Sex Offender Risk Factors

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Outline

- Defining the risk to be assessed
- Static versus dynamic risk factors
- Risk assessment tools
- Other factors to consider in assessing risk

Defining the Risk to be Assessed

- First question: "risk for what?"
- Dimensions for risk assessment:
  - (1) Nature of risk
  - (2) Probability or likelihood
  - (3) Severity or degree of harm
  - (4) Imminence
  - (5) Frequency (number of victims, and/or frequency against same victim)

Issue: Defining Relevant Type of Risk

- What type of behaviors matter?
  - (1) Any type of "physical harm"?
  - (2) Any type of physical contact sexual crime?
  - (3) Only "violent" sexual crimes?
- What time period of concern?
  - Weeks, months, 1-2 years, 5-15 years, life
- Proper assessment tool varies accordingly

Different Risk Assessment Models

- Hanson (1998) & Poythress & Hart (1998):
- Traditional clinical judgment (unstructured, structured, anamnestic approach)
- Empirically guided (structured) clinical judgment
- Clinically adjusted actuarial approach
- Pure actuarial approach

Models (continued)

- **Unstructured clinical opinion** (specific considerations not delineated; basis for opinions can change from case to case)
- **Structured clinical opinion** (a priori list of risk and protective factors used, may or may not have any empirical basis)

Models (continued)

- **Anamnestic approach**: involves analyzing the subject's life history to surmise the factors of particular importance to the specific subject's historically demonstrated risk and lack of risk, and then examine the degree to which those same conditions still exist (i.e., using the person as his/her own "comparison group")

Models (continued)

- **Empirically guided clinical assessment** (use of a priori list of research supported risk and protective factors; structures clinical judgment)
- **Clinically adjusted actuarial assessment** (use of actuarial instrument(s) potentially coupled with adjustments in overall risk assessment based on non-actuarial considerations)

Models (continued)

- **Pure actuarial assessment** (use of specifically delineated risk and protective factors, using explicitly stated a priori rules for their combination)

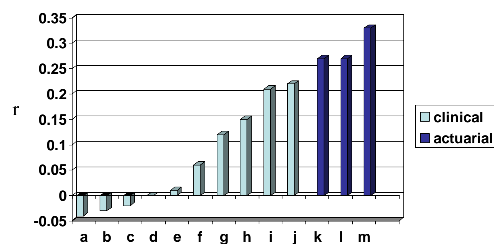
Relative Value of Different Methodologies

- Why not regularly use traditional "clinical judgment"?
- Basic answer: different degrees of accuracy

Why Should Actuarial Instruments (Typically) Be Used

- (1) Most accurate method for assessing "likelihood" (probability) for new sexual reconviction

Accuracy of Clinical and Actuarial Risk Prediction



Hanson & Morton-Bourgon (2004)

- http://www.psepc.gc.ca/publications/corrections/pdf/200402_e.pdf
- **Approaches to Risk Assessment** [for sexual recidivism] [from Table 1]

	Median	Mean	95% C.I.		k	Total
Clinical assessment	.34	.40	.24	.56	9	1,679
Empirically guided	.31	.41	.26	.55	9	1,270
With outlier	.34	.51	.37	.65	10	1,391
Actuarial risk scale: sex	.64	.61	.54	.69	33	6,792

Why Should Actuarials (Typically) Be Used

- (2) Minimizes degree to which risk overestimation bias occurs

High, Medium, and Low-Risk Rating Based on Criminal Risk Rating [Terry Nicholaichuk, 1999]

(Intake Assessment) and RRASOR Scores (N = 741)

Risk Level	Intake (Clinical Judgement)	RRASOR
Low	12%	54.5%
Medium	28.5%	35.6%
High	62.2%	9.8%

Why Should Actuarials (Typically) Be Used

- (3) Avoid the common bias of "knowing the person"

Do Treatment Staff Make Better Risk Assessments?

- No published research showing treaters are more accurate than "non-involved" raters in making recidivism risk assessments
- Most studies find treater's ratings less accurate in predicting recidivism than more structured procedures
- See Doren (2005) for summary

Issue: de Vogel & de Ruiter (2004) Findings

- "There were no significant differences between the mean HCR-20 scores of treatment supervisors and researchers, but there was a significant difference in the interpretation of the scores: treatment supervisors had more 'low risk' judgments than researchers. Furthermore, it was found that feelings of clinicians towards their patients were associated with their risk judgment. Feelings of being controlled and manipulated by the patient were related to higher HCR-20 scores, whereas positive feelings (helpful, happy, relaxed) were related to lower risk judgments."

Risk Assessment Instruments

- Following examples of:
- Structured clinical tools
- Actuarial assessment scales

Empirically Guided Approach

- Formalized lists for "structured clinical judgments":
- For violence risk: HCR-20, YASI
- For general criminality risk: SAVRY
- For sexual violence risk:
  SVR-20, RSVP, J-SOAP, ERASOR
- For spousal abuse risk: SARA
- For comm. supervision risk: VASOR

Empirically Guided Approach (continued)

- Historical, Clinical, Risk Management – 20 (HCR-20)
- Sexual Violence Risk – 20 items (SVR-20)
- Risk for Sexual Violence Protocol (RSVP)
- Spousal Abuse Risk Assessment (SARA)
- Vermont Assessment of Sex Offender Risk (VASOR)
- Each instrument (except HCR-20) little researched to date; mixed results for SVR-20 in research to date (overall +); VASOR looks promising

"Juvenile" Risk Assessment Instruments

- Structured Assessment of Violence Risk in Youth (SAVRY) [general criminality]
- Youth Assessment and Screening Instrument (YASI) [general criminality and violence]
- Juvenile Sex Offender Risk Protocol (- 2) (J-SOAP, J-SOAP-2) [sexual reoffending]
- Estimate of Risk of Adolescent Sexual Offense Recidivism (ERASOR) [sexual reoffending]

Where to Find Information

- www.atsa.com/pdfs/riskAssessmentBiblio.pdf
- HCR-20:
  Webster, C. D., Douglas, K. S., Eaves, D., & Hart, S. D. (1997). *HCR-20: Assessing the risk for violence* (version 2). Vancouver: Simon Fraser University, Mental Health, Law, and Policy Institute.
- SVR-20, RSVP, SARA: (same: Simon Fraser University, MHLP Institute)
- SAVRY:
- http://www.fmhi.usf.edu/mhlp/savry/SAVRY_Research.htm

Actuarial Risk Assessment Instruments

- Common actuarial instruments (for pure actuarial, or clinically-adjusted actuarial method):
- For violence risk: VRAG, SORAG
- For sexual violence risk: RRASOR, Static-99, MnSOST-R, SONAR, (Stable-2000, Acute-2000)
- For criminality risk: SIR, LSI-R (YLSI-R)
- For domestic abuse risk: ODARA
- For community supervision success/failure risk:
  VASOR, SONAR

Actuarial Instrumentation

- Most commonly employed relative to VIOLENT recidivism for sex offenders:

  (1) Violence Risk Appraisal Guide (VRAG)

  (2) Sex Offender Risk Appraisal Guide (SORAG)

- Very similar instruments: just use one
- Developed with some subjects as young as 13, though vast majority were adult

Actuarial Instrumentation (cont)

- Most common instruments for sexual recidivism risk:
- Rapid Risk Assessment for Sexual Offense Recidivism (RRASOR)
- Static-99
- Minnesota Sex Offender Screening Tool – Revised (MnSOST-R)
- Sex Offender Needs Assessment Rating (SONAR)

Actuarial Instrumentation (cont)

- Most common for general criminal risk:
- Level of Service Inventory – Revised (LSI-R), recently update to the Level of Service/Case Management Inventory (LS/CMI) and Youth Level of Service/Case Management Inventory (YLS/CMI)
- Statistical Information on Risk (SIR)
- Ontario Domestic Assault Risk Assessment (ODARA)

Where to Find Information

- VRAG & SORAG:
  Quinsey, V. L., Harris, G. T., Rice, M.E., & Cormier, C. A. (1998). *Violent offenders: Appraising and managing risk*. Washington, DC: American Psychological Association.

Where to Find Information (continued)

- RRASOR: http://www.sgc.gc.ca/publications/corrections/199704_e.pdf
- Static-99 : http://www.sgc.gc.ca/publications/corrections/199902_e.pdf [or Hanson, R. K., & Thornton, D. (2000). Improving risk assessments for sex offenders: A comparison of three actuarial scales. *Law and Human Behavior, 24*(1), 119–136.]

Where to Find Information (continued)

- Coding rules for RRASOR & Static-99: http://www.sgc.gc.ca , click “English”, click “Research”, click “Reports and Manuals” (under the heading of “Corrections”), click “Static-99 coding rules” under “2003”
- MnSOST-R: http://129.186.143.73/faculty/epperson/mnsost_download.htm

Where to Find Information (continued)

- LSI-R:
  http://www.mhs.com/onlineCat/product.asp?productID=LSI-R
- SIR (general research information):
  http://www.csc-scc.gc.ca/text/rsrch/reports/r126/r126e_e.shtml
- ODARA:
  http://www.gov.on.ca/opp/odara/english/default.htm

Where to Find Information (continued)

- VASOR
- http://www.csom.org/ref/assessment.html
- http://www.csom.org/pubs/vasor.pdf
- SONAR
  [Hanson & Harris (2001). A structured approach to evaluating change among sexual offenders. *Sexual Abuse: A Journal of Research and Treatment, 13*(2), 105-122.]

Potential Protective Factors

- Treatment completion
- Mandated community supervision
- Aging (?)
- Change in dynamic factors

Clinical Adjustment: Treatment Benefit

- Does sex offender treatment "work"?
- Association for the Treatment of Sexual Abusers (ATSA) sponsored a meta-analytic study (Hanson et al., 2002)
- 42 studies, mostly of recent type of treatment program (cognitive-behavioral)
- Over 9000 subjects, all male, some adolescent

ATSA Study

- Best 20 studies in research design:
- Average 46 month follow-up in community
- Untreated sex offenders = 17% sexual recidivism
- Treated = 10% sexual recidivism
- Difference statistically very significant
- Difference similar to 2005 study (Losel & Schmucker)

ATSA Study (continued)

- Institutional and community-based programs of equal utility for decreasing sexual recidivism
- Community-based programs were superior to institutional for decreasing violent recidivism
- Cognitive-behavioral programming appears more effective than other formats

ATSA Study (continued)

- Average 4-year follow-up period
- Untreated: about 17% recidivism
- Treated: about 10% recidivism
- Issue: How to interpret accurately?
- (a) 17-10 = 7% absolute gain in 4 yrs
- (b) (17-10)/17 = about 40% relative gain
- (c) 10% outcome for treated
- Issue: projecting into more than 4 yrs…

Long-(enough) Term Mandated Supervision

- General offender literature: supervision correlate with lower recidivism rates during period of supervision (not lasting afterwards)
- Built into RRASOR, Static-99, MnSOST-R: average 1-2 year mandated supervision, standard rules, for subjects in development studies
- What about longer periods, monitoring?

Supervision (continued)

- Sex offenders: study by Grant Duwe (in progress, in MN)
- Issue: increased monitoring: By 2002 with average 5 yrs supervision with 50% receiving "intensive supervision"
- Sexual recidivism for 1992 releases = about 20%; 2000 releases = about 5%
- [Low risk 1992 = about 10%; suggests highest risk managed well in 2000]

Effect of Mandated Supervision

- Known: recidivism reducing effect for general criminality and for violent reoffending **while supervision in place**
- Also known effect: **effect quickly dissipates once supervision discontinued**

Supervision (continued)

- "Failure" on past supervision: clear risk factor
- Formal violation on past supervision: clear risk factor
- Stable & Acute: what to watch for **during** supervision (few surprises: going back to substance use, deterioration in significant relationship, destabilization of various types)

Conclusions About Effect of Aging on Sexual Recidivism

- 1. Discrepancies concerning an **overall** age-reduction effect – 5 models:
- (a) steady reduction in risk,
- (b) lowered risk between younger and middle years, and middle years and older years, but not during middle years,
- (c) no effect until rapid risk reduction in older years,
- (d) no effect at all,
- (e) lowered risk for 40-54 with upward trend for 55+

Conclusions (continued)

- 2. Differences **may** be explained by:
- (a) whether offenders were treated or not
- (b) jurisdiction (US vs. other)
- (c) some sample sizes being small at least in the upper age categories
- (d) outcome measurement differences
- (e) lack of replication for some conclusions (i.e., spurious or sample-specific results)

Conclusions (continued)

- 3. Concerning "high-risk" offenders:
- (a) may depend on how risk is measured
- (b) may be no different from overall age effect (whatever that is)
- (c) may be different for treated vs. untreated offenders, at least for certain high-risk offenders (3-way interaction???)

Conclusions (continued)

- Overall effect: not so clear; significant variability across studies (Hanson & Bussière); only one "steady-rate" finding [from relatively smaller sample]
- Effect on "high-risk": depends on "who you ask" – age (a) may effect some high-risk offenders but not others, (b) may effect treated but not untreated, (c) may not even be relevant because no effect of age irrelevant of risk

Dynamic Factors

- Non-compliance with supervision
- Emotional identification with children
- Sexual preoccupation
- Lifestyle instability (also called "General self-regulation problems")
- Conflicts in intimate relationship [possibly a more accurate name would be "Lack of stable bonding"]
- Attitudes tolerant of sexual offending

Non-Compliance with Supervision

- **Non-compliance with supervision** (as distinct from "violation of conditional release", and not to be read as implying the necessity for "revocation" from that supervision) (variable was found statistically at level that is better than typical static variable)

Non-Compliance with Supervision (continued)

- Measured in various ways:
  - Failure to meet conditions of supervision
  - Alcohol or drug use
  - Failure to cooperate with treatment on supervision
  - Failure to keep appointments with supervising agent

Emotional identification with children

- Second highest correlate: **Emotional identification with children** (statistically at level of typical static variable)
- May be measured with scale or by history (history may simply be a surrogate measure for "sexual deviancy"; not specifically the "emotional identification with children")

Sexual Preoccupation

- Third highest correlate: **Sexual preoccupation (**statistically at level of typical static variable)
- Found to be of significance only when associated with sexual deviance
- Measurement by self-report questionnaires or structured ratings (versus general clinical determination)

Lifestyle Instability

- Fourth-fifth highest: Also called **"General self-regulation problems"** in the Hanson & Morton-Bourgon (2004) meta-analysis (statistically at level of typical static variable)
  - a lot more studies included in analysis, though not necessarily a lot more subjects than for most of these variables
  - the measurement appears largely to involve either a structured clinical process or a standard scale without clinical input

Lifestyle Instability (continued)

- Different underlying concepts exist in these measures: general impulsivity, substance dependence, general antisociality, and lifestyle instability:
- **impulsivity/recklessness** correlated with sexual recidivism when analyzed alone
- **any substance abuse** & **intoxicated during offense** both correlated with sexual recidivism when each was analyzed alone
- **employment instability** correlated with sexual recidivism when analyzed alone
- the **PCL-R** correlated with sexual recidivism when analyzed alone

Lack of Stable Bonding

- Fourth-fifth highest: also known as **Conflicts in intimate relationship** (statistically at level of typical static variable on average, though very small numbers of people studied so confidence interval is large)
  - the measures that correlated with recidivism outcome were clinical or items from scales and not truly based on any scale
  - the clinical measures were (i) "failure to establish stable intimate relationships" (from SVR-20 item 7: Relationship problems), and (ii) "not pair-bonded"

Lack of Stable Bonding (continued)

- a 5-item historical definition, with a final clinical interpretation of findings (also tested as a 3-item scale involving z-scores)
- SVR-20 Psychosocial Scale (items 1-11) total score, this being essentially a replicated definition
- the MAST,
- a certain cluster of items from the CPI (with an adolescent sample)
- possibly the Factor 2 score from the PCL-R

Attitudes Tolerant of Sexual Offending

- Sixth highest: (statistically at low end of level typically found for static variables)
- Measures here typically involve scales
- These include:
  - "Cognition" scales for child molesters
  - "Rape myth" scales for rapists

[Problem: face valid measures not useful in forensic assessments]

Psychopathy and Sexual Deviance

- Beyond current instruments, but clearly of utility:
  - Rice & Harris (1997)
  - Harris, Rice, Quinsey, Lalumière, Boer, & Lang (2003)
  - Hildebrand, deRuiter, & deVogel (2004)
  - Olver (2004) [Olver & Wong, 2006]
  - Abracen & Looman (2006)

Other than Sexual Recidivism Outcome

- Gretton, H.M, McBride, M., Hare, R.D., O'Shaughnessy, R., & Kumka, G. (2001). Psychopathy and recidivism in adolescent sex offenders. Criminal Justice and Behavior, 28(4), 427-449.
- Serin, R.C., Mailloux, D.L., & Malcolm, P.B. (2001). Psychopathy, deviant sexual arousal, and recidivism among sexual offenders. Journal of Interpersonal Violence, 16(3), 234-246.

Factors That Do NOT Matter (for sex offenders)

- General criminality risk:
- Childhood sexual abuse
- Social skills deficits
- General psychological problems (anxiety, depression, low self-esteem, severe psychological dysfunction)

- Loneliness
- Minimizing culpability
- Any sexual deviancy

Do NOT Matter (continued)

- Non-sexual violence risk:
- Adverse childhood environment (any type of abuse or neglect; negative relationship with either parent)
- General psychological problems (anxiety, depression, low self-esteem)
- Sexual deviancy

Do NOT Matter (continued)

- Sexual offending risk:
- Procriminal attitudes (only sexual specific)
- Most measures of adverse childhood environment (sexual abuse, negative relationship with either parent)
- General psychological problems (anxiety, depression, low self-esteem)

- Lack of empathy
- Low motivation for treatment at intake
- Denial of offending [though interferes with treatment]
- Ratings of poor treatment progress (after treatment)

Selected References

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