

RISK ASSESSMENT

OVERVIEW:

Clinicians and criminal justice officials who work with sex offenders are frequently charged with making decisions that require some degree of judgment about the level of risk posed by a particular offender. There is little evidence that clinical judgment alone is useful in predicting future criminal or deviant behavior. However, as we learn more about the motives and dynamics of sexual offenders, and begin to develop assessment tools that incorporate this knowledge, we improve our ability to predict deviant behavior. This section addresses the evolving art of risk assessment, current limitations, obstacles and considerations. The purpose of risk assessment in guiding dispositional decision-making is discussed, as is the recommended content of a risk assessment.

OBJECTIVES:

Participants in this training module will learn to

- ◆ Recognize the benefits and limitations of conducting risk assessments.
- ◆ Understand the purpose and goals of risk assessment.
- ◆ Develop a framework for evaluating the level of risk posed by a sexual offender.

RECOMMENDED READINGS:

Epperson, D.L., Kaul, J.D., & Huot, S.J., (1995). *Predicting risk of recidivism for incarcerated sex offenders: Updated development on the sex offender screening tools (SOST)*. A paper presented at the 14th Annual Research and Treatment Conference of the Association for the Treatment of Sexual Abusers, October 11-14, 1995, New Orleans, LA.

McGrath, R., (1990). Five critical questions: Assessing sex offender risk. *Perspectives*, 16(3), 6-9.

RISK ASSESSMENT

The identification of offenders most likely to commit future sexually violent or abusive behavior is of great importance to social service and criminal justice personnel, policy-makers and, indeed, to society as a whole. Sex offender treatment providers, probation and parole officers are often responsible for assessing the level of risk offenders present. It is important to keep in mind that being considered a high risk does not necessarily mean that someone will reoffend, just as being considered a low risk does not necessarily mean they won't reoffend. Risk assessment is not a precise science. Decisions must be made to safeguard the public while reducing the cost of false positives, as incarceration and intensive supervision is costly and should therefore, be used selectively. Many states are facing prison overcrowding and budget deficits as a result of increased incarceration rates and sentence lengths. The average cost per year to incarcerate one sex offender in Minnesota in 1994 was approximately \$25,800.

Predicting future criminal behavior is perhaps one of the most difficult jobs clinical and correctional personnel face. Professional clinical judgment alone has not proven reliable in predicting recidivism. In fact, clinicians often tend to over predict risk. As yet, there is no agreed upon and validated set of predictor variables to determine an offender's likelihood to

reoffend and level of dangerousness. However, combining clinical judgment with actuarial methods does increase the accuracy of efforts at risk prediction.

The purpose of risk assessment is to help with dispositional planning. Again, it is important to keep in mind that public safety is the primary goal. Risk assessment with sex offenders should focus on two variables (McGrath, 1990):

- ◆ Amenability to treatment
 - Ability/Capacity for treatment
 - Motivation for treatment
- ◆ Risk Level
 - Likelihood to reoffend
 - Degree of harm anticipated by reoffense

These factors are used to make dispositional recommendations.

- ◆ Assessing risk level is typically important at the following points in time:
 - Pre-Sentence
 - Pre-Release
 - Post-Release

Pre-sentence risk assessments are typically designed to assist the courts to determine an appropriate sentence length and to decide if a sentence will be imposed or stayed (i.e., the offender placed on probation rather than incarcerated). If the sentence is stayed, risk assessments help to determine appropriate conditions of probation. Conditions of probation may address treatment requirements, limitations on contact with children, frequency of contact with probation officer, etc.

Risk assessment pre- and post-release is pertinent to determining conditions of release and supervision as well as family reunification options. Such assessments may also aid in decisions regarding placement in the community and revocation of probation, should the offender fail to meet probationary conditions established. Possible options or outcomes are:

- ◆ Incarceration
 - With treatment
 - Without treatment
- ◆ Residential placement
 - With treatment
 - Without treatment
- ◆ Community supervision
 - With treatment
 - Without treatment

Residential placement and community supervision often follow a period of jail placement.

Though controversial, preliminary studies indicate that treatment does reduce the likelihood of reoffense and is cost-effective, (Prentky & Burgess, 1990). Clearly it would seem unethical to recommend options which do not include treatment unless there are extenuating circumstances.

In conducting a sex offender risk assessment it is important to gather information from various sources. **Never** assume that the offender's self-report is adequate or even accurate.

As much collateral information as possible should be gathered prior to interviewing the offender as this will be useful in eliciting honesty, assessing risk level, and confronting offender distortions.

It is of considerable importance that the clinician or P.O.'s evaluation or assessment address issues of disposition, amenability to treatment, level of risk, and/or diagnosis, NOT guilt or innocence. The latter is a legal issue. Clinical judgment and psychological tests are not reliable in determining guilt.

CONTENT OF A RISK ASSESSMENT:

The content of a risk assessment for sex offenders should include the following:

- ◆ ***Sex Offense History.** Sexual offense history is a well-established risk indicator, (Hanson, Cox, Woszczyzna, 1991). The evaluator should consider past convictions and arrests for sexual offenses. Self-report should also be considered, keeping in mind that honesty is often a quality we want to reinforce and that it may be counterproductive to “punish” someone for their forthrightness in admitting prior offending. It is also important to keep in mind that, as denial decreases, the amount and severity of self-reported prior sexual offending tends to increase. Offenders should be told of the potential consequences of their disclosure prior to beginning an assessment. It is recommended that this information be shared with them verbally and that they sign a written statement indicating that they have been fully informed.

- ◆ **Criminal History.** The offender's prior nonsexual offenses should be evaluated. Is this an individual who has demonstrated a long-standing criminal or anti-social lifestyle? What has been their pattern of offending? The evaluator should “look beneath the surface”, e.g., Has the offender committed a series of burglaries, which are motivated by sexually deviant interests?

- ◆ **Compulsivity/Impulsivity/Psychopathy.** Did the offender take great risk in committing his offense(s)? This may be an indication of a highly compulsive sex offender, whose compulsion to act on his deviant interests is so great that he overlooks great risks or is willing to gamble even with poor odds of not getting caught. Did the offender go to great lengths to avoid getting caught? This may point to a highly calculating individual, who spent considerable effort planning his offense(s) in order to avoid apprehension. Have they offended shortly after release from prison/jail, indicating that either they were planning to offend while still incarcerated or they have a very short cycle/high impulsivity?
Have they offended while on probation or parole? This may indicate that, even with considerable structure, they engage in deviant/rule-breaking behavior.

It is important for the evaluator to assess degree of compulsivity, impulsivity and psychopathy. Research has supported that psychopathy, as defined by rating on the Hare Psychopathy Check List, is a very powerful predictor of violent recidivism, (Hare, Rice, Cormier, 1991).

Rapists who scored on impulsivity measures in a 1990 study by Robert Prentky were almost three times as likely to be convicted of a new sexual offense than those in the low-impulsivity group (cited in McGrath, 1991). Studies which measure the pace of

reoffense for different offense types, have found that rapists tend to recidivate at a high rate during their first year after release, whereas child molesters tend to maintain a more stable curve over time (Frisbie, 1969, Sturgeon & Taylor, 1980).

Exposers have been found to reoffend at the highest rates across offender types. This group tends to score higher on measures of compulsivity.

- ◆ **Degree of Force/Violence (sexual and nonsexual).** A study on serial rapists by the FBI found that those who increased the amount of force used from first to last offense, assaulted significantly more victims (a mean of 40 for increasers versus a mean of 22 for non-increasers), over a shorter period of time (a mean of every 19 days versus a mean of every 55 days for non-increasers). By their last offense the increasers were inflicting significantly more serious injuries on their victims. Increasers tended to bind and transport their victims and incapacitated them longer. They did not negotiate with or reassure them and acted in a "macho" manner, (Warren, Reboussin, Hazelwood, & Wright, 1991).
- ◆ **Multiple Paraphilias and Deviant Arousal.** Is there evidence via self-report or documented history that the offender has been involved in multiple types of offending, i.e., rape, exposing, child-molesting? One study found that offenders who targeted both males and females and both children and adolescents recidivated at a considerably higher rate than the average for the sample as a whole, (Abel, Mittleman, Becker Rathner, & Rouleau, 1988).

Maletzky, (1990), found that those offenders with histories of multiple paraphilias failed treatment or recidivated at a rate five times greater than those without multiple paraphilias.

Do the results of testing, the offender's self-report or documented behavior suggest that the offender has a deviant or criminal sexual orientation, e.g., The offender's primary sexual attraction is to pre-pubescent males.

Phallometry has been found to be a useful measure of deviant arousal for child molesters. An estimated ninety percent of repeat extrafamilial molesters have an attraction to children, (Freund & Watson, 1991). Arousal level pre-treatment to deviant stimuli proved to be significantly related to recidivism in a study by Quinsey and Marshall, (1983).

Phallometry has not been found to be as useful with rapists, (who are more likely to be aroused to nonsexual violence) in measuring arousal to sexual stimuli. The role of deviant sexual arousal in rape is unclear. However, phallometry, when used to measure arousal to nonsexual violence can be useful in predicting recidivism in rapists, (Rice, Harris, & Quinsey, 1990).

Studies have found that extrafamilial offenders who molest male children offend at a higher rate than those who target female children, and that both groups offended at a higher rate than incest-only perpetrators (Hanson, Steffy, & Gauthier, 1992, Sturgeon & Taylor, 1980).

Interestingly, there is considerable evidence that offenders who have never married have recidivated at higher rates than those who have been married, (Hanson, et. al., 1992). One can surmise that a sexual orientation toward minors for at least one subgroup of offenders deters them from marrying.

In assessing the presence of deviant arousal the assessor should also note whether there is an absence of age-appropriate, nondeviant arousal.

- ◆ **Identification and Accessibility to Preferred Victims.** How difficult or easy will it be to restrict this individual from potential victims i.e., persons who match his target preference? If the offender indiscriminately molests children, male and female, under the age of 12, it is more difficult than restricting contact for the incest offender who has only molested within the immediate family.
- ◆ **Past Treatment Involvement.** What was the quality and outcome of any past treatment the offender may have participated in? What was his prognosis at the time?
Preliminary results from the Minnesota Department of Corrections on an incarcerated group of sex offenders suggests that those who enter treatment but fail to complete were more likely to be re-arrested for a sex offense than were persons who never entered or who completed treatment programming (Kaul, Huot, & Epperson, 1993). This is especially true for offenders who have a more than one felony sex offense. Of note is that Gordon et al., (1992), found psychopaths (as measured by their score on the Hare Psychopathy Check List) were more likely to fail to complete treatment.
- ◆ **Level of Honesty/Denial.** Does the offender admit the offense(s) and/or recognize that the behavior is wrongful or problematic? Does he admit planning the offense behavior? Does he accept responsibility for his behavior?

Unlike assessments typically conducted in a mental health setting, sex offender assessments are not anonymous and offenders may face considerable consequences if assessed at risk to reoffend. Thus, they may be highly motivated to present a favorable image to the assessor. Offenders may do so by attempting to minimize or deny their sexually deviant behavior, planning or fantasies, or they may admit, but rationalize and justify these elements. Their justifications are often useful for assessing deviant or problematic attitudes, beliefs and cognitive distortions.

Paper-pencil assessment tools, such as the Clarke Sex History Questionnaire and the Multiphasic Sex Inventory can be useful as offenders often disclose more on these assessments than in face-to-face interviews.

Some offenders will talk about their offending without reservation, sometimes even appearing to enjoy relaying this information. This offender seems lacking in shame about his behavior. “Honesty” may not be a useful indicator of treatment amenability or risk level for this individual. His absolute honesty may simply emphasize his extreme lack of boundaries regarding sexually inappropriate behavior.

- ◆ **Degree of Insight into Own Risk Level.** Does the offender believe and/or report that “it will never happen again”, or does he maintain a cautious awareness about his potential to

reoffend. The latter attitude may facilitate a greater likelihood of attending to precursors and avoiding high-risk situations, as well as a motivation toward treatment.

- ◆ **Type of Support Available.** It is important to assess the personal support an offender has available to him. Are support persons reliable or unreliable? Reliable support persons believe the offender is guilty, support change and will try to assist in preventing relapses. Unreliable support persons are those that collude in the offender's denial, are overprotective or unwilling to work with the system. Does the offender seek support primarily from other persons with criminal or deviant interests, persons who will encourage or contribute to the offender's deviant behavior? Is the offender satisfactorily involved in treatment support groups (e.g., AA) or appropriate social groups. Is he maintaining stable employment?
- ◆ **Chemical Abuse History.** Does the offender have a history of chemical dependency or chemical abuse that is associated with sexually deviant behavior? The importance of this factor is often overlooked. Kaul, et. al., (1993), found in a study of incarcerated sex offenders that, those who reoffended were more likely to be chemically dependent and to have failed to enter chemical dependency treatment while incarcerated. Overall, the rate of reoffense of the chemically dependent sex offender was approximately 20% higher than the norm in this study. Additionally, this study found that chemically dependent sex offenders reoffended more quickly than non-chemically dependent sex offenders.
- ◆ **Practical Issues in Assessing Treatment Amenability.**

Does the offender meet the treatment program's criteria? Such criteria often include issues such as admission of guilt, ability to pay, psychiatric stability, ability to accept confrontation, appropriate level of risk for treatment setting. It is important to know the criteria and policies of various sex offender treatment programs evaluators refer to. This will help insure that inappropriate referrals are not made and will assist in case disposition planning.

Is the offender willing to follow the policies of the treatment program? Is he willing to invest the time and money required? Is he willing to agree to the terms spelled out in the treatment contract and follow all rules? Some offenders opt to serve additional prison/jail time, in lieu of treatment in the community, as they don't want to spend the time and/or money without a guarantee of success. Offenders who fail treatment while on probation often face revocation and imposition of their original sentence.

Meeting any one of the above criteria does not necessarily make an offender a high risk to recidivate, nor is this a comprehensive list of factors. Risk assessment tools are available to help evaluators with these difficult decisions. However, the use of these tools typically requires a policy decision of the agency or department and evaluators should consult with appropriate personnel before utilizing such tools.

In assessing risk it is important to keep in mind that concerns are related to both degree of violence and frequency. Some offenders may be at low risk to reoffend with any frequency but at great risk to commit extreme violence in their future offending and vice versa. The community may be more tolerant of an exposer, whose frequency of offending is high, than of a violent stranger rapist, who offends at a much lower frequency but batters or even kills his victims.

References

Sex Offender Treatment Effectiveness & Risk Assessment

- Abel, G., Mittleman, M., Becker, J., Rathner, J., & Rouleau, J., (1988). Multiple paraphilic diagnoses among sex offenders. *Bulletin of the American Academy of Psychiatry and the Law*, 16, 153-168.
- Abel, G., Mittleman, M., Becker, J., Rathner, J., & Rouleau, J., (1988). Predicting child molesters' response to treatment. In R.A. Prentky & V.L. Quinsey (Eds.), *Human sexual aggression: Current perspectives* (pp. 223-234). New York: New York Academy of Science.
- Barbaree, H.E., & Marshall, W.L., (1988). Deviant sexual arousal, offense history, and demographic variables as predictors of reoffense among child molesters. *Behavioral Sciences and the Law*, 6, 267-280.
- Epperson, D.L., Kaul, J.D., & Huot, S.J., (1995). *Predicting risk of recidivism for incarcerated sex offenders: Updated development on the sex offender screening tools (SOST)*. A paper presented at the 14th Annual Research and Treatment Conference of the Association for the Treatment of Sexual Abusers, October 11-14, 1995, New Orleans, LA.
- Freund, K., & Watson, R.J., (1991). Assessment of the sensitivity and specificity of a phallometric test: An update of phallometric diagnosis of pedophilia. *Psychological Assessment: A Journal of Consulting and Clinical Psychology*, 3, 254-260.
- Frisbie, L.V., (1969). *Another look at sex offenders in California*. (California Mental Health Research Monograph No. 12). Sacramento: California Department of Mental Hygiene.
- Frisbie, L.V., & Dondis, E.H., (1965). *Recidivism among treated sex offenders*. (California Mental Health Research Monograph No. 5). State of California Department of Mental Hygiene.
- Hall, G.C.N., (1995). Sexual offender recidivism revisited: A meta-analysis of recent treatment studies. *Journal of Consulting and Clinical Psychology*, 63, 802-809.
- Hanson, R.H., Cox, B., & Woszczyna, C., (1991). Assessing treatment outcomes for sexual offenders. *Annals of Sex Research*, 4, 177-208.
- Hanson, R.K., Steffy, R., & Gauthier, R., (1992). *Long-Term Follow-up of Child Molesters: Risk Predictors and Treatment Outcome*. (User Report No. 1992-02). Ottawa: Ministry Secretariat, Solicitor General Canada.
- Hare, R.D., Harpur, T.J., Hakstian, A.R., Forth, A.E., Hart, S.D., & Newman, J.P., (1990). The revised psychopathy checklist: Reliability and factor structure. *Psychological Assessment: A Journal of Consulting and Clinical Psychology*, 2, 338-341.
- Harris, G.T., Rice, M.E., & Cormier, C.A., (1991). Psychopathy and violent recidivism. *Law and Human Behavior*, 15, 625-632.
- Huot, S.J., Kaul, J.D., & Desjarlais, J., (1996). *Sex offenders entering Minnesota correctional facilities: A descriptive study*. Unpublished manuscript. Available from the Minnesota Department of Corrections.

Kaul, J., Huot, S., & Epperson, D., (1993). Sex offenders released in 1988 from Minnesota Department of Corrections institutions. St. Paul: Department of Corrections.

Maletzky, B., (1990). *Treating the sexual offender*. Newbury Park, CA: Sage Publications.

McGrath, R., (1991). Sex offender risk assessment and dispositional planning: A review of empirical and clinical findings. *International Journal of Offender Therapy and Comparative Criminology*, 35, 328-350.

McGrath, R., (1990). Assessment of sexual aggressors: Practical interviewing strategies. *Journal of Interpersonal Violence*, 5, 507-519.

McGrath, R., (1992). Five critical questions: Assessing sex offender risk. *Perspectives*, 16(3), 6-9.

Prentky, R., (1990). Sexual violence: A review. Paper presented at the Ninth Annual Clinical and Research Conference on the Assessment and Treatment of Sexual Abusers, Their Families and Victims, Toronto, Canada.

Prentky, R., & Burgess, A., (1990). Rehabilitation of child molesters: A cost benefit analysis. *American Journal of Orthopsychiatry*, 60, 108-117.

Quinsey, V.L., & Marshall, W.L., (1983). Procedures for reducing inappropriate sexual arousal: An evaluation review. In J.G. Greer & I.R. Stuart (Eds.), *The sexual aggressor: Current perspectives on treatment* (pp. 267-289). New York: Van Nostrand Reinhold.

Quinsey, V.L., Rice, M.E., & Harris, G.T., (1995). Actuarial prediction of sexual recidivism. *Journal of Interpersonal Violence*, 10, 85-105.

Quinsey, V.L., Rice, M.E., & Harris, G.T., (1990). A follow-up of rapists assessed in a maximum security psychiatric facility. *Journal of Interpersonal Violence*, 5, 435-448.

Quinsey, V.L., Lalumière, M.L., Rice, M.E., & Harris, G.T., (1995). Predicting sexual offenses. In J.C. Campbell (Ed.), *Assessing dangerousness: Violence by sexual offenders, sexual batterers, and child abusers* (pp. 114-137). Thousand Oaks, CA: Sage Publications.

Rice, M.E., Quinsey, V.L., & Harris, G.T., (1991). Predicting sexual recidivism among treated and untreated extrafamilial child molesters released from a maximum security psychiatric institution. *Journal of Consulting and Clinical Psychology*, 59, 381-386.

Sturgeon, V.H., & Taylor, J., (1980). Report of a five-year follow-up study of mentally disordered sex offenders released from Atascadero State Hospital in 1973. *Criminal Justice Journal*, 4, 31-63.

Warren, J.I., Reboassin, R., Hazelwood, R.R., & Wright, J., (1991). Prediction of rapist type and violence from verbal, physical, and sexual scales. *Journal of Interpersonal Violence*, 6, 55-67.