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Risk assessment and treatment planning

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Introduction

The assessment of a sexual offender's risk of recidivism is an essential task that influences all aspects of their management. Risk assessments inform decisions with respect to sentencing, community registration or notification, release from prison or a hospital, release conditions, and levels of supervision and monitoring. The results of a comprehensive risk assessment will also provide information as to *who* should be treated, *how much* treatment they might require, *what* treatment should seek to change, and *when* risk might be reduced as a consequence of treatment. As noted by Collie, Ward, and Vess (2008) "without accurate [risk] assessment it is impossible to determine the suitability and focus of treatment, nor whether treatment has had any positive impact" (p65).

In completing a risk assessment that will be used to assist in treatment planning, professionals typically will use information based on both static or historical (largely non-changeable) factors and dynamic (changeable) factors. Most commonly they will use a combination of actuarial risk assessment measures and structured professional judgement protocols (Craig, Beech, & Harkins, 2009).

Within this chapter we will explore how the information gained from a comprehensive risk assessment can be used in treatment planning. We will examine in turn the usefulness of information from risk assessments that focus on static or historical and dynamic risk factors. Specific to static and historical risk factors, we will examine how these can be used to determine who should complete treatment, how much treatment is required, and how these historical factors may actually serve as potential markers of treatment targets. We briefly consider the limitations of these measures, if used in isolation, for treatment planning. We will then examine the relative importance of dynamic risk factors arguing that individualized formulations of each sex offender's risk is essential to treatment and that the sharing of the risk assessment results with sex offenders is an important treatment (planning) opportunity. We will discuss the types of dynamic risk measures and their usefulness for treatment planning and then point out the differences in dynamic risk measures in terms of what risk factors they measure. Then, we will discuss the use of dynamic risk measures to assess treatment changes (and subsequent risk reduction) before finally reflecting on whether treatment programs are, in fact, adequately using the results of risk assessments in their treatment planning.

We note at this point that there remain limitations in administering the majority of established static or historical and dynamic risk assessment measures with unique groups of sexual offenders including females, those who offended using the internet, individuals who are cognitively impaired, and juveniles. While the broad uses of risk assessment for treatment planning that we will outline can, in many instances, be applied to these groups, practitioners should be informed by the literature on the most appropriate risk assessment measures to identify risk factors for these unique populations (see Craig & Beech, 2010).

Risk assessments focusing on static or historical factors

Irrespective of the reason for a risk assessment, whether it be for the courts for sentencing or a treatment provider to plan treatment, actuarial risk assessments focusing on static or historical (unchangeable) factors are the most commonly used approach (Kingston et al., 2008). The assessment of static or historical risk factors is best done by using one of the many actuarial risk measures developed for that specific purpose. These measures consist of a number of empirically derived items (individual risk factors) that are scored as present or not and in some instances are weighted. The sum scores of these items are then translated into a level of risk (e.g., low, medium, high). Essentially the individual offender, on the basis of his sum score, is compared to a group of sex offenders with similar sum scores. The reconviction rates of the offenders from the validation sample group are then used to describe what percentage of similar offenders can be expected to re-offend over particular time periods.

The reliability and validity of this approach has been well established (Craig, Beech, & Harkins, 2009) and actuarial risk measures consistently outperform empirically guided clinical judgement (e.g. Hanson & Morton-Bourgon, 2007). Examples of actuarial measures with established predictive validity include the Static-99 (Hanson & Thornton, 2000), Static-2002 (Hanson & Thornton, 2003), Rapid Risk Assessment of Sexual Offence Recidivism (RRASOR) (Hanson, 1997), Sex offender Risk Appraisal Guide (SORAG) (Quinsey, Harris, Rice, & Cormier, 1998), Risk Matrix 2000 (Thornton et al., 2003), and the Minnesota Sex Offender Screening Tool – Revised (Epperson, Kaul, & Hesselton, 1998). The value of these measures is that they are relatively quick to administer based on file information alone, they are cost-effective, have a large evidence base, and provide a baseline measure of risk of sexual recidivism for an individual compared to a group.

Usefulness of static or historical risk measures for treatment planning

The widely adopted context for the incorporation of assessment of risk in treatment planning for offenders is the risk, needs, responsivity (RNR) model (Andrews & Bonta, 2010). The RNR model operates at the broad level of program or treatment design. It tells us that treatment should focus on offenders who pose the highest risk and should vary in dose according to risk (*risk principle*), should target the issues that caused the offending or correlate with recidivism (*needs*), and should to be delivered in a way to which offenders will respond (responsivity). Treatment for offenders that adheres to these principles is more effective at reducing re-offending than treatment that does not (Andrews & Bonta, 2010; Hanson et al., 2009). Hanson and colleagues (2009) specifically conducted a review of 23 sex offender treatment program evaluations to examine whether these RNR principles applied to sex offenders. Treatment programs adhering to RNR principles had lower recidivism rates (10.9%) than programs that did not (19.2%). Similarly, general (non-sexual) recidivism rates were also lower in these programs (31.8% v 48.3%). Clearly it is important to use risk assessment results in order to adhere to the RNR principles. Actuarial risk measures, based upon static or historical factors, represent the clearest cut and cost efficient approach of determining who needs treatment and how much treatment is required. They may also provide clear markers of longstanding psychological and behavioral issues that require change.

Static or historical factors can serve as markers of treatment targets

There are a number of static or historical factors that are consistently associated with sexual recidivism. These include prior criminality, diagnosis of psychopathy or anti-social personality disorder, previous sexual offences, sexual preoccupation, relationship to the victim, gender of victim, and relationship history (Hanson & Morton-Bourgon, 2004). Meta-analyses of risk factors for sex offenders demonstrate that there are two dimensions predicting recidivism for sex offenders: (1) sexual deviance and repeat sexual offences and (2) criminality/anti-sociality (Hanson & Morton-Bourgon, 2005; Parent, Guay & Knight, 2011). It makes some intuitive sense that an individual with an enduring interest for deviant sexual activity who also displays a willingness to disregard the rights of others will be assessed as higher risk.

From a treatment planning perspective the presence of criminality/anti-sociality is an important consideration. Treatment refusal, a lack of treatment engagement, and

treatment non-completion are all more likely in sex offenders who have characteristics related to anti-social personality disorder or certain features of anti-social personality disorder (Olver & Wong, 2009). Nunes and Cortoni (2008), for example, found that it was higher general criminality and not sexual deviance that predicted treatment attrition. Non-completion is an important issue for sex offender treatment programs. Sex offenders who commence yet do not complete treatment have higher recidivism rates than those who do not commence treatment (Hanson et al., 2002)

Static or historical factors may also point to other areas of treatment need. Beech and Ward (2004) argued that historical or static risk factors reflect "markers" of longstanding or important psychological problems. They posit that static factors (items within actuarial risk measures) will therefore reflect psychological vulnerabilities or dispositional behaviors and that these can be grouped across four domains: sexual interests/ sexual self-regulation, attitudes supportive of sexual assault, interpersonal functioning, and Impulsive/ emotional lability problems. These domains largely reflect dynamic risk factors and, indeed, Mann, Hanson and Thornton (2010) suggest that if "this conceptualization is adopted; the conceptual distinction between static and dynamic factors loses meaning". (p. 194). According to Beech and Ward (2004), the Static-99 (Hanson & Thornton, 2000), as an example, would measure sexual self-regulation through the items assessing Non-contact offences and Prior sex offences. A marker of long standing difficulties with impulsive/emotional liablity problems would be items assessing index non-sexual violence and prior non-sexual violence. The SORAG (Quinsey, Harris, Rice, & Cormier, 1998) would measure sexual self-regulation through the Evidence of deviant sexual preferences and Previous sexual convictions items, and difficulties with impulsive/emotional liablity through Violent criminality, Non-violent criminality, Evidence of psychopathy, and Failure on conditional release.

The assessment of static and historical risk factors therefore provides important opportunities for those planning treatment that are not, at first sight, so obvious. If, as Beech and Ward (2004) surmise, these factors are reflective of long standing psychological issues causing sex offending, then the presence of these factors may alert those planning treatment to areas of particular focus (see also Olver, Wong, Nicholaichuk & Gordon, 2007).

Determining who needs treatment and how much treatment is required

The risk principle suggests that treatment will be most effective when intensive services are reserved for the higher risk offenders and that these offenders will require a higher intensity of treatment. Very few treatment programs or private practitioners have the resources to treat all sex offenders even when all are seeking and volunteering for treatment. Prioritising those sex offenders assessed as high risk into treatment is therefore important. The treatment provided for these high risk offenders has to, however, be of adequate intensity. A sex offender assessed as high risk using static or historical factors alone will, in most instances, require more treatment than a low risk sex offender. These offenders may have a longer history of sexual offences, a greater level of sexual deviancy, and criminality/anti-sociality. They are therefore assumed to have a greater number or severity of criminogenic needs and will require extensive treatment in order to change entrenched and long-standing attitudes, beliefs, and behaviours, and that this will take considerably increased efforts and time. Allocating sex offenders to the most appropriate level of treatment is therefore a critical issue in treatment planning and one that often occurs at a program or referral level (Hanson et al., 2009; Mann, Ware, & Fernandez, 2011).

There is now increasing research evidence indicating that treatment providers should focus their attention on the higher risk sex offenders including those assessed with an actuarial risk measure as low risk but who might have a high number or severity of dynamic risk factors (see next section of dynamic risk). In a large meta-analysis of treatment effectiveness and the importance of the RNR principles, Hanson and his colleagues (2009) found that there were stronger treatment effects for the higher risk offenders. They concluded that "treatment providers should be cognizant that noticeable reductions in recidivism are not to be expected among the lowest risk offenders" (p. 886) (see also Lownekamp, Latessa, & Holssinger, 2006).

Importantly, contrary to public opinion, recidivism rates for sexual offenders, particularly for those assessed as low risk, are comparatively low, even without treatment. This raises the question of whether lower risk sex offenders even require treatment and, if so, how much. Many correctional jurisdictions will still provide some form of treatment to low risk sex offenders due to the political concerns of ignoring this group. Clearly private practitioners will provide treatment irrespective of risk particularly if the offender himself is seeking it.

Mailloux, Abracen, Serin, Cousineau, Malcolm, and Looman (2003) examined this issue concluding that, in their study, low risk sex offenders may have received too

much treatment and that this "over-treating" could lead to increased recidivism rates. Lowenkamp and Latessa (2002) reported that a halfway house residential treatment program that treated low, medium, and high risk sex offenders was not found to be effective overall. When risk was controlled for, the high risk offenders had a 7% reduction in recidivism whereas there was a 9% increase in recidivism for low risk offenders. The inference is that the low risk sex offenders received too much treatment which may have disrupted their life circumstances or were adversely affected by being placed in the vicinity of high risk offenders and their antisocial or sexual deviant beliefs and behaviors (see also Lovin, Lowenkamp, and Latessa, 2009).

There is very little research evidence to date examining *how much* treatment is required for higher and lower risk sex offenders (Ware, 2011). Beech, Fisher, and Beckett (1999) examined the benefits of different doses of treatment for sexual offenders. They categorized offenders in terms of deviancy and denial rather than to divide their sample into different risk groups. As noted by Wakeling, Mann, and Carter (2012), these "high deviancy" offenders had more sexual offence victims, were more likely to have a previous conviction for a sexual offence, and were more likely to have committed non-familial offences and therefore it is reasonable to assume that the deviancy classification broadly approximates risk groups. Beech and colleagues found that, for low deviancy (low risk) sex offenders, there was no difference in terms of improvement in pro-offending attitudes and overall change on psychometric measures between an 80-hour and 160-hour program. Higher deviancy offenders (higher risk) showed significantly more progress in the longer 160-hour programme.

Friendship, Mann, and Beech (2003), in a large scale evaluation of a 160-hour treatment program in the United Kingdom found that treatment was effective (in terms of reduction of recidivism) for medium-low and medium-high risk sexual offenders (using the Static-99) but was *not* effective for offenders assessed as low or high risk. Noting that the follow-up period was only 2-years, they suggested that that the re-offending rates for untreated low risk sex offenders were so low as to expect no statistical difference between groups. With respect to the high risk sex offenders, they concluded that this was sufficient evidence that these high-risk offenders required a higher "dose" of treatment.

Until further research is conducted to clarify the issue of how much treatment is required (including the issue of individual [not group-based] treatment), treatment planners need to broadly follow the RNR principle of risk, based upon the outcomes of an actuarial risk measure examining historical or static factors, and then use professional

judgment to decide what constitutes an appropriate treatment dose to enable a client to make and sustain change. Ideally, this suggested treatment dosage then should serve as a guide only as certain offenders will make progress quicker than others. Individual treatment and open-ended groups, where offenders complete the treatment only when their treatment needs have been satisfactorily addressed, will allow for this flexibility (Marshall, Marshall, Serran, & O'Brien, 2011; Ware & Bright, 2008; Ware, Mann, & Wakeling, 2009). Professional judgements relating to treatment dosage and progress should be based on an examination of changes in dynamic risk factors (see later section).

Limitations of static or historical risk measures for treatment planning

There are a number of limitations of static or historical risk measures for treatment planning, particularly if they are used in isolation (see Craig, Beech, & Harkins, 2009). Generally speaking, the most important limitation is that actuarial risk measures can only ever relate the individual to a group of similar individuals. If, say, 49% of the validation sample who scored a particular score re-offended over a particular time period, this does not suggest that an individual whom has just been scored with the same total score has a 49% chance of re-offending or that the individual will be one of the 49% who might be expected to re-offend.

Actuarial risk measures may under- or over-estimate the risk of certain groups of sex offenders. Parent, Guay & Knight (2011) studied the predictive validity of nine risk assessment instruments including actuarial measures (e.g. MnSOST-R, RM2000, RRASOR, SORAG, Static-99, Static-2002, VRAG) and found these instruments were more effective at predicting the sexual recidivism of child molesters and the violent and general recidivism of rapists. Bartosh and colleagues (2003) found the RRASOR, Static 99 and SORAG predicted sexual, violent and general recidivism with intra-familial child sex offenders but had less predictive validity with rapists and were not significantly valid for non-contact offenders. Rettenberger, Matthes, Boer, and Eher (2010) also found differences between instruments (Static 99, SORAG, RRASOR, SVR-20 and PCL) in predicting re-offending in offender subgroups such as child molesters, rapists, and "hands off' sexual offenders. Although they were unable to provide further analysis on the rapist subgroup due to very low rates of recidivism, they found the RRASOR failed to predict re-offence of any kind for child molesters. The Static-99 and SORAG failed to predict violent re-offences in intra-familial child molesters.

A treatment plan based solely upon historical or static risk factors may also be of limited use in the case of first time or young offenders who have not had the chance to "build" a sexual and non-sexual criminal history despite the fact that they have committed many instances of sexual offending initially (Craig, Browne, Stringer, & Beech, 2005). Notwithstanding these limitations static or historical risk factors are critical to treatment planning.

Risk assessments focusing on Dynamic factors

Whilst static and historical risk factors provide a useful method for predicting long term risk of recidivism and therefore who may need treatment and of what intensity, they can only serve as "markers" of what needs to change to decrease an individual offender's risk. A detailed examination of dynamic or changeable factors is also included within comprehensive risk assessments. These are characteristics of the individual that have a demonstrated empirical relationship with sexual offending behavior and that, when reduced, may lead to reductions in recidivism (Hanson, 2006). These factors were assessed to be present at the time of offending and therefore may have directly precipitated or caused the offending, can change over time or with intervention, and are therefore arguably amenable to treatment. Hanson and Harris (2000) usefully distinguished between stable and acute risk factors. Stable dynamic risk factors were defined as relatively enduring characteristics related to risk. Acute dynamic risk factors are rapidly changing situations or context or expression of stable dynamic risk factors that are useful in identifying when, or in what circumstances, an offender is most at risk of sexual offending.

Clearly these are fundamentally important to treatment planning. A number if treatment related terms are used to describe these dynamic risk factors. They have been variously labelled criminogenic needs (Andrews & Bonta, 2010), causal psychological risk factors (Beech & Ward, 2004), or psychologically meaningful risk factors (Mann, Hanson, & Thornton, 2010). Craissati and Beech (2003) reviewed the role of dynamic risk factors in risk prediction and outlined five core domains of dynamic risk; intimacy deficits/social competencies, social influences, pro-offending attitudes, sexual self-regulation, and general self-regulation. These factors provide an overview of treatment targets relevant to the offender. For example, individuals who show patterns of deviant arousal may require sex offender specific treatment (e.g. fantasy or arousal modification)

where others may require intervention in other areas (e.g. impulsivity, aggression/anger management, community support) (Wong, Olver & Stockdale, 2009).

A number of risk measures have been developed that assess dynamic factors. Examples include Sexual-Violence-Risk Management 20 (SVR-20; Boer, Hart, Kropp & Webster, 1997), Risk of Sexual Violence Protocol (RSVP; Hart, Kropp, Logan. Klaver, Laws & Watt, 2003), Structured Risk Assessment (SRA; Thornton, 2002); the Sex Offender Treatment Intervention and Progress Scale (McGrath, Lasher, & Cumming, 2012), the Violence Risk Scale- Sex Offender Version (Olver, Wong, Nicholaichuk, & Gordon, 2007), and STABLE-2007/ACUTE-2007 (Hanson, Harris, Scott & Helmus, 2007). These dynamic risk measures show similar levels of predictive validity to the actuarial risk measures using static or historical factors and, indeed, appear to strengthen their predictive validity when used in combination (Beech, Friendship, Erikson, & Hanson, 2002; Beggs & Grace, 2011; Hanson et al., 2007; Knight & Thornton, 2007; Olver et al., 2007).

Usefulness of dynamic measures for treatment planning

Relative importance of dynamic risk factors

The risk measures developed to assess dynamic factors invariably assess for the relevance or existence of a large number of these factors. These are not necessarily weighted by the risk measure and consequently may be treated equally by a treatment provider when, in fact, the risk factors with the strongest evidence should be emphasized in treatment.

In their review of sex offender dynamic risk factors (which they called 'psychologically meaningful' risk factors), Mann, Hanson, and Thornton (2010), listed risk factors into four groups, on the basis of their predictive validity. They categorized risk factors as being: empirically supported risk factors, promising risk factors, risk factors that are unsupported overall, but with interesting exceptions, and factors with little or no relationship to sexual recidivism.

Risk factors that are empirically supported (defined as at least three studies suggesting significant predictive value) and therefore should be prioritized in treatment include sexual preoccupation, any deviant sexual interest, offence-supportive attitudes, emotional congruence with children, lack of emotionally intimate relationships with

adults, lifestyle impulsivity, poor cognitive problem solving, resistance to rules and supervision, grievance/hostility, and negative social influences.

Promising risk factors with at least one study demonstrating significant predictive value for sexual recidivism, and where there is other kinds of relevant supportive evidence included hostile beliefs about Women, Machiavellianism, lack of concern for others, and dysfunctional, sexualized, or externalized coping. These should also be prioritized in treatment if relevant to the individual.

Mann, Hanson, and Thornton (2010) listed depression, poor social skills, poor victim empathy, and lack of motivation for treatment at in-take as having little or no relationship with recidivism and therefore should not be considered risk factors. In the strictest sense, these should not be treatment targets. They also noted that certain factors, such as mental illness and denial, may be a risk factor for some but not for others. In their view, denial might represent a dynamic risk factor "when it is motivated by the crass desire to avoid punishment or by a failure to recognize their transgression as sexual crimes" (p 206). However for others they noted that "it is likely that some aspects of denial are genuinely protective". Ware and Mann (2012) examined this issue in more detail arguing that, given the lack of relationship with re-offending, for the most part denial represents a normal human reluctance to admit one's errors rather than pathology of sexual offending. They highlighted the fact that denial occurs after the offending and is not causal and, in fact, is likely to be used as an understandable strategy by the offender to minimize negative consequences (rather than to explicitly continue offending) in certain situations or contexts. They recommended that denial should not necessarily be an explicit treatment target.

Importantly, in Mann, Hanson, and Thornton's (2010) view, none of the risk factors alone had an overly strong relationship to sexual offending. This has important treatment implications, specifically that treatment providers should not be over-influenced by the presence of any single risk factor and that treatment, therefore, needs to be comprehensive targeting multiple risk factors (Marshall, Marshall, Serran, & O'Brien, 2011). Secondly, many treatment providers or programs should examine the content of their treatment to see if there is sufficient focus on empirically supported risk factors and not an over-emphasis on too few risk factors (at the expense of others) or an over-emphasis on risk factors that do not appear to be valid (such as victim empathy). Thirdly, the presence of factors such as denial need to be understood by the treatment provider in

order in order to understand it's relevance to risk of recidivism (and therefore treatment goals). This requires a clear individualized case formulation.

Individualized formulations for dynamic risk factors

An assessment of dynamic risk should include a detailed functional analysis of an individual's offending behavior and an individualised case formulation that provides a meaningful framework for understanding risk for the individual sex offender (Boer, Thakker, & Ward, 2009; Collie, Ward, & Vess, 2008). Mann, Hanson, and Thornton (2010) usefully proposed the individual risk factors as "propensities" in order to emphasize that these risk factors will only be present in certain environmental contexts. As Doren (2002) noted, no sex offender will be at risk of harming everyone all the time or indeed even children or vulnerable adults unless the context is right.

This is important to treatment planning. Conveying the message to a sex offender, as an example, that they are sexually deviant all the time is, in almost all contexts, simply not true. Maruna and Mann (2006) argue that what treatment providers should be emphasising is a sense of personal agency and an ability to control their propensities in similar circumstances in the future (see also Ware & Mann, 2012). Treatment planning therefore should consider the contextual aspects in any dynamic risk assessment and needs to be individualized to the offender's personal circumstances in order to maximise his or her engagement and treatment benefit. We will describe the differences in how dynamic risk measures construe risk in a later section.

Collaboration in dynamic risk assessment and treatment planning

Shingler and Mann (2006) argue for risk assessments to be completed collaboratively, or at least their details shared, with offenders. The result of this collaborative process is a much stronger connection for the offender between risk assessment and his treatment. Shingler and Mann (2006) recommend informing the offenders about the risk assessment process and explaining how it can benefit the offender including planning for how best to assist him through treatment. In their view the results of all static and dynamic risk measures should be shared openly with the offender and the scoring explained. The offender should be encouraged to draw his own conclusions as to his risk. From a treatment planning perspective, instances where an offender disagrees that a particular dynamic risk factor is relevant to him is important

information to be used in motivational and engagement strategies prior to and during treatment.

Differences in how dynamic risk measures assess risk factors

Dynamic risk measures provide the assessor an opportunity to consider a more individualized picture of an offender's behaviour but these measures vary in their purpose and the way they are scored and interpreted. They also differ in terms of the number and type of dynamic risk factors included. The majority, if not all, of the most commonly used dynamic risk measures listed above have a range of risk items that can be categorized into four domains; intimacy deficits/social competencies, social influences, sexual self-regulation, and general self-regulation. The extent to which each dynamic risk measure focuses on these domains differs. Similarly, as illustrated in Table 1, there are distinct differences in the number and descriptions of risk items. Certain dynamic risk measures include risk items that sit outside of the domains and that have no empirical relationship to recidivism. Those tasked with planning treatment must understand these differences and the limitations of particular measures.

[INSERT TABLE 1 HERE]

Dynamic risk measures are either actuarial tools or structured professional judgements (SPJs). Measures that employ an actuarial approach to dynamic risk, such as the Stable and Acute 2007 (Hanson, Harris, Scott & Helmus, 2007), include only those risk factors that have been empirically linked to sexual recidivism. A structured professional judgement approach to dynamic risk, such as the RSVP, include most of these factors shown to be related to sexual recidivism as well as others that may seem more intuitively relevant but have little to no empirical relationship to sexual recidivism based on current findings. There are strengths and limitations with these approaches which are considered in turn.

There are very clear advantages to actuarial dynamic risk measures. The risk factors included in the Stable and Acute 2007 (Hanson, Harris, Scott & Helmus, 2007), for example, have a moderately strong statistical relationship with sexual recidivism. The Stable 2007 and Acute 2007 are also able to be combined with the Static-99 score (Hanson & Thornton, 2000) which provides an actuarially adjusted estimate of overall risk. This estimate has a slightly greater predictive validity than the Static-99 alone

(Hanson et al., 2002). Matrices have been developed that combine these measures to assist treatment planners. As an example, a sex offender who is assessed as moderate-low risk on the Static-99 but high risk on the Stable 2007 will require intensive treatment. These measures have clear scoring rules and are validated on large normative groups from which risk probabilities are derived.

Actuarial risk measures do have limitations. Factors that did not predict recidivism in the original research samples are excluded even when other research has consistently demonstrated their relationship to recidivism. This has implications for those planning treatment. The Stable 2007, for example, does not include 'offence supportive attitudes' as a risk factor. A recent large scale meta-analysis by Helmus and colleagues (2013) found that attitudes supportive of sexual offending had a small but consistent relationship with sexual recidivism. Mann, Hanson, and Thornton (2010) also identified offence supportive attitudes as a psychologically meaningful risk factor. Interestingly, the original version of the Stable (Stable 2000) did include three items relating to offence supportive attitudes (sexual entitlement, rape attitudes, and child molester attitudes) however these were omitted in the Stable 2007 as they were no longer found to statistically predict recidivism (in the newer samples of sex offenders). Because of the strict algorithmic application of actuarial dynamic risk measures they also do not necessarily allow for inclusion of unique factors which may be relevant in the prediction of an individual's future offending (see previous section on relative importance of risk factors). These approaches may not identify all of an individual's risk factors or treatment needs.

Actuarial dynamic risk measures also do not explicitly require a detailed formulation of an individual's risk (Collie, Ward, & Vess, 2008). Parent, Guay, & Knight (2011) argue that applying an actuarial model may not account for context or differences in etiology of offending pathways. While they refer primarily to actuarial instruments using static or historical factors, the same argument may apply to the actuarial approach to dynamic risk assessment. We have seen in practice that assessors can score a Static-99 and a Stable 2007 by following the explicit scoring rules, have a sense of what should be targeted in treatment, but still cannot conceptualize why and how the individual offended and consequently what situations may present the greatest risk for the individual upon release and what his treatment needs actually are.

The use of structured professional judgment (SPJ) measures as a part of a convergent risk assessment (using an actuarial or static assessment as a baseline measure)

has gained increasing support in the field (Rettenberger & Hucker, 2011). Although there is presently less empirical evidence supporting SPJ measures, in practice they provide the ability to make a distinctly individualized formulation or treatment plan because they directly consider the context of the offending. Most of these assessments consider historical factors or "psychological vulnerabilities" (e.g., the psychological adjustment factors and the nature of the previous sexual offences) in the same context with the meaningful or causal psychological dynamic risk factors (Boer & Hart, 2009). The SPJ approach encourages (even forces) the practitioner to think critically about the individual they are assessing in a more holistic way rather than rely on a formula or algorithm. The risk assessment is therefore contextualized and specific to the individual. However treatment planners must be mindful that many of the SPJ measures include a number of items that do not have a relationship to sexual recidivism. Denial and being a victim of child abuse are two clear examples. Further, it is often difficult in practice to rate the items and subsequently inter-rater reliability can be problematic. Another issue that we have observed in practice is the potential for an assessor to focus on particular risk items and to rate them heavily (without explicit instruction or guidance to do so).

There are, however, many aspects of SPJ measures that are attractive to those planning treatment. Structured professional judgment measures such as the Risk of Sexual Violence Protocol (RSVP) (Hart et al., 2003) and Sexual Violence Risk scale (SVR-20) (Boer et al., 1997) ask the evaluator to consider historical, dispositional, contextual and clinical factors related to recidivism. The individual offenders' risk factors can be divided into motivators, disinhibitors and destabilisers in order to make comment on nature, severity, imminence, frequency, duration, and likelihood of future sexual violence presented as "risk scenarios". These scenarios are based on the individual's offending history, the risk factors identified as present and relevant, and future situational or protective factors, such as where the person will be living (Hart & Logan, 2011). These scenarios may then directly inform treatment and management (and case prioritisation) and assist in informing the evaluator's overall judgment of the individual as low, moderate or high risk. These broad descriptors of risk that can be applied may be considered somewhat unscientific and open to bias or subjectivity hence the necessity to use an actuarial measure to provide a baseline assessment of risk (Rettenberger & Hucker, 2011). If the practitioner anchors their judgment to an actuarial assessment and is provided with supervision or case team discussion to avoid "drift", this approach has many strengths for individual treatment planning.

Other measures have more specific purposes such as examining change after treatment. For example the Violence Risk Scale: Sexual Offender (VRS: SO; Wong, Olver, Nicholaichuk, & Gordon, 2003) is a 'conceptual actuarial' measure. It provides an estimate about probability of reoffence (compared to a normative group) based on both static and dynamic risk factors but was also developed with the intention of directly informing individual treatment planning and measuring change (Wong, Olver & Stockdale, 2009). Because of its actuarial nature it does not allow for inclusion of additional unique risk factors however it does include numerous factors that are not considered for example by the Stable 2007. It has been found to reliably measure post-treatment change on the included dynamic risk factors, leading Olver, Lewis & Wong (2013) to suggest this is evidence that these risk factors must be causally related to sexual offending. Measuring change after treatment will be discussed later in the chapter.

Dynamic risk assessment and measuring treatment changes

Treatment planning is an ongoing process. Dynamic risk measures, by virtue of their ability to measure change, are essential as post-treatment measures. How otherwise can one assess whether treatment has reduced risk of re-offending or if further treatment needs to be planned? A number of studies have now demonstrated that the measurement of dynamic risk factors pre- and post-treatment adds incremental predictive validity to static risk factor measures.

Olver, Wong, Nicholaichuk and Gordon (2007) used the Violence Risk Scale – Sexual Offender version (VRS-SO; Wong, Olver, Nicholaichuk & Gordon, 2003) to assess change in dynamic risk factors after treatment. Using a sample of 321 sexual offenders who completed a 6-8 month treatment program followed up for an average of 10 years post release, they found that change on the dynamic scales of the VRS-SO was negatively related to sexual recidivism and increased predictive validity over the scales measures static or historical factors. Positive changes, therefore, were significantly related to reduction in recidivism. When their sample was divided into low and high risk groups, these positive changes were only predictive in reductions in recidivism amongst the high risk offenders. Olver and Wong (2009) also found that changes in the VRS-SO dynamic scales were associated with reductions in sexual and violent recidivism for psychopathic high risk offenders.

To strengthen this research approach, Beggs and Grace (2011) compared three methods for assessing treatment change with a sample of 218 lower risk child molesters

treated in prison and followed up for an average of 12 years. They used pre- and post-treatment change scores from a battery of psychometric self-report instruments, the VRS-SO, and post treatment ratings on the Standard Goal Attainment Scaling for sex offenders (SGAS; Hogue, 1994). They found that, in particular, the changes in the self-reported psychometric instruments significantly predicted reductions in sexual recidivism. Interestingly the VRS-SO results were similarly predictive but non-significant. An important finding from this study is that changes in dynamic risk factors can be assessed using common psychometrics and not just specific dynamic risk measures.

Olver & Wong (2011) also found that the predictive validity of static risk assessments (Static-99) decreased with treatment improvements as measured by the VRS-SO. This would make intuitive sense as static risk factors are not amendable to change and may therefore effectively "penalize" those offenders who have made the most treatment gains. While they interpreted their findings with caution they suggested that use of static instruments alone post-treatment may actually be over-estimating risk in instances where the offender has made significant changes in treatment.

Do treatment programs adequately target risk factors?

The extent to which treatment planning informs treatment programs is clearly important. The assumption is that treatment programs or an individual clinician will focus a large part of their treatment efforts on those risk factors assessed as most relevant for each offender. Mann, Hanson, and Thornton (2010) argued that treatment programs should focus the majority of their efforts on sexual preoccupation and sexual deviance, sexual preference for pre-pubescent or pubescent children, sexualised violence, offence supportive attitudes (which is distinct from denial and minimizations, see Marshall, Marshall, & Ware, 2009), emotional congruence with children, lack of emotionally intimate relationships with adults, lifestyle impulsiveness, poor problem solving, resistance to rules and supervision, grievance/hostility, and negative social influences.

It appears, however, that many treatment programs place an emphasis on treatment targets which are not empirically established risk factors (Mann, Ware, & Fernandez, 2011). McGrath and colleagues (2010) completed a large scale survey of North American and Canadian sex offender treatment programs for juveniles and adults in community and residential settings. They found that offense responsibility and victim awareness / empathy were to the two most common treatment targets in spite of the lack of evidence indicating that addressing these treatment targets results in reduced

reoffending rates. In contrast, they noted that a comparatively small percentage of treatment programs reported targeting offense-supportive attitudes and problems controlling their arousal (e.g., sexual preoccupation and deviant sexual interests) within their programs. Ware and Mann (2012) suggested that therapists can fall victim to "correctional quackery" (Gendreau, Smith, & Theriault, 2009), where they can prioritize personal experience, values, and anecdotal evidence, or the pressure from non-therapists involved in sex offender management or even the general public, above evidence resulting from rigorous, large-scale research efforts into risk factors. McGrath and colleagues (2010), however, also noted that some treatment targets, such as self esteem or lack of motivation, may not be related directly to the reduction of risk factors but may be necessary for treatment engagement purposes

Conclusions

Mann and Marshall (2009) argued that there is "little excuse for providing treatment that is not preceded by careful risk and need assessment". This risk assessment ought to be based on a careful examination of both static or historical and dynamic risk factors, through the use of any of a number of validated risk measures. Static or historical risk factors will provide a valid predictor of long term risk that assists the treatment provider to plan for how much treatment will be required and who should be prioritized into treatment when resources are scarce. Static or historical risk factors may also serve as useful markers of long term psychological issues that have caused sex offending. Treatment providers also require information relating to dynamic or changeable risk factors. These are essentially the targets of treatment. Treatment providers should ensure that they have completed an individualized formulation of the sexual offending and understand the context around the offender's future risk. This should be conveyed to the offender. Treatment providers should also ensure that they are aware of, and targeting the dynamic risk factors with the strongest empirical relationship to sexual recidivism. It appears that this is not always the case. Sexual deviance, if present, must be targeted in treatment. In contrast, denial, if present, may not be so important to target. Treatment providers need to understand the differences in dynamic risk measures – what these will tell them that is relevant to treatment, and what they will not. Finally, treatment providers should use dynamic risk assessments to evaluate treatment outcomes. Risk assessment therefore is essential to treatment planning both prior to, and at the conclusion of, treatment.

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Table 1 – Five core dynamic risk domains measured on selected risk assessment instruments

	Stable 2007	**Acute 2007**	**SVR-20**	**RSVP**	**VRS: SO**
Intimacy deficits/social competencies	Capacity for relationship stability Emotional identification with children Hostility towards women General social rejection Lack of concern for others		Intimate relationship problems	Intimate relationship problems	Intimacy deficits
Social influences	Significant social influences	Collapse of social support	-	Non-intimate relationship problems	Community support
Pro-offending attitudes	-	-	Attitudes that support or condone sex offences	Attitudes that support or condone sex offences	Cognitive distortions
Sexual self-regulation	Sex drive/ preoccupation Sex as coping Deviant sexual preference	Sexual preoccupation Victim access	Sexual deviance High density sex offences Multiple sex offence types Physical harm to victims Use of weapons or threats of death Escalation in frequency or severity of sex offences	Sexual deviance Chronicity of sex offences Diversity of sex offending Physical coercion Psychological coercion Escalation in frequency or severity of sex offences	Sexually deviant lifestyle Sexual compulsivity Offence planning Sexual offending cycle Deviant sexual preference
General self-regulation	Impulsive Poor problem solving skills Negative emotionality Co-operation with supervision	Emotional collapse Hostility Substance abuse Rejection of supervision.	Substance use problems Employment problems Past non-sexual violence Past non-violent offences Prior supervision failure Lacks realistic plans Negative attitude towards intervention	Substance use problems Employment problems Problems with stress or coping Non-sexual criminality Problems with planning Problems with treatment Problems with supervision	Interpersonal aggression Emotional control Substance abuse Impulsivity Compliance with community supervision Treatment compliance
Items that sit outside the five core domains	-	-	*Extreme minimisation or denial* *Victim of child sexual abuse* *Psychopathy;* *Major mental illness* *Suicidal or homicidal ideation*	*Extreme minimisation or denial* *Victim of child sexual abuse* *Psychopathy* *Major mental illness* *Suicidal or homicidal ideation* *Problems with self-awareness*	*Criminal personality* *Insight*
****Allows for inclusion of "other" unique factors***	No	No	Yes – suggested inclusions: psychological coercion; non-intimate relationship problems; self-awareness; stress/coping	Yes	No