. Compared to other groups of offenders (with equally low conviction rates), the overall recidivism rate of sex offenders is relatively low. However, sex offenders do form a very heterogeneous group that includes individuals at very high risk to reoffend. The most accurate indication of recidivism risk is produced by structured actuarial sex offender risk assessment instruments.

**Risk Need Responsivity**

One principal approach to decrease the number of victims of sexual offenses is to prevent recidivism of captured sex offenders by means of intervention. The treatment of sex offenders is best considered an intervention targeting the prevention of new offenses. Put differently: Rather than on curing the underlying disorders, the focus is on mitigating risk. Current best practice of correctional interventions reflects the What Works principles or the Risk-Need-Responsivity model (RNR; Andrews, Bonta and Hoge, 1990). This evidence-based model focuses primarily on risk management (Andrews & Bonta, 2010; Ward, Melser, & Yates, 2007). The basic premise of the RNR-model is that interventions should be structured according to three important rehabilitation principles: Risk, Need and Responsivity.

The first principle, the risk principle, consists of two elements: (1) offenders should, prior to treatment, be subjected to a risk assessment with empirically validated and reliable risk assessment instruments, and (2) offenders with a high-risk profile should receive more intensive treatment than offenders with a low-risk profile. In other words: high-risk offenders should be referred to high-intensity treatment and low-risk offenders should be referred to low-intensity treatment, or to no treatment at all. The notion that ‘nothing ventured, is nothing gained’, may not apply, as there is evidence that the overtreatment of low risk general offenders increases their recidivism risk (Bonta, Wallace-Capretta, & Rooney, 2000; Lowenkamp & Latessa, 2002). This might also specifically apply to sex offenders. The risk principle is the main focus of this thesis.

The Need principle emphasizes that treatments should center on the characteristics that are related to reoffending: the offender’s criminogenic needs. For instance, sexual preoccupation is an example of a criminogenic need empirically related to sexual reoffending, while sexual knowledge or social skills are non-criminogenic needs, which the offender may lack but show no empirical relationship to recidivism. The
Responsivity principle dictates the adaptation of the treatment program to the learning style, capabilities, and limitations of the offender and thus provide treatment that the offender ‘gets’. Besides internal factors such as cognitive impairments, this also includes factors that lend themselves to external influencing, such as treatment motivation. Responsivity in terms of motivation is not only a function of the practitioner, but also of the treatment facility and ultimately of societal policy. A complete lack of perspective for sex offenders will reduce their responsivity and therefore possible treatment effects (Ward, Day, Howells, & Birgden, 2004).

The effect of sex offender treatment is usually measured in the reduction of recidivism rates (Brown, 2005; Prentky, 1995). This evaluation is problematic, because the outcome of such research, i.e., recidivism, is exactly what we aim to avoid at all costs. This greatly complicates adequately controlled research. Ideally, a control group would consist of offenders of equal risk levels released into society without treatment, which of course is out of the question for ethical reasons. Treatment evaluations have taken refuge to weaker designs that include treatment drop-outs or normative groups as control groups. A recent meta-analysis of treatment evaluation studies judged to have employed acceptable designs (Hanson, Bourgon, Helmus & Hodgson, 2009) concluded that sex offender treatment does reduce recidivism and, more importantly, that the RNR principles also apply to sex offenders. Treatment programs that conform to all three principles were by far the most effective.

Current practice in The Netherlands
In The Netherlands, almost half of all convicted sex offenders are referred to a treatment program, and about 5 percent of convicted sex offenders are imposed with mandatory inpatient treatment (TBS; ter beschikking stelling) (Brouwers & Smit, 2005). Compared to other countries, treatment duration in The Netherlands is quite long. The average sex offender inpatient spends over ten years in treatment, which is not approximated in any other country. Likewise, the less intensive outpatient treatment programs are of considerably longer duration than seen in international practice (Beech, Fisher & Beckett, 1999; Marshall, Marshall, Serran & Fernandez, 2006). The Netherlands does not have a strong tradition in the standard use of structured risk assessment to refer sex offenders to these different forms of treatment. Periodic risk assessment has been mandatory for offenders when in mandatory inpatient treatment since 2005, but referral to this treatment is not prefixed with standardized risk assessment.

Most pre-trial assessments for sex offenders in The Netherlands are performed by probation officers. Since 2006, the STATIC-99 is used routinely in the assessments performed by one of three national Parole Authorities in The Netherlands. However,
the Static-99 score is used as additive information to their risk assessments, and does not play a decisive role. Pre-trial assessment of a selection of cases is provided by psychologists and/or psychiatrists attached to the National Institute of Forensic Psychiatry and Psychology (NIFP). These comprehensive assessments can be requested by the magistrate hearing the case. Before 2007, magistrates requested these assessments fully at their own discretion. Starting in 2007 however, their decision to request assessment is supported by a specific instrument (BooG; Van Kordelaar, 2002) but ultimately remains their personal decision. The BooG consists of the most common denominators for requesting an assessment (e.g. unusual, complicated, high profile) but has no known relationship to recidivism risk levels.

Presence of a mental disorder and diminished accountability caused by this disorder are the main prerequisites for the assignment of sex offenders to treatment, followed by risk of recidivism. The assessment of recidivism risk, like the assessment of disorders and accountability, were, until recently, all but completely achieved by means of unstructured clinical judgment. Even though the use of structured risk assessment instruments is nowadays strongly encouraged in these NIFP assessments, there is no prescribed (actuarial) instrument nor mandatory training, and the acquired scores are merely used as one of the inputs for an overall clinical evaluation procedure. None of the internationally widely used sex offender risk assessment instruments has been validated in a representative group of Dutch sex offenders.

Taken together, sex offender risk assessment policies in The Netherlands do not seem to be systematically risk oriented. However, this does not rule out that the results are in line with the risk principle as stated by the RNR principles. This thesis looks into the effects of current sex offender policies in the Netherlands from the perspective of the risk principle. Do the Dutch policies yield concordance with well the established RNR risk principle and if not, how might we improve upon current policies and practice?

The first study (Chapter 2) of this thesis investigates whether the Dutch method of treatment referral results in an adequate match between sex offenders’ risk levels and their treatment referrals: i.e., are high-risk offenders referred to high-intensity treatments, and low-risk offenders to low-intensity treatments? The second study (Chapter 3) specifically tests whether clinical treatment selection – representative of much of current practice – yields treatment group composition that is homogeneous in risk level (as would be dictated by the RNR principle).

The third study (Chapter 4) compares the psychometric properties and predictive power of nine widely used sex offender risk assessment instruments on a large cohort of Dutch sex offenders including all offenders who were discharged from inpatient treatment between 1996 and 2002 as well as 25% of the sex offenders discharged from
prison during that same period. Presumably, this comparison may guide the selection of the most efficient instrument for the Dutch situation.

Study four (Chapter 5) describes a quasi-experimental test of the efficacy of high intensity inpatient sex offender treatment on recidivism (Ter Beschikking van de Staat, TBS; at the disposition of the state, i.e., state mandated, involuntary treatment). Is this treatment effective in reducing recidivism in sex offenders and if so, are the effects contingent upon sex offender risk level?

The final study of this thesis (Chapter 6) aims to inform prioritization of child pornography cases to focus police efforts. The large numbers of CP offenders and their overall low recidivism risk call for a different type of risk assessment. This study empirically explores the possibility to identify, at a very early stage of the investigation, the most dangerous individuals in terms of likelihood of the subsequent discovery of contact offenses.

In closing, Chapter 7 provides a brief summary of the main findings, discusses the methodological strengths and imitations of this body of research, and describes (policy) implications and directions for further research.
Chapter 1


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