

**MANAGING UNACCEPTABLE RISK:  
THE RISK ASSESSMENT AND MANAGEMENT OF  
CHILD SEXUAL OFFENDERS**

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I'd like to commence with the obligatory statement of authorship; that is all of the thoughts and opinions expressed in the course of this paper today are those of myself, and do not necessarily represent the views of those institutions of which I am associated; namely the University of South Australia and the Sexual Offender Assessment and Treatment Program.

When reflecting on my initial abstract during the forming of this paper, I noted that I was perhaps naively optimistic regarding the amount of material which I anticipated that I would traverse. Generally speaking my intention is to present a succinct yet informative review of the extant literature related to the:

- Features and characteristics of those child sexual offenders who reoffend
- A discussion of those approaches concerning the risk assessment of sexual offenders which currently predominate
- A discussion of the role of risk management strategies (specifically psychological intervention programs) in managing the risk posed by sexual offenders, and
- A discussion of the inherent problems posed by a risk based focus to the assessment and treatment of sexual offenders.

Rather than attempting to discuss the theoretical underpinnings and implications of the literature in any detail, the aim is to provide a general overview of the knowledge base so that you may in your own time think about its implications and relevance. I apologise in advance for not having the time to delve greatly into the many issues associated with this topic, often to the detriment of the subject matter, but am amenable to further discussion on the topics addressed in today's paper if people so require.

### **Risk Assessment of Sexual Offenders**

We all seek to make a difference. By addressing the problem of child abuse, whether as therapists, researchers, policy advisors, or victim advocates we aspire to a world in which children are safe in their homes and their daily environs. But what needs to change? Potential victims can learn to better protect themselves, but surely any enduring solution requires that we change offenders. This leads me to the crux of today's paper. Specifically ascertaining and managing the risk posed by those who offend against children.

The need for accurate risk assessment permeates work conducted with sexual offenders, with these assessments aiding in decisions spanning the criminal justice process including sentencing, institutional placement, treatment planning, recommendations with regard to parole, and the restrictiveness of conditions attached to supervision in the community. This need has been made more salient by the recent enactment of 'sexual predator' laws in the United States, (see Lieb & Matson, 1998) and recent 'retributive' based sentencing and parole considerations being employed increasingly within the Australian correctional environment.

Unfortunately, though, the exact prediction of recidivism is an expression of wishful thinking rather than empirical reality. The scientific studies as to the prediction of recidivism, however, provide information that may be used to improve the accuracy of the decisions of those who are associated with assessing and managing the risk posed by sexual offenders.

Specifically, predictors of sexual reoffending may be divided into two main categories: static predictors and dynamic predictors. Static predictors are generally unchangeable variables of an offenders past such as criminal history, age, and demographic characteristics. These static factors predict reoffending, but are immutable to outside influences.

In contrast, dynamic predictors, are potentially changeable variables; they may be relatively stable and enduring characteristics of individuals, such as criminal attitudes and criminal associates (referred to as stable dynamic predictors), or they may be rapidly changing, more proximally based variables such as emotional states, victim access, and sexual preoccupations. These are referred to as acute dynamic predictors.

In summary, static factors are useful for making assessments of an offender's overall risk level. Knowledge of dynamic factors, however, is required to identify targets for intervention, and assess potential changes in risk (e.g., benefit from treatment).

A colleague applied the following useful analogy when reflecting on the distinction between static and dynamic risk variables. Consider the instance of an individual being considered as a risk for heart disease. A static assessment of such an individual's risk status can be gleaned by gaining a knowledge of the individual's family history of heart disease and age, etc. No matter what the individual does, he or she will always have that underlying static risk.

Dynamic considerations of this risk would include ascertaining the individual's current lifestyle and associated factors which may moderate that underlying static risk potential. This may include considering whether the individual consumes fatty foods, or exercises regularly, etc. All of these considerations are amenable to change.

Applying this same analogy to the issue of sexual offender risk assessment, an individual's static risk is ascertained by examining to a large extent his or her offending background and the characteristics of that offending. If an individual has offended sexually against other individuals a number of times, and has offended against strangers for instance, then no matter what that individual does subsequently, he or she will always be regarded as likely displaying a high static risk level, or more broadly speaking, his or her past behaviour has demonstrated a possible underlying propensity or potential to offend sexually.

Dynamic considerations of this risk would include ascertaining those factors which may moderate that risk and possibly indicate the potential onset of new offending behaviour. For instance, whether the individual is currently engaging in an antisocial type lifestyle (ie viewing pornography, abusing substances, etc) or seeking victim access. These dynamic factors provide the main focus during a treatment program, and provide targets for supervision and cues as to when supervision may be relaxed or needs to be intensified (Quinsey, Harris, et al, 1998, pp.37).

### **Predictors of Sexual Recidivism**

The strongest evidence for identifying risk factors comes from follow-up studies (Furby, Weinrott & Blackshaw, 1989). In this manner, offenders who are released from custody are followed over a period of time, with the features of those who reoffend being contrasted with those who do not reoffend.

Rather than discuss individual follow-up studies in detail, it would seem pertinent to refer to recently completed meta-analyses of sexual offender recidivism studies (Hanson & Bussiere, 1998; Hanson & Bussiere, 1996). Such quantitative summaries, or meta-analyses, summarise the results of many follow-up studies in a quantitative manner.

Perhaps the most widely cited meta-analysis of the literature is that provided by Hanson & Bussiere (1998) which examined 61 different follow-up studies, including a total of in excess of 28,000 sexual offenders mainly in North America and the United Kingdom. In summary, the review asked the following question: compared to other sexual offenders, what are the characteristics that increase or decrease the reoffending risk of a particular sexual offender?

When considering demographic information, the younger sexual offenders were more likely to recidivate than were the older sexual offenders. As well, single unmarried sexual offenders were at higher risk than other offenders.

The strongest predictors of sexual reoffending were measures of sexual deviancy. Sexual interest in children as measured by phallometric assessment (a method utilised to detect likely sexual arousal) was the single strongest predictor found. Related predictor variables included phallometric assessment of sexual interest in boys as well as any deviant sexual preference.

The risk for sexual reoffending was increased for those who had any of the following characteristics: prior sexual offenses, had victimised strangers, had an extrafamilial victim, began offending sexually at an early age, had selected male victims, or they had engaged in diverse sexual crimes as opposed to one specific form of sexual offence.

After sexual deviance, the next most important predictors were general criminological factors such as the total number of prior offences, age, and having a diagnosis of antisocial personality disorder.

Few of the general psychological variables showed significant relationships with reoffending. The most consistent psychological risk factor was a diagnosis of personality disorder, typically antisocial personality disorder or psychopathy. None of the general measures of distress or psychological dysfunction were related to sexual offense recidivism (e.g., depression, anxiety, social skills). Failure to complete treatment was a moderate predictor of sexual reoffending.

### **Model of Recidivism Risk**

The predictor variables evidenced in the Hanson and Bussiere (1998) study highlighting the importance of variables related to sexual deviancy and general criminality are provided with theoretical support also. For example, Knight (1999) formulated a theory of sexual coercion, involving two underlying independent drives: (a) sexual deviance/preoccupation and (b) hyper (or negative) masculinity. The first type of drive involves either sexual interest in actions that are illegal and/or preoccupation with sexual behavior in general. The second route to sexual offence is through the influence of a set of personality characteristics related to aggressiveness, hostile attitudes toward women, gratification from dominance, and acceptance of violence against women as appropriate. The two risk factor rubrics of sexual deviancy and general criminality identified by Hanson & Bussiere (1998) seem conceptually related to Knight's two dimensions.

Recent research from the treatment realm is suggestive of a similar theoretical perspective, with Hudson, Ward and McCormack (1999) documenting 'multiple offence pathways in sexual offenders'.

In summary, a number of follow-up studies as presented in the aforementioned meta-analysis have identified a number of static or highly stable predictors that can usefully identify an enduring propensity for sexual offending. However, as indicated earlier, the main focus in treatment programs are those individually based factors which can be changed, that is dynamic predictors of sexual reoffending. Until recently there has been a general lack of empirical evidence investigating the role of dynamic factors, but some of the more recent studies have identified some of the more promising dynamic factors.

## **Dynamic Variables**

A recent Canadian based study (Hanson & Harris, 2000) involving approximately 400 sexual offenders retrospectively compared those sexual offenders who recidivated whilst on community supervision with those who did not. The sample did not include incest offenders, and information was gained via detailed interviews with supervising correctional officers and through detailed file review.

There were significant differences between the recidivists and non-recidivists on most of the dynamic variables examined in the study. Dynamic variables were classified as stable or acute depending on when they were noted during the course of supervision. Stable predictors were those factors which differentiated recidivists versus non-recidivists during the full course of supervision, whereas acute dynamic variables were those factors which were noted in the recidivists as changing during the course of supervision and typically just prior to the recidivism event.

The recidivists as compared to the non-recidivists generally had poor social supports (ie the offenders social environment more negative then positive influences, with the repeat offenders more often experiencing intimacy problems (including no intimate partner and current relationship conflicts)).

In addition the repeat offenders evidenced greater attitudes tolerant of sexual assault such as low remorse, victim blaming, child molester type attitudes () and attitudes related to sexual entitlement.

The repeat offenders further evidenced more antisocial lifestyles generally (ie tended to use their leisure time aimlessly, to resist personal change, and to hold strongly antisocial attitudes, with their release environment being relatively uncontrolled in terms of access to victims, drugs and alcohol).

Poor self-management strategies and saw themselves as being at little risk for committing a new sexual assault, and took few precautions to avoid high-risk situations (ie more likely to create or expose themselves to situations in which access to potential victims was likely such as child-oriented hobbies and flashy cars).

Generally, the correctional officers considered the recidivists to have displayed poor cooperation with supervision during the supervision period, with this including being disengaged, manipulative or absent.

Specific acute predictors of sexual offending included an increase in anger and subjective distress prior to reoffending.

The recidivists and non recidivists were equally likely to display psychological symptomatology at some point during their supervision period, however it was noted that the recidivists' mood decreased prior to committing their new offence. This change in mood incorporated symptomatology such as negative mood, anger, and general psychiatric symptoms (acute).

Without elaborating to any extent on the implications of these studies, all of these variables provide useful input for correctional officers and those associated with assessing and monitoring the risk posed by sexual offenders. Correctional officers should be encouraged to monitor offenders being supervised for changes in their status during the course of supervision, and the study also provides useful information for treatment providers, with most of the variables being amenable to treatment and thus change. By carefully monitoring the offender's risk indicators, we may be able to provide graduated and responsive interventions well before the point of no return (Hanson & Harris, 2000).

## **Risk Assessment: Available Methods in the Assessment of Sexual Recidivism**

Since the literature has indicated that no single unitary factor has been demonstrated to be sufficiently able to determine whether convicted sexual offenders will or will not reoffend, evaluators need to consider a range of relevant risk factors. The procedures currently utilised by clinicians to make risk assessments have been subject to ongoing controversy with the debate largely centering around the issue of which is the most reliable or accurate method.

Currently there appear to be three main approaches to risk assessment in this area: (1) professional judgement (structured and un-structured); (2) actuarial prediction; and clinically adjusted actuarial prediction (Campbell, 2000). Each of these will be discussed in turn.

### **Professional Judgement**

Generally, clinicians may make a professional judgement that is either aided or unaided by empirically supported data (Hanson, 2000).

Unstructured professional judgement refers to the formulation of predictions of future offending based on idiosyncratic impressions. Research indicates that the unstructured approach is perhaps the least reliable and valid method of sex offender risk assessment. For example, Hanson & Bussiere (1998) indicated that the ability of professional judgement to predict recidivism was only slightly better than chance. The poor accuracy of professional judgements in risk assessments has further been evidenced by Monahan (1981), who in a review of the violence risk prediction literature, concluded that mental health clinicians were only accurate in approximately one in three predictions of violent behavior among institutionalised populations who had been diagnosed with a mental illness. Clearly, therefore, there is a risk that by employing unstructured professional judgement to make a risk assessment decision, a clinician is doing so in the knowledge that this method is associated with little validity or accuracy.

The alternative approach to employing unstructured professional judgement is to employ structured professional judgement based approaches, referring to empirically validated or grounded risk factors and combining ratings on these factors to guide the overall assessment of risk (Hanson, 2000). Typically then this approach involves the application of an a priori set of factors to be considered and given weight in the risk assessment, which are explicit but the method for weighing the importance of the risk factors is left to the judgement of the evaluator (Boer, Wilson, Gauthier & Hart, 1997).

Generally, this approach of may be considered more adequate than its unstructured counterpart. However, there are a number of limitations that should be noted.

Specifically, without an explicit method of determining recidivism probabilities from risk factors, it is difficult to determine the risk of the offender who has some risk predictors but not others (Hanson, 2000). Such difficulties translate into variations in risk assessments of the same offender by different clinicians, who are ultimately forced to fall back on their professional judgement in determining which risk factors carry the most weight.

Fortunately, recent research has provided the opportunity for the development of a more accurate and valid approach to the risk assessment of sexual offenders that improves on the many limitations associated with both structured and unstructured professional judgement. The approach is referred to as the actuarial approach.

## **Actuarial Procedures**

In contrast to the professional judgement approach, actuarial procedures generally constitute a more objective, valid and reliable approach to risk prediction (Grove & Meehl, 1996). This approach is based on explicit rules for combining variables already demonstrated to predict recidivism (Quinsey et al, 1995).

In contrast to the structured professional judgement approach, the actuarial approaches explicitly state not only the variables to be considered but the precise procedure through which ratings on these variables will be translated into a risk level.

Utilising the procedure of combining risk factors into specific probability estimates, a number of actuarial instruments have been developed. These instruments, as compared to the professional judgement approach, have the advantage of, typically, being easy to score and interpret while their validity is likely to have been established by previous research (Hanson, 2000). There are, however, limitations and advantages that are specific to particular actuarial instruments.

## **Clinically Adjusted Actuarial Prediction**

While the actuarial approach to risk assessment has a number of advantages over the professional judgement approach in terms of accuracy and validity (Grove & Meehl, 1996), there remains a considerable amount of research to be conducted to establish satisfactory evidentiary reliability for instruments currently available, particularly within the Australian setting (Campbell, 2000). Furthermore, a problem associated with all actuarial procedures is that no-one scale can purport to consider all relevant risk factors. As a direct result of this latter issue, many clinicians have begun to refer to external factors to adjust their actuarial predictions either up or down – referred to as clinically adjusted actuarial prediction. For example, an offender classified as ‘high risk’ using actuarial methods, may be reclassified as ‘medium’ risk if he demonstrates significant progress in treatment (Hanson, 2000).

Whilst such approaches and frameworks represent a promising comprehensive approach to the assessment of sexual recidivism, it is yet to be subject to empirical evaluation.

In summary, generally, it is considered that as research develops, actuarial approaches shall be expected to consistently outperform clinical predictions (Grove & Meehl, 1996). With the current state of knowledge, however, both actuarial and structured professional judgement approaches can be expected to provide risk assessments with moderate levels of accuracy.

## **Risk Management of Sexual Offenders**

The supervision of high risk persons in the community is one of the most complex and difficult tasks currently facing criminal justice personnel. It is one area where the credibility and effectiveness of criminal justice agencies is harshly measured, particularly in the light of serious incidents and risk management failures. However, the effective risk management of offenders is seen as central to public protection through the prevention or reduction of harmful behaviours (Home Office, 1997b). While risks cannot necessarily be prevented, they can be reduced (Laws, 1996; Ryan, 1996). Risk management should therefore be understood as risk reduction rather than prevention, that is, reducing:

- the factors which lead to risks occurring; or
- the impact of the risk once it has occurred.

This approach is more commonly known as ‘harm reduction’ (Laws, 1996) and is widely used in the treatment of drugs and alcohol abuse. The key principle of harm reduction is that reduction in the frequency of harmful behaviours is a gain, as this reduces the number of victims, and, that any positive change in harmful behaviours will lessen the impact of such behaviours on others.

This section reviews the risk management strategy of psychological intervention programs, and also details the efficacy of such endeavours. Psychological treatment in this instance refers to those programmes designed to assist offenders to change their criminal behaviour through control and/or management of thinking patterns, feelings, drives and attitudes (Scottish Office, 1997: 34). Programmes may use a range of methods, but in practice they have been based upon intensive cognitive behavioural methods delivered both residentially (for example in custody) and within the community (Vennard and Hedderman, 1998).

The cognitive- behavioral method of treatment has developed through the combination of both cognitive and behavioral approaches to therapy, and to provide a brief synopsis, the behavioral component addresses the overt and covert behavior of an individual utilising the principles of learning theory. Originally this was confined to the use of procedures to alter behavior (ie rewarding desirable behaviors and punishing unwanted behaviors), but has since broadened to include modeling (ie demonstrating an desired behavior) and skills training (ie teaching specific skills through behavioral rehearsal).

The cognitive component addresses the thoughts or cognitions that individuals experience, their ways of thinking about the world and their social environment, which are known to affect mood states and hence have an influence on subsequent behavior. Cognitive therapy therefore aims to encourage an individual to think differently about events, thus giving rise to different affect and behavior. The use of self-instruction and self-monitoring, and the development of an awareness of how one thinks affects how one feels and behaves, are vital components of cognitive therapy.

By combining these two approaches, cognitive-behavioral therapy provides a comprehensive approach to treating sexual offenders. Treatment has generally been provided in group format, with program content coalescing around a series of core components. These include interventions directed at modifying, changing and reducing pro-offending thinking or rather modifying thinking which makes it acceptable for sexual offenders to offend, deviant sexual arousal and fantasizing, increasing victim empathy, and decreasing the risk of relapse. More variable across programs are adjunct interventions that can include self-esteem, intimacy and relationship enhancement, loneliness and attachment styles, mood management, and coping skills and sexual education (Marshall & Serran, 2000; see also Marshall, Fernandez, Hudson & Ward, 1998).

Specific relapse prevention based modules are ordinarily incorporated into sexual offender treatment program content, and such models assume that offending behavior is typically preceded by an identifiable and predictable chain of behaviors, emotions and cognitions. Consequently relapse is considered to constitute a process or chain of behavior occurring across time, which can be avoided if offenders and their supervisors have adequate insight into their offending process.

## **Evaluation**

If treatment is to be widely used in the management of sex offenders, though, then it is important that it work.

Despite more than 35 review papers since 1990, and a review of reviews (United States General Accounting Office, 1996), researchers and policy-makers have yet to agree on whether treatment effectively reduces sexual recidivism. This lack of consensus is rooted in inherent difficulties with the evaluation of sex offender treatment programs. On the surface, the evaluation process appears straight-forward: the sexual offence recidivism rate of a treated group of sex offenders should be

compared to the recidivism rate of an equivalent group of offenders who did not receive treatment. Researchers who attempt such comparisons are faced, however, with the challenge of low recidivism rates even among untreated offenders (Barbaree, 1997). On average, only 10%-15% of sex offenders are detected committing a new sexual offence after 4-5 years (Hanson & Bussière, 1998). The typical treatment program provides service to relatively few offenders. To achieve sufficient statistical power, researchers who initiate new studies have to wait many years before treatment effects can be detected.

Notwithstanding the difficulties associated with evaluation though, both evaluative studies (Barbaree, 1997; Barker and Morgan, 1993; Marshall and Barbaree, 1988; Marshall et al, 1991; Marshall et al, 1999) and meta-analyses (Hall, 1995; Nagayama-Hall, 1995) have indicated that cognitive-behavioural programmes are the most effective in managing the risk of reoffending in child sexual offenders. Alexander (1999) reviewed 79 treatment outcome studies (11,000 participants) and concluded that treatment was effective in reducing recidivism. Nagayama-Hall's (1995) meta-analysis of twelve studies further found that cognitive-behavioural treatments and hormonal treatments were significantly more effective than behavioural treatment alone, although not significantly different from one another. However, cognitive behavioural treatment enjoyed better compliance rates than hormonal treatments (p.807).

Hanson and colleagues (2002) recently offered a comprehensive meta-analytical review of 43 treatment studies dating from 1980 to 2000. Averaged across all studies, the sexual offence recidivism rate was lower for the treatment groups than the comparison groups. Current treatments (cognitive behavioral,  $k = 13$ ; systemic,  $k = 2$ ) were associated with reductions in both sexual recidivism (from 17.4% to 9.9%) and general recidivism (from 51% to 32%). Older forms of treatment (prior to 1980) appeared to have little effect.

Although the meta-analysis provided evidence about the overall effectiveness of treatment, it provided little direction on how to improve current practise. The treatments that appeared effective were recent programs providing some form of cognitive-behavioral treatment. Further research is needed though in order to make reliable distinctions between types of treatment and types of offenders.

Based on the studies mentioned, it is possible to conclude that cognitive-behavioural methods have a growing track-record of effectiveness with child sexual offenders. The findings are consistent with the general 'what works' literature related to the efficacy of psychological interventions in attempting to rehabilitate offenders, but further distinction is still required to differentiate what works best for which specific forms of offenders and the associated conditions.

## **Conclusion**

I'd like to briefly conclude with a caution regarding imposing an inherently risk based focus to the assessment and treatment of sexual offenders.

I agree with Professor Tony Ward of the University of Melbourne who cautions against broadly applying the current dominant view of offender rehabilitation with treatment efforts being targeted toward risk reduction. Here the primary concern is with a deficit based focus to offender rehabilitation, where the primary aim is to avoid harm to the community rather than to improve offender's quality of life, and by virtue of such reducing reoffending. For example, utilising the risk based model, at the end of the assessment process the therapist is essentially left with a depiction of an individual's vulnerability factors and problems. What is missing is the integration of this knowledge with different more constructive ways of living. This failure to explicitly link constructive ways of living with risk assessment and management can make it difficult to motivate

offenders and encourage them to invest in the change process, and Ward (2002) makes a convincing argument regarding how it may be preferable to capitalise on the strengths of the risk based perspective by locating or embedding it within a more constructive, strength based capabilities approach, what he has referred to as the 'good lives' model of offender rehabilitation (Ward, in press). Thus, the therapeutic focus should be on implementing an offender's 'good lives' conceptualisation rather than simply managing risk. It is anticipated that the modification of dynamic risk factors will occur as a consequence of implementing a good lives plan. Although yet to be provided with empirical support, Ward's (2002) model provides useful consideration as a focus for further discussion.

In summary, in this paper today I have endeavoured to provide a brief yet informative review of the literature related to the assessment and management of risk in child sexual offenders. I provide such with the intention of seeking to promote discussion on the issues inherent, with the aim of such ultimately being the facilitation of more effective ways of dealing with the risks posed by such offenders and their behaviour. Thankyou for your consideration.

In the good lives model, risk factors are viewed as obstacles that erode an individual's capacity to live more fulfilling lives. Essentially, risk factors function as indicators or markers that an individual's pursuit of primary human goods is compromised in some way. That is, the internal and external conditions necessary to achieve valued outcomes may be missing or incomplete.