Council on Sexual Offender Treatment
21st Annual Conference on the Management of Adults and Juveniles with Sexual Behavior Problems.
Austin, Texas

Updates and the Empirical Base in Juvenile Sexual Risk Assessment and its Application in Evaluation and Treatment

Sunday March 3, 2013
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Precursor: Understanding the Population

Glued Together by Life

- Joseph LeDoux writes that “people don’t come preassembled, but are glued together by life” (2002, p.3).
- Similarly, Pless and Stein (1996) write that much of the research on stress, risk, protection against risk, and the development of resilience in children and adolescents makes sense only when seen from a developmental point of view, in which a central feature of juvenile experience and behavior is “the dynamic background of developmental change” (p. 343).
- Our current thinking is that children and adolescents are still being glued together by life and, in reality, are very much in that process.

The Backdrop to Juvenile Risk Assessment

The Basis for Juvenile Risk Assessment

- The process of juvenile assessment was once largely driven by the literature, research, and the instrumentation of adult risk assessment.
- However, over the past decade the field of juvenile risk assessment has largely developed in its own right, and continues to develop, both informed by and independent of research and development into the process and practice of adult risk assessment.
- For both juveniles and adults, assessment of risk for sexual re-offense serves two significant tasks.
- As a stand-alone process, independent of any other processes or goals, risk assessment serves to project and describe the potential or probability of a sexual re-offense at some point in the future, following apprehension for a sexual offense.
- Risk assessment also serves as a central element and foundation for treatment, if treatment is considered an important element in preventing sexual recidivism.
- In both cases, risk assessment is built upon the identification of factors that increase (and possibly predict) risk for sexual re-offenses and the evaluation of the presence, quantity, and effect of such factors in individuals being assessed for future risk.
- Although most typically built upon developmental or historical (static) risk factors, contemporary risk assessment instruments and processes include, and increasingly lean upon, the presence of currently present and active (dynamic) risk factors in the life of the individual being assessed.
- Although the measurement and evaluation of one or both types of risk factors (static and dynamic) serves as the basis of the risk assessment process, the presence and effect of dynamic risk factors is of particular importance when treatment is provided, as the reduction or elimination of dynamic risk factors often serves as a foundation for treatment and rehabilitation (Beggs & Grace, 2011; Olver & Wong, 2009; Pedersen, Rasmussen, & Elsass, 2010).

Adult and Juvenile Sexual Offenders: Different Worlds

- Although the process of adult and juvenile assessments are similar, and similar processes and instruments have been developed for juvenile risk assessment, the assessment of juvenile sexual offenders has been informed by a recognition of the different developmental, social, and contextual circumstances that surround juvenile sexually abusive behavior.
- For instance, the locus of control for children and adolescents is usually outside of their own control, and they are almost always heavily involved with adult caretakers and others who make daily decisions on their behalf, provide supervision, and exercise control over their lives.
- Not only do juveniles live in a different world than that of adults, embedded as children within family and community systems, but they are also subject to a different set of rules, expectations, and obligations.
- Juveniles are also substantially different in their physical development; their cognitive, neurological, and personality development; their formation of attitudes and acquisition of information; and in their emotional and behavioral maturity (Rich, 2009; Steinberg, 2009, 2010, Steinberg & Scott, 2003; Zimring, 2004).
The Developmental and Contextual Nature of Juvenile Assessment

- Accordingly, the assessment of juveniles takes into consideration many elements that are involved in child and adolescent behavior but not likely to be relevant in the assessment of adults.
- Caldwell (2010) writes that the development of adolescent sexual misconduct differs from that of persistent adult sexual offending, and methods of risk assessment methods developed for adult sexual offenders are unlikely to produce valid estimates when applied to juvenile sexual offenders.
- “Risk factors that have proven reliable predictors of adolescent recidivism should not be assumed to be valid in predicting adult sexual offending, and vice versa” (p. 206).
- Juvenile assessment, therefore, focuses not only on understanding the adolescent offender but also the systems within which children and adolescents live, learn, and function and upon which they depend for structure, guidance, and nurturance.
- Assessments of juveniles take into account the still developing nature of the child/adolescent and concepts that place behavior in the context of the social environment, as well as the context of child and adolescent development.
- Risk assessment for juvenile sexual offenders thus provides a contextual basis for the evaluation of risk and considers risk factors in light of developmental considerations regarding the biological, psychological, and social growth and emergence of adolescence.
- Hence, Caldwell and Dickinson (2009) write that factors in the juvenile’s social context play a more important role than they do among adult offenders, and that peer groups, family dynamics, involvement in prosocial activities, and community factors should all be carefully considered in juvenile risk assessment.
- Further, given the developmental nature of adolescence, “all risk assessment with juvenile offenders should be considered reliable (only) over a relatively short time horizon” (Caldwell & Dickinson, 2009, p. 952).

Measuring Risk for Re-Offense

- Risk assessment is always based upon a history of prior harmful behavior and is therefore an assessment for recidivism and not first time behavior.
- The process of risk assessment always draws on the past in order to highlight possible future behavior.
- This is the static element of risk assessment. The very presence of a history of antisocial behavior predicts future antisocial behavior.
- Further, understanding an individual’s past behaviors and experiences can lend itself to projections about future behavior based on an understanding of why (and under what circumstances) the prior behavior occurred.
- Recognizing and understanding the presence of past and current experiences and behaviors allows us to project a trend into the future which, if uninterrupted, may lead to a recurrence of the same behavior.

Time Limits on Juvenile Risk Assessments

- Because juvenile risk assessment processes include a focus on development and social context, unlike adult risk assessment instruments, the most current and widely used juvenile risk assessment instruments define time limitations, or expiration dates, for the assessment of risk, either requiring re-assessment of risk within a specified time period, such as every six months, or noting that the prediction of risk is limited to a sexual re-offense prior to the 18th birthday.
- For instance, Fanniff and Letourneau (2012) recommend that evaluators focus on short-term risk, recognizing the fluid nature of both risk and sexuality among juveniles, also highlighting the low base rate of juvenile sexual recidivism and positive responses to treatment noted in the JSO literature, additionally focusing on the juvenile’s social context as well individual risk factors.

Models of Risk Assessment: Actuarial and Clinical

The Practice of Risk Assessment

- Despite significant differences in juvenile and adult risk assessment, the underlying ideas are identical, including the basis for types of assessment process, the selection of risk factors, and the design of risk assessment instruments, including their development, their limitations, and their strengths, as well as professional disagreements about the “best” model for risk assessment.
Two Models of Risk Assessment

- There are essentially two models of risk assessment, for both adult and juvenile sexual offenders, each of which attempts to predict or project the likelihood, potential for, or probability of sexual recidivism.
- In both cases the construction of the risk assessment process is built upon the presence and measurement of risk factors known or believed to be associated with sexual recidivism.

Actuarial Risk Assessment

- In the case of the actuarial model of risk assessment, also known as statistical or mechanical assessment, a determination of risk is based entirely on a statistical comparison of the personal characteristics and past behavior of the individual to those of known recidivists, in which the distinguishing feature of the assessment is the static, or unchanging and historical, quality of risk factors.
- Hence, actuarial risk assessment is based on a statistical analysis of static risk factors and a resulting statistical projection of future behavioral trends.
- Actuarial assessment does not take into account environmental factors that may contribute to or produce risk.
- In assessing risk, actuarial assessment considers only attributes related directly to the individual, treating these as static and unchanging things from which future behavior can be statistically predicted.
- The actuarial assessment model is unable to give meaning to the behavior that is being assessed or understand the individual engaging in the behavior.

Clinical Risk Assessment

- Clinical risk assessment is based on observation rather than statistical analysis, and the development of an understanding about the individual and the presence of defined risk factors at play within the individual and in the individual’s environment, and the assessment of risk or probability of sexual recidivism is based upon the professional clinical judgment of the evaluator.
- However, in contemporary application, for both adult and juvenile risk assessment, clinical judgment is guided through a defined and structured risk assessment instrument, and is hence considered to be structured or anchored clinical risk assessment, as opposed to clinical judgment that is unstructured and in which there is no defined risk assessment instrument guiding or defining the process of clinical judgment.
- Unlike actuarial assessments, clinical risk assessments typically evaluate both static and dynamic risk factors.
- Also unlike actuarial assessments, clinical assessments have the potential for including, not only risk factors that increase the potential for re-offense, but also the assessment of protective factors that may decrease and reduce the risk of re-offense.

Actuarial and Clinical Judgments of Risk

- Of the two models, it been strongly asserted that, when compared to clinical assessment, actuarial assessment is more capable of accurate predictions of risk (Hanson & Thornton, 2000; Harris & Rice, 2007; Meehl, 1996; Quinsey, Harris, Rice, & Cormier, 1998; Steadman, et al. 2000).
- Quinsey, Harris, Rice, and Cormier (2006) advocate for a strictly actuarial approach, supporting the complete elimination of clinical practice in risk assessment, and other researchers supporting actuarial assessment assert that the two methods of assessment are incompatible (Grove & Lloyd, 2006; Harris & Rice, 2007).
- However, Sjöstedt and Grann (2002) write the implications of the pure actuarial position are extremely problematic, and Monahan et al. (2001) write that actuarial instruments should be used to support, rather than replace, the exercise of clinical judgment.

Which Is More Accurate?

- Kahneman (2011) describes approximately 200 comparison studies of clinical and statistical predictions, with 60% showing accuracy for statistical assessment. Many of the other comparison showed a draw in accuracy, which Kahneman describes as a win for statistical methods as these are normally less expensive to apply than expert judgment.
- However, much of the disagreement regarding the capacity of clinical assessment to effectively predict risk regards unstructured clinical judgment, or professional judgment that is not supported, anchored, or guided by a structured or defined assessment instrument or process.
Which Is More Accurate?

• In fact, there is continuing disagreement on the greater predictive power of actuarial over clinical risk assessment (Boer, Hart, Kropp, & Webster, 1997; Hanson & Morton-Bourgon, 2007; Hart, Michie, & Cooke, 2007; Litwack, 2001), and Sjöstedt and Grann (2002) and Pedersen, Rasmussen, and Elsass (2010) reported strong predictive validity (in effect, the accuracy of a risk assessment instrument in predicting risk) for structured clinical risk assessment.

• Describing this model as “structured professional judgment,” Hart et al. (2003) write that structured professional guidelines improve the consistency and usefulness of decisions and improve the transparency of decision making, important in absence of a method for making scientifically precise estimates of risk.

• Heilbrun, Yasuhara, and Shah (2010) conclude that on the basis of their review of published studies conducted within the prior decade, there is strong evidence that structured professional judgment provides a meaningful and effective approach to risk assessment, with evidence that suggests both actuarial and structured clinical approaches are comparable in their capacity for predictive accuracy.

• Indeed, Rettenberger, Boer, and Eher (2011) write that one of the most significant limitations of the actuarial assessment is that it provides no idiographic or individualized information about risk for the individual being assessed, or possible risk management strategies, and therefore fails to meet the practical, ethical, and legal issues and requirements relevant to any individual case (p. 1010).

The Weaknesses of Both Risk Assessment Models

• Douglas, Cox, and Webster (1999) conclude that both actuarial and clinical assessments have clearly identified, but different, strengths.

• Nevertheless, both methods of assessment are flawed.

• Campbell (2004) writes that neither actuarial or clinical risk assessment instruments stand up to rigorous scientific scrutiny, noting that all current actuarial and clinical risk assessment instruments are insufficiently standardized, lack inter-rater reliability, are absent of adequate operational manuals, and generally fail to satisfy significant scientific standards.

• Similarly, Grisso (2000) and Hart et al. (2003) write that such instruments have not yet achieved the level of psychometric rigor to meet publication standards.

Difficulty with Standardization, Validity, and Reliability

• In terms of standardization and validity, for instance, Boccaccini, Murrie, Caperton, and Hawes (2009) examined the predictive validity (i.e., the accuracy) of the Static-99 and MnSOST-R, two of the most commonly used adult actuarial risk assessment instruments, on a sample of almost 2000 adult sexual offenders.

• They concluded that the instruments performed inconsistently and weakly in actual practice, writing that the field validity of the instrument may differ from the instrument’s performance in controlled research studies.

• With respect to inter-rater reliability, Murrie et al. (2009) found that assessed risk levels on three instruments in common use with adult sexual offenders (the STATIC-99, MnSOST–R, and PCL-R) yielded different results when administered by evaluators retained by the defense and those retained by the prosecution, suggesting that assessed scores on measures commonly used in legal proceedings may be influenced by the allegiance of the evaluator.

What Does Inter-Rater Reliability Assure?

• Despite positive inter-rater reliability coefficients, Boccaccini et al. (2012) continue to point out significant difficulties in actual field reliability.

• They write that, “it appears that two conscientious raters should rarely disagree about an offender’s Static-99 total score. After all... scores are based on counts of offenses and the presence or absence of offender and victim characteristics... and the items appear to require little, if any, subjective judgment to score. Scoring disagreements should be rare “ (p. 51).

• However, in a study of over 700 adult sexual offenders in two states, Boccaccini et al. note that despite strong inter-rater reliability for Static-99 total scores, the total score assigned by pairs of evaluators differed for approximately 45% of the adult sexual offenders being assessed. That is, there was agreement in only 55% of the cases.

• In other words, “excellent ICC values for the Static-99 cannot be interpreted to mean that two evaluators will necessarily assign the same score to the same offender” (p. 52).
Does Statistical Outperform Clinical Judgment?

- In terms of whether actuarial assessments have a greater capacity to more accurately and consistently assess the probability of future behavior when compared to structured clinical judgment, Kahneman and Klein (2009) note that concluding statistical judgment to be superior to clinical judgment is unwarranted.
- Clinical judgment performs significantly more poorly than statistical methods when there is unstable, uncertain, or inadequate information, but not in an informational environment in which a great deal of information is available to evaluators, thus providing adequate and meaningful information upon which to base judgment.
- Kahneman and Klein thus conclude that statistical judgments outperform clinical judgment only in weak and limited informational environments because of their advantage of consistency. For that reason, Kahneman (2011) recommends that in “low validity” environments statistical prediction maximizes predictive accuracy.
- Karelaia and Hogarth (2008) similarly conclude that evaluators are capable of high levels of judgmental accuracy in well-known and rich informational environments, although statistical models have the advantage of consistency under less certain conditions.
- The American Psychological Association Presidential Task Force on Evidence-Based Practice (2006) also describes and supports the significance of clinical expertise, writing that clinical expertise integrates the best research evidence with clinical data, while also understanding the influence of individual, cultural, and contextual differences in individual cases.

The Importance of Risk Assessment Theory

- All of this background is important because juvenile sexual risk assessment is presently characterized largely by the use of structured clinical assessment instruments and processes, although, described below, there is now one actuarial assessment in development for juvenile sexual offenders, in use in several states (JSORRAT-II).

Development and Design of Risk Assessment Instruments

Risk Assessment Instruments

- Risk assessment instruments provide a structured and anchored means for assigning risk.
- They not only serve to define the risk assessment process, but they also define the risk factors upon which the assessment is based and how these risk factors are to be assessed.

The Evolution of Instruments for Risk Assessment

- “First generation” instruments were based largely on unstructured clinical judgment, whereas the second generation assessments that followed resulted in statistically derived and static actuarial assessments of risk.
- Third generation instruments, now in increasingly common use in sexual risk assessments of adult offenders, incorporate the actuarial base of the static assessment and the dynamic factors of the clinical assessment.
- Fourth generation models integrate an even wider range of dynamic factors, incorporating factors relevant to treatment interventions, case management, and monitoring.
- Third and fourth generation instruments not only recognize the utility of both static and dynamic risk factors, but also recognize that “there is no reason to think that one type is superior to another when it comes to the predicting recidivism” (Bonta, 2002, p. 367), and that the inclusion of dynamic measures improves risk prediction beyond that which may be achievable by assessing only static risk factors (Allan, Grace, Rutherford, & Hudson, 2007).
- Indeed, actuarial assessments are rigid and lack the ability to provide meaning or render judgments about data. They lack the ability to formulate, and are thus able to present only a simple picture without any explanation.
- Boer et al. (1997) describe actuarial assessments as “passive predictions of limited practical use” (p. 4).
The Expansion of the Risk Assessment Model

• Indeed, in his evaluation of the actuarial Risk Matrix 2000 Grubin (2011) notes that the RM cannot be used as an indicator of the imminence of reoffending or the seriousness of any subsequent offence, and writes that the Risk Matrix is best viewed as a “screening tool.”
• Whereas non-actuarial dynamic risk assessments and guided clinical judgment may not improve the estimation of long-term risk, because they identify specific factors that contribute to an individual’s risk, Grubin notes they can contribute to a determination of current risk. He concludes that Risk Matrix should be seen as “part of an assessment process, not a substitute for the assessment process itself; to be effective, it must form part of a wider package of evaluation” (p. 431).
• In their study of 321 adult sexual offenders, Olver and Wong (2011) found evidence of reductions in risk for sexual re-offense resulting from treatment and reductions in dynamic risk factors. They argue that purely static tools are insensitive to such change and underscore the dynamic nature of risk and the utility of dynamic risk assessment tools in treatment.
• Beggs and Grace (2010) similarly write that assessment of dynamic factors make independent contributions to risk predictions among sex offenders beyond that predicted by static factors alone.

The Predictive Power of Dynamic and Static Risk

• For instance, in their meta-analysis of adult sexual offender recidivism, Gendreau, Little, and Goggin (1996) concluded that dynamic risk factors performed at least as well as static risk factors in the prediction of general criminal recidivism, and concluded that different types of assessment procedures should be compared and combined.
• In an Australian study, McGrath and Thompson (2012) report that both static and dynamic risk factors both predicted sexual recidivism in juvenile sexual offenders, but a combination of both static and dynamic factors resulted in a significant improvement in prediction.
• They argue that their findings clarify the contribution of both static and dynamic risk factors to predictions of recidivism.
• Mills (2005) similarly describes an integrated method approach that blends actuarial results and clinical data into risk assessment.
• Beech and Ward (2004) criticize solely actuarial assessments as they make “invisible” risk factors relevant to individual cases, and exclude contextual risk factors that may signal increased risk.

No Risk Assessment Instrument is Sufficient in Predicting Sexual Recidivism

• These ideas, presented largely in the literature of adult sexual offender assessment, remain the same with regard to juvenile sexual offender risk assessment, and are essential for an understanding of the groundwork upon which juvenile sexual offender risk assessment is built.
• That is, research and practice are not uniformly agreed upon and there are substantial, long-standing, and ongoing differences in models and designs of risk assessment instruments and processes.
• Of significance is the observation that when used alone, no instrument is sufficient to fully complete the task of risk assessment (Bonta, 2002; Conroy & Murrie, 2007).

The Focus and Breadth of Juvenile Risk Assessment

The Breadth of Juvenile Risk Assessment

• Epps (1997) describes the target of juvenile risk assessment as the synthesis of psychosocial, statistical, factual, and environmental information, thus allowing defensible decisions to be made about matters of management, treatment, and placement.
• Describing the elements of this process, Will (1999) describes three broad purposes of juvenile sexual offender evaluation as:
  1. The assessment of risk for re-offense.
  2. The development of a clinical formulation upon which treatment can be based and developed.
  3. Assessment of juvenile’s motivation to accept and engage in treatment.
The Breadth of Juvenile Risk Assessment

• Also promoting a more global view of juvenile risk assessment, Graham, Richardson, and Bhave (1997) describe six overarching and interactive goals:
  1. Identifying troubled patterns of thoughts, feelings, and behavior,
  2. Recognizing and understanding learned experiences and processes contributing to the development and maintenance of juvenile sexually abusive behavior,
  3. Identifying situational contexts and correlates of sexually abusive behavior,
  4. Evaluating the probability of sexual recidivism,
  5. Assessing the juvenile’s motivation to engage in treatment aimed at emotional and behavioral regulation,

The Comprehensive Nature of Juvenile Risk Assessment

• Each of these authors adopts a definition of risk assessment that implicitly recognizes that the goals of a comprehensive risk assessment process extend beyond the concrete assessment of “risk” alone (that is, the possibility that an individual will sexually re-offend, assessed as low, moderate, or high, for instance).
• In each case, the formal evaluation of risk (that is, the assignment of a level of risk for re-offense) is but one part of, and embedded within, a larger and more comprehensive process of assessment, the purpose of which is to understand the juvenile being assessed as fully and deeply as possible.

Predictions of Juvenile Risk Emerge From Comprehensive Assessment

• The recommendation that juvenile risk assessment should be comprehensive, including much information about the child or adolescent, is included in the standards and guidelines for the evaluation, treatment, and supervision of sexually abusive youth, developed by the Colorado Sex Offender Management Board (Colorado Department of Public Safety, 2002).
• The Board asserts that a juvenile’s level of risk should not be based solely on the sexual offense, and requires that a complete knowledge of the history, extent, type of sexual offending and other factors is needed before a risk of re-offense and risk to community safety can be adequately determined.
• The standards note also that risk evaluations of sexually abusive youth must be comprehensive and, in addition to an evaluation of sexual behavior, must include assessment of multiple domains of cognitive, psychosocial, and family functioning.
• In fact, there is broad agreement in the literature that evaluation of risk in juvenile offenders should be comprehensive, and include a wide range of individual, social, interactional, and contextual factors (Borum & Verhaagen, 2006; Grisso, 1996; Rich, 2009; Righthand & Welch, 2004; Theriot, 2006), as well as factors related directly to the sexually abusive behavior.
• Indeed, in the literature on general (non-sexual) delinquency and violence among juveniles, Lipsey and Derzon (1998) identify risk factors residing within and spread throughout five essential domains (individual, family, school, peer group, and community), illustrating the idea that risk factors are not limited to simply those that appear directly or specifically related to acts of violence or delinquency.
• Hence, the assessment of juvenile risk for sexual re-offense results in a prediction of future behavior based upon a wide range of information about the juvenile and his or her prior and current behavior, in which “risk” emerges as a property of the person within his or her environment.
• Assessed risk, in this case, is neither absolute as in its more narrow counterpart, nor is it assessed or understood in absence of a deep understanding of the individual and his or her circumstances.

Risk Factors for Juvenile Sexual Offending

The Nature of Static and Dynamic Risk Factors

• Historical behaviors and experiences related to sexually abusive behavior are static risk factors because they have previously occurred and will remain unaltered over time.
• Dynamic risk factors are those associated with current behaviors, thoughts, feelings, attitudes, situations, interactions, and relationships.
• Sometimes referred to as criminogenic needs because they are factors that contribute directly and drive to criminal behavior, dynamic factors also include situational variables that may change over time, including family factors and other environmental conditions that may affect and influence individuals and their behavior.
The Nature of Static and Dynamic Risk Factors

• An important characteristic of dynamic risk factors is that reductions in such factors are often related to progress in treatment and the reduction of recidivism (for instance, Olver & Wong, 2009; Pedersen, Rasmussen, & Elsass, 2010).
• Beggs and Grace (2011) write that measures of treatment change point to effective treatment targeting dynamic risk factors, leading to a reduction in sexual recidivism.
• Unlike actuarial assessments, which are usually based entirely on static risk factors, clinical risk assessment tools, for both adolescents and adults, include both static and dynamic risk factors.

Static and Dynamic Factors in Risk Assessment and Treatment

• Static factors are useful for making assessments of an offender’s general/overall risk level, because risk level is often associated with past behavior.
• Knowledge of dynamic factors, however, is required to identify targets for intervention, assess changes in risk, and reduce active and current elements that may result in re-offense.
• Dynamic factors are the targets of treatment programs because treatment aims at changing these factors (static factors, by definition, cannot be changed, so it’s pointless to address treatment towards them).
• Accordingly, a clinical assessment tool designed for both broad assessment and treatment planning must necessarily take into account both static and dynamic risk factors.

Common Risk Factors for Juvenile Sexually Abusive Behavior

• A great many articles have been written over the past decade and more that have identified and discussed risk factors for juvenile sexual offenses.
• Although these can largely grouped into several general categories, at least 101 risk factors have been described in the professional literature.
• However, similar risk factors appear in each of the most commonly available and used juvenile risk assessment instruments, both clinical and actuarial.
• Despite differences among instruments, in their design and in their inclusion of risk factors, across these instruments risk factors that commonly appear are grouped into ten essential categories.

Ten Common Categories of Risk Factors

1. Sexual Beliefs, Attitudes, and Drive includes those factors most relevant to the youth’s experience of sexuality, nature of sexual ideation and level of preoccupation, and drive to engage in sexual behavior.
2. History of Sexually Abusive Behavior, which includes severity and type of behavior, duration and number of incidents, progression of sexually abusive behavior over time and range of sexually abusive behavior, number and gender of victims, victim age in relationship to the offender, victim relationship to the offender, the use of violence or aggression, the role of planning and intentionality, and continued sexually abusive behavior after apprehension.
3. History of Personal Victimization, involving a history of physical or sexual abuse and details related to that history, including both past and current responses to these experiences.
4. History of General Antisocial Behavior, including general behavioral problems in the community and school and age of onset, aggression, the seriousness and range of antisocial behaviors, substance abuse, and antisocial attitudes, including peer group association.
5. Social Relationships and Connection, primarily involving a lack of close peer relationships and deficits in social relationships in general.
6. Personal Characteristics includes a wide range of characterological features, including motivation for change, deficits in empathy and remorse, denial and lack of responsibility and denial of behaviors, and deficits in cognitive ability and insight.
7. General Psychosocial Functioning is a broad category, but includes poor self-regulation and impulse control, poor anger management, deficits in social skills and social competency, and overall difficulties in social functioning.
8. Family Relationships and Functioning pertains to the family environment past and present. It includes generally stressful family life, general family and parental figure functioning, the consistency of parental figures, and parent figure functioning, history of and exposure to family violence, internal family boundaries, the quality of parent-child relationships, and the attitude of parent figures towards and involvement in treatment.

Continued
Ten Common Categories of Risk Factors (continued)

9. **General Environmental Conditions** incorporates the general stability of the youth's living situation, the stability of school, the nature and quality of support systems, general environmental conditions, and opportunities for sexual re-offense.

10. **Response to Treatment**, including both the youth's response to and success in prior treatment, and in current treatment if the youth is presently in treatment. It especially includes failure to complete treatment, as well as grasp of and response to treatment ideas.

Limitations in the Research

- However, despite a growing literature on risk factors for juvenile sexual abuse, much of it is theoretical and descriptive rather than the result of statistical research.
- Spice, Viljoen, Latzman, Scalora, and Ullman (2012) note that this limited body of research literature is characterized by a number of methodological problems, furthering limiting and weakening the research.
- Of most significance, Spice et al. note that the risk factors selected vary widely from study to study, thus creating inconsistency.
- Given these problems, Spice et al. write it is not surprising that findings across studies vary and that findings from different studies are inconsistent.
- Nevertheless, this represents the state of research into juvenile sexual offending, including both the identification of risk factors for sexually abusive behavior and the capacity of risk assessment instruments to accurately and meaningfully estimate risk.

The Interactive Effect of Multiple Risk Factors

- Of importance, it is the presence and interaction of multiple risk factors, rather than any single risk factor, that is most significant in understanding the nature and effect of risk factors.
- Accordingly, whether adult or juvenile, actuarial or clinical, all risk assessment instruments include multiple risk factors, and through the assessment process evaluate the presence, interaction, and amplificative effect of multiple factors on the individual being assessed and his or her risk for re-offense.
- No single factor alone, even one with relatively high predictive strength, is capable of predicting recidivism (Hanson & Bussière, 1998; Hanson & Morton-Bourgon, 2005, 2007; Roberts, Doren, & Thornton, 2002).
- Thus, risk assessment instruments, and the risk assessment process, must consolidate information about multiple aspects of risk, in which the final assignment of risk is based upon both the presence of a number of risk factors and the inter-relationship among risk factors, or groups of risk factors.
- Illustrating this point, of the 23 childhood (non-sexual) risk factors identified in the U. S. Surgeon General’s report on youth violence (U.S. Department of Health and Human Services, 2001, largely based on the work of Lipsey and Derzon, 1998), none showed a strong effect size.
- Only six risk factors fell into the moderate range, and of these only two fell toward the higher end of moderate.
- However, this does not mean that these risk factors are inconsequential.
- Instead, it suggests that it is a combination of risk factors, and no single factor alone, that best predicts risk, also noted by Hanson and Bussière (1998) in their meta-analysis of sexual offender recidivism.

The Cumulative Power of Risk Factors

- That is, although some risk factors are stronger in effect than others, and are therefore better predictors of later antisocial behavior, no single factor is itself necessary for nor sufficient enough to predict or produce antisocial behavior.
- For instance, Caldwell and Dickinson (2009) write that studies have shown that the characteristics of a specific sexual offense are poor predictors of future risk, although in many jurisdictions sex offender registration is nevertheless contingent on the specifics of an adjudicated sexual offense.
- In addition, not only is risk best predicted by multiple risk factors, but the likelihood that an individual will engage in antisocial behaviors is greatly increased by the number of risk factors to which the individual is exposed (Farrington, 1997; Garmey, 1987; Hawkins et al., 2000).
- Further, risk that produces antisocial behavior is driven, not just by multiple risk factors, but, as noted, by interactions among risk factors across multiple domains of risk (Haggerty & Sherrod, 1996; Loeber et al., 2005).
The Cumulative Power of Risk Factors

- For instance, Casey, Beadnell, and Lindhorst (2009) examined data from 5,649 male participants in the National Longitudinal Study of Adolescent Health.
- Their study strongly suggests that different experiences of child maltreatment may have additive effects on risk for later sexually coercive behavior, as a combination of factors, such as early physical and sexual abuse, vastly increased the likelihood of subsequent coercive behavior.

The Empirical Basis of Juvenile Risk Factors

Juvenile Risk Factors Lack Consistent Empirical Validity

- Despite the fact that the evaluation and projection of risk requires the assessment of multiple risk factors rather than one or two in isolation, many of the risk factors included in juvenile risk assessment instruments only have face validity... that is, an intuitive and perhaps common sense appeal that appears to reflect aspects of risk, but very little proven validity (effectively, evidence that the risk factors actually do predict risk for re-offense).
- That is, despite their inclusion and use in juvenile risk assessment instruments, many of the included risk factors have very little, if any, empirical or predictive validity.

Lack of Empirical Support for Theoretically Derived Risk Factors

- Regardless of our selection process and combinations of included risk factors, in their review of risk factors associated with juvenile sexual recidivism, Worling and Långström (2003, 2006) write that most identified risk factors for juvenile sexual offending (that is, those included in risk assessment instruments) actually lack empirical validation.
- Describing 21 commonly cited risk factors, they write that only five are empirically supported through at least two published independent research studies, with an additional two “promising” factors that have empirical support in at least one study.
- The remaining 14 factors they describe as either third tier “possible” risk factors, based on general clinical support, or fourth tier “unlikely” risk factors that either lack empirical support or are contradicted by empirically derived evidence.

Worling and Långström’s Typology of Validated Risk Factors for Juvenile Sexual Re-Offense

| Empirically Supported | 1. Deviant sexual arousal |  
| 2. Prior convicted sexual offenses |  
| 3. Multiple victims |  
| 4. Social isolation |  
| 5. Incomplete sexual offender treatment |  
| Promising | 1. Problematic parent-child relationships |  
| 2. Attitudes supportive of sexually abusive behavior |  
| Possible | 1. Impulsivity |  
| 2. Antisocial orientation |  
| 3. Aggression |  
| 4. Negative peer group association |  
| 5. Sexual preoccupation |  
| 6. Sexual offense of a male |  
| 7. Sexual offense of a child |  
| 8. Use of violence, force, threats, or weapons in sexual offense |  
| 9. Environmental support for re-offense |  
| Unlikely | 1. History of sexual victimization |  
| 2. History of non-sexual offending |  
| 3. Sexual offenses involving penetration |  
| 4. Denial of sexual offending |  
| 5. Low victim empathy |  

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Updates and the Empirical Base in Juvenile Sexual Risk Assessment: Page 10
Inconsistency in and the Changing Nature of the Literature Regarding Empirical Validation

- It is important to recognize, however, that Worling and Långström’s (2006) typology of empirically supported risk factors has not been replicated in the literature.
- Further, contradictory evidence regarding some elements of the typology can be found in other studies, as well as supporting evidence. Indeed, the literature is mixed and inconsistent.
- For instance, Worling, Bookalam, and Litteljohn (2012) report further support for five of the risk factors identified in the Worling and Långström typology as tier 1 or 2 factors: (I) Obsessive sexual interests and/or preoccupation, (ii) antisocial interpersonal orientation, (iii) lack of intimate peer relationships/social isolation, (iv) interpersonal aggression, and (v) problematic parent–child relationships/parental rejection.
- Långström (2011) offers further support for multiple (two or more) victims as a risk factor.
- Seto and Lalumière (2010) also found deviant sexual interest to be a significant risk factor for juvenile sexual recidivism, as well as social isolation, which was also found to be a risk factor by van der Put, van Vugt, Stams, Deković, and van der Laan (2013).
- However, Worling and Långström’s typology does not take into account empirical and statistical support found by Epperson,Ralston, Fowers, and Gore (2006) for history of sexual victimization and history of non-sexual offending, both of which Worling and Långström describe as unlikely risk factors.
- Similarly, Mallie, Viljoen, Mordell, Spice, and Roesch (2011) also find empirical support for a history of sexual victimization as a risk factor for sexual recidivism in sexually abusive youth, as do Carpentier and Proulx (2011) who describe childhood sexual victimization as a risk factor associated with the risk for both sexual and nonsexual recidivism.
- Knight, Ronis, and Zakireh (2009) found some support for (i) hypersexuality/sexual deviance, (ii) impulsivity-antisocial behavior, (iii) arrogant/deceitful personality, (iv) violent behavior/fantasies, and (v) history of victimization.
- However, among these five factors only one (deviance) is included among Worling and Långström’s tier one risk factors, whereas the other four are described as tier three or four factors.
- Indeed, since the 2006 typology, Långström himself (2011) has found (i) sexual offense in a public area, (ii) sexual offense involving a stranger victim, and (iii) sexually offending on two or more occasions as risk factors although none are included in Worling and Långström’s earlier typology.

Empirical Support for Still More Risk Factors?

- However, there are still more risk factors that have been offered some level of empirical support.
- In their meta-analysis, involving over 3,100 juvenile sexual offenders, McCann and Lussier (2008) found support for deviant sexual interests, stranger victim, prior non-sexual offenses, use of threats or weapons, male victim, and child victim.
- In their smaller meta-analysis, Heilbrun, Lee, and Cottle (2005) concluded that younger age upon first offense, prior non-contact sexual offenses, and having an acquaintance victim, rather than a stranger victim, were risk factors for sexual recidivism.
- In their study of 351 sexually abusive adolescent boys, Carpentier and Proulx (2011) argue that overall, violent, and sexual recidivism can be predicted by a variety of developmental, social, and criminological factors.
- They describe paternal abandonment, childhood sexual victimization (described by Worling and Långström as an unlikely risk factor), association with significantly younger children, and prior victimization of a stranger statistically associated with sexual recidivism.

30 Partially Validated Risk Factors

1. Antisocial orientation
2. Arrogant/deceitful personality
3. Association with younger children
4. Deviant sexual interests
5. Duration of sex offending history
6. History of aggression
7. History of non-sexual offending
8. History of non-sexual/physical victimization
9. History of sexual victimization
10. Hypersexuality/sexual deviance
11. Impulsivity-antisocial behavior
12. Incomplete sexual offender treatment
13. Lack of intimate peer relationships
14. Multiple offenses
15. Multiple victims
16. Negative peer group association
17. Obsessive sexual interests and/or preoccupation
18. Parental/paternal abandonment
19. Placement in special education
20. Prior convicted sexual offenses
21. Problematic parent–child relationships/rejection/abandonment
22. Sexual offense in a public area
23. Sexual offense of an acquaintance
24. Sexual offense of a child
25. Sexual offense of a stranger
26. Social isolation
27. Under supervision when any sex offenses occurred
28. Use of violence, force, threats, or weapons in sexual offense
29. Violent behavior/fantasies
30. Younger age upon first offense
Weak Evidence of Empirical Validity

• Nonetheless, evidence of the validity of commonly identified risk factors for juvenile sexual offending is weak.
• Arriving at a similar conclusion as Worling and Långström (2006), Prentky, Pimental, Cavanaugh, and Righthand (2009), following their overview and review of risk factors commonly associated with juvenile sexual recidivism, also conclude that the vast majority of juvenile risk factors are only weakly related to sexual re-offense, and that note that most have never been examined empirically.
• Accordingly, Powers-Sawyer and Miner (2009) conclude “a great deal of continued research is needed” (p. 9) to identify, understand, and construct both static and dynamic risk variables linked to juvenile sexual recidivism.

The Complexity of Risk Factors

• Research on the risk factors for sexual recidivism has produced inconsistent and sometimes contradictory results.
• Whether these disparate findings are an artifact of the methodological variations found across studies, a reflection of real-world risk factor dynamics, or some combination of the two remains unknown at this time.
• Spice et al. (2012) and McCann and Lussier (2008) have voiced concerns about the idiosyncratic nature of individual studies, as well as the lack of consistency across studies in terms of their research designs, samples, hypotheses, and statistical procedures.
• However, risk factors for sexual recidivism may operate differently in different people, and at different points in child and adolescent development.
• For instance, in a recent study of 1,396 juvenile offenders, van der Put et al. (2011) found that the effect of both static and dynamic risk factors on recidivism varied by adolescent age.

The Empirical Validity of Juvenile Dynamic Risk Factors Within Adolescence

• van der Put and colleagues (2011) add an interesting dimension to understanding risk factors for juvenile sexual recidivism, and especially dynamic risk factors.
• Following their study of almost 1,400 juvenile offenders, van der Put et al. suggested that juvenile risk assessment instruments should not only be separated from adult instruments, but also that adolescent instruments should be further divided by age range within adolescence, as they found that the effect of static and dynamic risk factors on recidivism varies developmentally by adolescent age and over time.
• They assert it is not only important that risk assessment instruments include dynamic risk factors, but also that these are empirically established and sufficient for each age group because the impact of static and dynamic risk factors on recidivism differs greatly among child and adolescent age groups.

Further Complexity

• Finally, both Seto and Lalumière (2010) and van der Put et al. (2013) describe further subtlety in understanding and indentifying risk factors for juvenile sexual recidivism.
• Both sets of authors recognize prior childhood sexual victimization as a risk factor for later juvenile sexually abusive behavior.
• However, Seto and Lalumière describe childhood sexual abuse as a risk factor for the onset of juvenile sexually abusive behavior, but not sexual re-offense.
• Similarly, in their study of 625 sexually abusive youth, van der Put et al. found that a history of childhood sexual abuse was not a risk factor for recidivism, although they reported significant differences in the incidence of prior sexual victimization among different types or groups of sexually abusive youth, reflecting heterogeneity within the population and the multi-faceted nature of risk factors.

Risk Factors for Juvenile Sexual Recidivism

• Despite a developing research base, the empirical evidence concerning the validity of commonly identified risk factors for juvenile sexual offending remains weak and inconsistent.
• As a result, our knowledge regarding risk factors for juvenile sexual recidivism is speculative and provisional at this point in time, but it is evolving.
• The inability of research to thus far produce trustworthy and definitive evidence regarding juvenile risk factors for sexual recidivism may reflect problems with the research undertaken to date.
• But it also is likely that complex interactions among different risk factors are at play at different times in the development of children and adolescents and that these dynamics are exceptionally difficult to disentangle and document empirically.
Risk Factors for Juvenile Sexual Recidivism

- Similarities found between risk factors that place juveniles at risk for sexual offending and those that place juveniles at risk for many other problem behaviors, including general delinquency, complicate matters even further.
- Far more research is needed to identify, understand, and construct both static and dynamic risk variables linked specifically to juvenile sexual recidivism.

Validation of Juvenile Risk Assessment Instruments: The Current State of Research

Validation of the Most Commonly Used Juvenile Risk Assessment Instruments

- Although there are a number of juvenile risk assessment instruments in use, the three currently most commonly used instruments in North America are the Juvenile Sex Offender Assessment Protocol-II (J-SOAP-II) and the Estimate of Risk of Adolescent Sexual Offense Recidivism (ERASOR), both of which are structured and empirically-based instruments designed for clinical assessment, and the Juvenile Sexual Offense Recidivism Risk Assessment Tool-II (JSORRAT-II) which is currently the only available actuarial assessment for juvenile sexual offenders.

Weak Empirical Support

- Of these three instruments, the J-SOAP has received the most attention and been subject to the most empirical scrutiny in terms of validation studies.
- Regardless, among the studies of each instrument completed thus far, in terms of validation, overall the literature is scattered and inconsistent and does not offer a great deal of statistical support for any of the risk assessment instruments.
- The literature instead largely describes risk assessment instruments as failing to show high, consistent, or universal levels of reliability or predictive validity.
- Nevertheless, the research literature has yielded mixed and inconsistent, and hence, contradictory, results.

Lack of Consistent Validity

- On the whole, the clinical and research literature provides mixed, rather inconsistent, and often contradictory results regarding juvenile risk assessment instruments and evaluation of their empirical validity.
- In general, the bulk of the independent literature suggests that juvenile assessment instruments are far from empirically validated, raising concerns about their capacity to reliably and accurately predict the risk of juvenile sexual recidivism or inform public policy and debate, as well as juvenile court decisions.
- Although Viljoen (2012, personal communication, April 23, 2012) notes some optimism about the capacity of risk instruments to accurately predict risk, she also notes considerable, and unexplained, heterogeneity across studies.

Inter-Rater Reliability

- Despite weaknesses and inconsistencies with predictive validity, a key and the most significant element in the validity of risk assessment instruments, the J-SOAP, ERASOR, and JSORRAT-II have each been generally reported to show inter-rater reliability (Caldwell, Ziemke, & Vitacco, 2008; Knight, Ronis, & Zakireh, 2009; Martinez, Flores, & Rosenfeld, 2007; Parks & Bard, 2006; Rajlic & Gretton, 2010; Viljoen et al., 2008).
- This means there is some support for their capacity to yield consistent results when used by different evaluators on the same cases, and with the same information available to them.
- Nevertheless, despite reports of significant inter-rater reliability, the research literature yields mixed results in this arena as well.
- Vitacco, Caldwell, Ryba, Malesky, and Kurus (2009) report an absence of well-designed or implemented inter-rater reliability studies, and the additional necessity of conducting inter-rater reliability studies across juvenile sexual offender populations in different treatment settings.
- With respect to inter-rater reliability, Vitacco et al. (2009) also describe the necessity for research that examines the potential for allegiance bias regarding the reliability of the instruments when used under different conditions, and potentially for different purposes.
Inter-Rater Reliability Does Not Equal Predictive Validity

- Inter-rater reliability and predictive validity are not the same thing. Regardless of inter-rater reliability, Elkovitch, Viljoen, Scalora, and Ullman (2008) reported that evaluators using the J-SOAP-II were not able to predict detected cases of either sexual recidivism or non-sexual violent recidivism above chance, and a high degree of inter-rater confidence was not associated with higher levels of accuracy.
- Thus, inter-rater reliability scores on the JSOAP-II were unrelated to sexual recidivism in the sample of juvenile sexual offenders included in Elkovitch et al.’s study, highlighting that it is predictive validity that most distinguishes the value of a risk assessment instrument in accurately predicting risk, despite strong internal construction of an instrument or positive inter-rater reliability.

Limited/Mixed Support for Predictive Validity: J-SOAP, ERASOR, and JSORRAT-II

- Worling (2004), Worling and Långström (2006), and Viljoen et al. (2008) have each noted the absence of prospective empirical data regarding predictive validity for both the J-SOAP-II and the ERASOR, or the JSORRAT-II which lacks any prospective data.
- Similarly, Prentky and Righthand (Righthand et al., 2005), the authors of the J-SOAP, have written that they can provide no definitive feedback regarding the critical question of predictive validity for the J-SOAP.
- Prentky, Li, Righthand, Schuler, Cavanaugh, and Lee (2010) write “in sum, J-SOAP-II is not a predictive instrument upon which long-term decisions should be made... (although) the pattern of individual J-SOAP-II scale scores may be especially useful for guiding effective treatment interventions” (p. 26).
- Indeed, Viljoen et al. (2008) and Viljoen, Elkovitch, Scalora, and Ullman (2009) report that there are no currently well-validated risk assessment instruments for the prediction of sexual recidivism among juvenile sexual offenders.
- Vitacco, Viljoen, and Petrila (2009) write that juvenile risk assessment instruments do not perform in a manner that provides confidence regarding their ability to predict juvenile sexual recidivism.

Limited/Mixed Support for Predictive Validity: J-SOAP, ERASOR, and JSORRAT-II

- Similarly, Knight, Ronis, and Zakireh (2009) write that independent research has produced inconsistent and poor results for the J-SOAP-II, ERASOR, and JSORRAT-II in predicting either sexual or general (sexual and non-sexual) recidivism, and especially for the prediction of sexual recidivism.
- Hence, Caldwell, Ziemke, and Vitacco (2008) conclude that, at this time, research does not support the use of any of the specialized juvenile risk assessment instruments due to inconsistent and overall limited predictive validity, and that no instruments have yet emerged as an empirically validated approach to juvenile sexual risk assessment.
- More recently, Fanniff and Letourneau (2012) note an overall lack of and mixed evidence regarding individual scales and the total score of the J-SOAP-II. “Until the psychometric properties of the J-SOAP-II are more consistently supported by empirical evidence, evaluators should not base significant decisions, such as opinions regarding registration and notification or youth confinement status, on J-SOAP-II results....”
  “Moreover, mental health professionals conducting predisposition evaluations should proceed with great caution when interpreting J-SOAP-II scores as part of broader risk assessments. Even when the J-SOAP-II is only one source informing clinical judgment, evaluators have been unable to produce valid estimates of risk.” (p. 403).

Mixed and Inconsistent Results Across Studies

- In their studies of the ERASOR and J-SOAP, Viljoen et al. (2008, 2009) reported that both instruments failed to demonstrate predictive accuracy in the assessment of juvenile sexual recidivism.
- However, in their study of the ERASOR and the J-SOAP-II in Singapore, Chu, Ng, Fong, and Teoh (2012) found that the ERASOR’s overall clinical rating and total score significantly predicted sexual recidivism, and the ERASOR and J-SOAP each significantly predicted non-sexual recidivism.
- However, only the ERASOR showed predictive validity for sexual recidivism, whereas Chu et al. found that the J-SOAP total score showed poor predictive validity for sexual recidivism, and only the Sexual Drive/Preoccupation scale showed significant predictive validity for sexual recidivism.
Increasingly, the predictive validity of risk assessment instruments is measured in terms of their AUC values.

- AUC values between .66 and .70 are often considered to show mild predictive validity.
- Scores between .71 and .80 support moderate predictive accuracy.
- Scores of .81 and above show strong predictive validity.
- Scores between .50 and .60 suggest that predictive accuracy is either no better or little better than chance.
- Scores between .61 and .65 fall into the weak and close to chance range in terms of accuracy in prediction.

The J-SOAP-II

- The strongest support for the predictive validity of the J-SOAP-II comes from Prentky et al. (2010). Of note, Prentky, the primary author of the study, and Righthand, the third author, are two of the primary authors of the J-SOAP-II.
- Prentky et al. report AUC (area under the curve) values of .80 for the total (overall) score for their pre-adolescent sample and .83 for the adolescent sample.
- The J-SOAP-II is comprised of two scales, each of which has two sub-scales, for a total of four sub-scales.
- In addition to strong AUC values for the total score, Prentky et al. also report AUC subscale values that range between .56 and .78 for the pre-adolescents and .66 and .83 for the adolescent sample.
- With the exception of the .56 AUC, all of these subscale AUC values fall into the range of mild to strong predictive validity.

The J-SOAP-II

- However, in contrast, Fanniff and Letourneau (2012) found significant limitations in the J-SOAP-II’s total score as a accurate or consistent predictor of sexual recidivism.
- In their study, the J-SOAP-II total score was marginally predictive of general recidivism with an AUC of .60, but not predictive of sexual recidivism, with an AUC of .58.
- Fanniff and Letourneau found significant limitations in the J-SOAP as an accurate or consistent predictor of sexual recidivism, and concluded that weak performance of the J-SOAP-II total score either reflects limitations in their particular study or a true lack of predictive validity.
- Their findings are consistent with those of Chu, Ng, Fong, and Teoh (2012), who studied both the J-SOAP-II and the ERASOR in Singapore.
- They found that the J-SOAP-II predicted non-sexual recidivism, with an AUC of .79, but the total score showed poor predictive validity for sexual recidivism, with an AUC of only .51, or chance levels.

The J-SOAP-II Sub-Scales

- In their study of the J-SOAP-II, Chu et al. (2012) found that the J-SOAP total score failed to show predictive validity for sexual recidivism, and only the Sexual Drive/Preoccupation scale showed significant predictive validity for sexual recidivism.
- However, in contrast, in their study, Fanniff and Letourneau (2012) found that the although having adequate reliability, the Sexual Drive/Preoccupation domain did not predict sexual recidivism.
- Similarly, in their study Caldwell and Dickinson (2009) found the Sexual Drive/Preoccupation scale yielded an AUC of only .47.
- On the other hand, both Fanniff and Letourneau and Caldwell and Dickinson found the Impulsive/Antisocial Behavior scale showed mild-moderate levels of predictive validity.
- Parks and Bard (2006) also found only the Impulsive/Antisocial Behavior scale of the J-SOAP-II predicted sexual recidivism, but that the other scales did not.
- Aebi, Plattner, Steinhausen, and Bessler (2011) also found that J-SOAP total score did not show predictive validity, but found that both the Impulsive/Antisocial and Community Adjustment scales did, although the Sexual Drive/Preoccupation scale did not.
- Conversely, Powers-Sawyer and Miner (2009) found that the predictive accuracy of the Sexual Drive scale was moderately good, whereas the Impulsive/Antisocial Behavior scale demonstrated weak/mild predictive validity.
- Overall, Fanniff and Letourneau report that, consistent with other studies, measures of the predictive validity of the J-SOAP sub-scales are inconsistent.
### Aggregating Scores

- Consistent with Chu and colleagues (2012), Fanniff and Letourneau (2012) found limited support for the J-SOAP total score as a predictor of recidivism, and note that the available literature is mixed regarding the predictive validity of the J-SOAP total score.
- However, Viljoen, Mordell, and Beneteau (2012) consolidated 33 published and unpublished studies involving over 6,000 male adolescent sexual offenders and conducted two separate meta-analyses, resulting in an aggregated AUC score of .67 for the J-SOAP-II, narrowly falling into the range of mild predictive validity.
- This perhaps demonstrates, not only the inconsistency of research results and outcomes, but also that the design, method, and process of statistical analysis may itself have a noticeable effect on the results of research.
- In this case, it is the aggregated score that increases the apparent predictive validity of the instrument, rather than the result of consistency among different research studies.
- Indeed, the aggregated score overlooks important differences and variation in different study outcomes and creates a homogenized view of predictive validity rather than reflecting actual and consistently stable and reliable evidence of empirical validity across studies.

### More on the J-SOAP

- In their study of 60 juvenile sexual offenders, Martinez, Flores, and Rosenfeld (2007) reported low to mild predictive validity for the instrument.
- As opposed to Waite et al. (2005), who found the significant correlation between sexual recidivism and the static scales of the J-SOAP, Martinez et al. found that the dynamic scales were moderately correlated with sexual recidivism, whereas the static scales were not correlated at all.
- On the other hand, Powers-Sawyer and Miner (2009) found that the static variables demonstrated strong predictive accuracy for sexual recidivism.
- Rajlic and Gretton (2010) conducted a retrospective study of the predictive accuracy of the ERASOR and J-SOAP, based on the records of 286 juvenile sexual offenders.
- They found both instruments were highly correlated (relatively consistent) with one another in their estimates of risk for sexual re-offense, with high inter-rater reliability for both instruments, and both were moderately predictive of juvenile sexual recidivism.
- However, they reported that, although both instruments were accurate in their predictions of sexual recidivism in a group of juveniles who had committed only sexual offenses, neither instrument showed accuracy in predicting sexual recidivism among juvenile sexual offenders who had committed both sexual and non-sexual offenses.
- Both instruments failed to predict sexual recidivism in the mixed offense group of juvenile sexual offenders, with predictive accuracy no better than chance.
- For juvenile “sexual only” recidivists, Rajlic and Gretton reported an AUC.80 for the J-SOAP-II. However, in predicting sexual recidivism for juvenile sexual offenders who had committed both sexual and non-sexual offenses, they found an AUC of only .51.

### J-SOAP-II Summary

- Although there is some support for the J-SOAP-II, it is limited and uneven, mixed, and inconsistent across and within supporting studies, such as Rajlic and Gretton’s (2010) study which found significant differences in the predictive capacity of the instruments based on the composition of the juvenile sexual offender group being assessed.
- In addition, in some studies evidence of predictive accuracy has been shown for the total score of the J-SOAP-II, whereas other studies have shown the total score to be less predictive than the individual sub-scales of the instrument or not predictive at all.
- Further illustrating inconsistencies in research outcomes, in the case of some independent research the J-SOAP-II has been found to be effective in predicting general, but not sexual, recidivism. Thus, even among studies yielding evidence of predictive validity, the results are mixed and contradictory.
- Accordingly, although there is some support for the J-SOAP-II, the wide variation in results either demonstrates difficulties, weaknesses, and/or inconsistencies in research studies or reveals weaknesses in and the unreliability of the instrument itself in terms of predictive validity.
- As such, despite promise and its value in case planning and perhaps case management, the J-SOAP-II cannot be considered to be an empirically validated instrument.
The ERASOR
- The ERASOR has not been as widely examined as the J-SOAP-II, with few published studies.
- However, like the J-SOAP-II, the available research offers inconsistent and weak support for the predictive validity of the instrument.
- In their study of the ERASOR and the J-SOAP-II, Chu et al. (2012) found that the ERASOR’s overall clinical rating and total score significantly predicted sexual recidivism, and both instruments significantly predicted non-sexual recidivism.
- However, only the ERASOR showed predictive validity for sexual recidivism. In addition, they also found the clinical judgment method for scoring the ERASOR was more accurate than actuarial methods in which a score is assigned to each risk factor and then totaled for the overall assessment of risk.

More on The ERASOR
- Viljoen, Elkovitch, Scalora, and Ullman (2009) reported that ERASOR did not accurately or dependably predict juvenile sexual recidivism, reporting an AUC of .64.
- Also, unlike the Worling et al. study (2011), Viljoen et al. found that the clinical rating score provided a stronger AUC (.64) than the total score (.60).
- Viljoen, Mordell, and Beneteau’s (2012) consolidation and meta-analysis of 33 studies involving over 6,000 adolescent sexual offenders, and involving the J-SOAP-II, the JSORRAT-II, and the ERASOR, produced an aggregated AUC score of .66 for the ERASOR with respect to sexual recidivism, falling into the very mild range of predictive validity, but only .59 for non-sexual recidivism.
- As previously described, the creation of an aggregated score overlooks the differences and variation in different study outcomes and potentially inflates the AUC value.
- Nonetheless, in this case Viljoen et al.‘s assessment of the ERASOR still produces only marginal-mild evidence of predictive validity for the instrument.
- Rajlic and Gretton’s 2010 study found that both the J-SOAP and ERASOR predicted sexual recidivism in a group of juveniles who had committed only sexual offenses, but that neither tool showed accuracy in predicting sexual recidivism among juvenile sexual offenders who had committed both sexual and non-sexual offenses.
- For juvenile “sexual only” recidivists, they reported an AUC of .86 for the ERASOR total (numerical) score. However, in for juvenile sexual offenders who had committed both sexual and non-sexual offenses, they found an AUC of only .54 for both the clinical rating and total score of the ERASOR.
ERASOR Summary

- Indeed, the strongest support for the predictive validity of the ERASOR comes from Worling, Bookalam, and Litteljohn (2011) with an AUC value of .82 for the clinical rating score, but only with an average follow-up period of 1.4 years. However, the AUC drops to .61 when the follow-up period increases to an average of 3.7 years.
- Worling et al. note that this may reflect the deterioration of accurate risk prediction in still developing adolescents, and note that the instrument is intended to measure risk in adolescent only over a two year period.
- Indeed, they write that “the fact that more contemporaneous ratings were… more predictive of subsequent sexual offending suggests that it is important for clinicians to reassess adolescents and that clinical and forensic decisions are likely to be more accurate if they are based on more recent risk assessments” (p.14).
- Nevertheless, the limited research on the ERASOR again points to limitations in studies and/or the instrument itself. Without more consistent, and independent, research results the ERASOR can only be considered a promising, but not empirically validated, risk assessment instrument.

Mixed and Inconsistent Results for Both the J-SOAP and ERASOR

- Despite a lack of consistent statistical support among independent researchers for the predictive validity of the J-SOAP and ERASOR, there is nonetheless also some independent support for the validity of both.
- However, such support is limited, and is uneven, mixed, and inconsistent within and across supporting studies, such as Rajlic and Gretton’s (2010) which found significant differences in the predictive capacity of the instruments based on the composition of the juvenile sexual offender group being assessed.
- Overall, although finding some support for the J-SOAP, Powers-Sawyer and Miner (2009) reported little cumulative evidence for strong predictive strength among risk assessment tools for juvenile sexual recidivism.

The JSORRAT-II

- As the first juvenile actuarial assessment instrument, the introduction of the JSORRAT-II has added a significant new dimension to the assessment of juvenile sexual offenders.
- However, although the JSORRAT-II is validated in Utah and Iowa, and approved for use in Georgia and California where it is undergoing validation studies, it remains largely a research instrument.
- However, despite its increasing use and increasing interest in the instrument, the JSORRAT-II has little empirical support at this time.
- The very limited research on the instrument has produced mixed results, with currently low AUC scores, indicating mild predictive validity at best although, as with all other risk assessment instruments that have been researched, results are inconsistent.

Validation of the JSORRAT-II

- Only two studies have been conducted by independent researchers, and these have failed to demonstrate predictive validity or suggest very marginal validity at best.
- Nevertheless, the authors of the JSORRAT-II have conducted their own studies, as a critical element in the development and validation of the instrument; however, there has been significant variation in the results of the two validation studies conducted by the instrument’s authors.
- Based on an initial sample of 636 male juvenile sexual offenders, the instrument’s authors (Epperson, Ralston, Fowers, Dewitt, & Gore, 2006) initially reported an AUC value of .89 for predicting sexual recidivism prior to the age of 18, and .79 for the predictive accuracy of the JSORRAT-II in predicting anytime (prior to or after age 18) sexual recidivism, both of which are strong indicators of predictive accuracy.
- However, in predicting sexual recidivism only after age 18, the authors reported an AUC of .64, a relatively weak AUC value, thus leading the authors to speculate that different risk factors may be in play for young adult recidivists as opposed to juvenile recidivists.
- However, in a later study in Utah, Epperson and colleagues reported an AUC of only .66, and an AUC value of .65 in a validation study in Iowa (Epperson & Ralston, 2009; Epperson, Ralston, and Edwards, 2009).
- These are weak, or marginal, indicators of predictive accuracy, and significantly lower than the values the authors of the instrument found in their first study.
- Most recently, in an Iowa study, Ralston and Epperson (2012) report an AUC of .70 for sexual recidivism, although only .54 for any (i.e., general) recidivism.
- However, although Epperson et al. (2006) reported a high degree of inter-rater reliability (reported ICC of .96), indicating the instrument is well designed and capable of yielding the same results for different evaluators, predictive validity has nonetheless ranged from excellent (AUC .89) to marginal and mild (.65-.70) in the authors’ own studies.
Independent Validation of the JSORRAT-II

- Other than Epperson and Ralston’s own studies, Viljoen et al. (2008) have conducted the only truly independent study of the instrument.
- However, in their study of 169 male juvenile sexual offenders, Viljoen et al. found no evidence of predictive validity for either sexual or non-sexual recidivism, reporting an AUC of only .53 for sexual recidivism and .54 for general recidivism, both falling at chance levels.
- Viljoen, Mordell, and Beneteau’s (2012) meta-analysis of juvenile risk assessment instruments resulted in a composite AUC value, which included the AUC values previously reported by Epperson and Ralston. However, the meta-analysis for sexual recidivism resulted in an AUC of only .64 for the JSORRAT-II, falling just below a marginal level of predictive validity despite the aggregated score.

JSORRAT-II Summary

- Given both the limited research and the considerable variation, even within the limited literature, despite its promise and the new direction it offers for juvenile risk assessment as the first actuarial instrument, the JSORRAT-II cannot yet be considered to be a consistently accurate risk assessment instrument.
- Despite some evidence of mild validation, it should not be considered to be an empirically validated instrument until there is independent research that shows consistent and stable predictive validity.
- Nevertheless, although not yet validated and still in development, in California the instrument has been selected by the State Authorized Risk Assessment Tool for Sex Offenders Committee (SARATSO) as the required instrument to be used in the assessment of male juvenile sexual offenders.

Validation of the In-Development MEGA

- The currently in-development Multiplex Empirically Guided Inventory of Ecological Aggregates for Assessing Sexually Abusive Adolescents and Children (MEGA), a structured clinical risk assessment instrument, has undergone preliminary validation studies by its author that have focused on the internal construction and consistency of the instrument, reporting evidence of strong item consistency (Miccio-Fonseca, 2009).
- However, the instrument is not yet available, no independent studies have yet been conducted, and no studies have yet published regarding other important properties of the instrument, including inter-rater reliability and predictive validity.
- Of particular and special note, the MEGA is intended for use with male and female children, adolescents, and young adults ages 5-19 of all IQs, a remarkably wide range for a single evaluation instrument.
- Indeed, the wide range of applications in terms of age, gender, and cognitive capacity, may represent a significant problem for the instrument, highlighted by the recent study of van der Put et al. (2011).
- They suggested that juvenile risk assessment instruments should not only be separated from adult instruments, but that adolescent instruments be further divided by age range within adolescence, as the authors found that the effect of static and dynamic risk factors on recidivism, and hence predictive validity, varied by adolescent age.
- However, the capacities, reliability, and validity of the MEGA as a risk assessment instrument are untested at this time and will remain so until its release. Nevertheless, the wide range of applications in terms of age, gender, and cognitive capacity, may represent a significant problem for the instrument.

Texas Juvenile Sex Offender Risk Assessment Instrument

- Structured and empirically-based risk assessment instruments have been developed and tailored for use in Texas (Texas Juvenile Sex Offender Risk Assessment Instrument: TJSORA-2), New Jersey (Juvenile Risk Assessment Scale:JRAS), and Wisconsin (Wisconsin Department of Corrections Guidelines for Release: WDOC).
- However, although based on the professional literature and appearing actuarial in design, in that they neither require nor permit clinical judgment, none of these instruments are based on actuarial validation, nor are they empirically-validated instruments (Vitacco, Caldwell, et al., 2009). Caldwell, Ziemke, and Vitacco (2008) write that none of the three instruments predict sexual re-offending.
Inconsistency and Uncertainty in the Literature

- Vitacco, Viljoen, and Petrila (2009) describe current instruments as important developmental milestones in further refining the risk assessment process and method, but far from complete.
- Viljoen, Elkovitch, Scalora, and Ullman (2009) recommend that, until there is clear and consistent evidence of the capacity for the risk assessment process to accurately predict risk for juvenile sexual recidivism, court systems and policy makers should be cautious in developing, adopting, and implementing laws and policies based on the belief or assumption that precise and accurate predictions can be made.
- In fact, inconsistencies and contradictions abound in published studies, including those independently researched and those conducted by instrument authors, regarding the predictive accuracy and capability, as well as inter-rater reliability, of juvenile sexual risk assessment instruments.
- The failure to consistently and independently substantiate inter-rater reliability and predictive validity, and/or studies that show a lack of predictive accuracy, make clear that it is not possible to conclude with any level of confidence or certainty the scientific/empirical validity of any juvenile risk assessment instruments at this time. Indeed, Vitacco et al. (2009) have written that, at this time, research does not support the use of any of the juvenile risk assessment instruments, and no single instrument or combination of instruments has demonstrated adequate predictive power for reliably or accurately predicting risk for juvenile sexual recidivism.
- This mirrors Bonta (2002) and Conroy and Murrie (2007) who have also noted that, when used alone, no instrument is sufficient to fully complete the task of risk assessment.

The Current State of Juvenile Risk Assessment Instruments

- The very fact that the literature is so mixed reflects deficits in statistical design and methods, as much as it does gaps in the professional knowledge base.
- However, at best, the professional literature tells us that, despite some mixed and inconsistent validation of juvenile risk assessment instruments, it is not possible to describe or treat such tools as validated or scientific instruments, despite their roots in the empirical literature.
- At this time, it may be most useful to consider juvenile risk assessment as a means and process by which to identify and recognize the presence of risk factors, in terms of their type, number, frequency, and combination, in light of research that highlights these factors as elements of risk for future sexual and non-sexual offenses.
- However, this stands in contrast to the conclusion that risk assessments can, with any level of statistical certainty, predict the incidence or probability of a future offense.
- Knight, Ronis, and Zakireh (2009) write that the few studies of juvenile risk assessment instruments have not consistently found the J-SOAP-II, ERASOR, or JSORRAT-II to be effective in predicting sexual recidivism, and that testing of the instruments by independent investigators has yielded mixed to poor results for both sexual and non-sexual risk, and especially for the prediction of sexual recidivism.
- Despite offering mild support and an endorsement for the capacity of such instruments to predict juvenile sexual recidivism, Viljoen, Mordell, and Beneteau (2012) recognize that research has yielded mixed and inconsistent results.
- Despite their support, they note that juvenile risk assessment instruments are not sufficient for predictions that require a high degree of precision, such as the civil commitment of adolescent sex offenders or the placement of adolescents on lifetime sexual offender registries.

Risk Assessment and Risk Management

- Despite inconsistent and/or mild (and sometimes marginal) statistical support for the J-SOAP-II, ERASOR, and JSORRAT-II, none of the instruments has a consistently demonstrated record of predictive validity.
- This results in the conclusion that the instruments do not perform in a manner that suggests or proves their ability to accurately predict juvenile sexual recidivism (Caldwell et al., 2008; Viljoen et al., 2009; Vitacco, Viljoen, & Petrila, 2009).
- Accordingly, in their review of juvenile sexual risk assessment instruments, Hempel, Buck, Cima, and van Marle (2011) conclude that “the predictive validities of the risk assessment instruments for JSOs are still insufficient to accurately predict recidivism” (p. 16).
Risk Assessment and Risk Management

• However, Viljoen, Mordell, and Beneteau (2012) report that despite weaknesses risk assessment instruments offer clear benefits over unstructured clinical judgments.
• Of special note, they write that despite the research focus on the prediction of sexual recidivism, these instruments are also intended to help manage risk and plan treatment to prevent re-offense.
• They note that increased attention to the utility of tools for these purposes will enable us to move beyond simply the prediction of sexual re-offense and toward the prevention of sexual re-offense.
• Similarly, Prentky, Li, Righthand, and colleagues (2010) write that despite concerns regarding predictive validity, the J-SOAP-II may be useful for making short-term case management decisions and “especially useful for guiding effective treatment interventions” (p. 26).

The Current Status

• Fanniff and Letourneau (2012) recognize that their recommendation that clinicians be very cautious in using juvenile risk assessment instruments to inform critical decisions, “places clinicians in a bind” (p 403).
• However, they write that evaluators of juvenile sexual risk should “focus on short-term risk, acknowledge the fluid nature of both risk and sexuality in juvenile populations, highlight the low base rate of sexual recidivism, as well as the positive response to treatment demonstrated in the JSO literature, and focus on the juvenile’s social context in addition to individual risk factors,” and note “These recommendations are sound” (p. 403).
• “Until existing or new instruments are better validated, evaluations in this context will remain a complex balancing act between the need to provide the courts and other stakeholders with useful information sexual risk and the serious limitations in empirically based knowledge about sexual risk” (pp. 403-404).

The Role of Protective Factors in Risk Assessment

Protective Factors in Assessments of Juvenile Sexual Risk

• Although risk factors make up the basis of virtually all risk assessment instruments, in recent years more attention has been turned to the presence and effects of protective factors in mediating and buffering risk, and reducing or even neutralizing the effects of risk factors.
• Most typically, protective factors have been described in the general literature of child development rather than the forensic literature, but there has been increasing focus on the role of protective factors and their insertion into the process of evaluating and treating risk for juvenile sexual and non-sexual recidivism.
• In his critique of forensic risk assessment, Rogers (2000) describes assessment as inherently flawed if it pays attention only to risk without consideration given to the presence, weight, and action of protective factors.
• As Rutter (2003) has noted, “it seems obvious that attention must be paid to the possibility of factors that protect against antisocial behavior as well as to those that predispose to it” (p. 10).
• Similarly, in writing that protective factors may mitigate the effects of risk factors in high-risk adolescents, Stouthamer-Loeber, Loeber, Wei, Farrington, and Wikström (2002) and Lodewijks, de Ruiter, and Doreleijers (2010) note that this has direct implications for programming to reduce violent recidivism, in which both risk and protective factors should be targets of management, intervention, and treatment programs.
• Indeed, Lodewijks et al. (2010) write, “We can safely conclude that protective factors should be an inextricable part of all risk assessment instruments used with youth” (p. 584).

Protective Factors

• However, whereas the actuarial model of risk assessment focuses on elements of risk only, and particularly static risk, a clinical model of risk recognizes a greater interaction between risk elements and other elements or conditions that serve to advance or inhibit the transformation of risk into actual harm.
• Nevertheless, there are few instruments developed for the incorporation of protective factors into the assessment of juvenile sexual risk, and these either have no empirical support or are in development and have not yet been empirically validated.
• To this end, Worling, Bookalam, and Littlejohn (2011) note there is very little research regarding factors that lead to the cessation of sexual offending behaviors for adolescents, and that it will be important for research to identify protective factors and determine how best to combine risk and protective factors to enhance judgments of future sexual behavior.
• Similarly, Spice et al. (2012) note there have been no studies published concerning protective factors among this population.
Protective Factors and Sexual Recidivism

- Still, work on protective factors has perhaps begun, with the study completed by Spice et al. (2012) that examined the relationship of risk and protective factors to sexual and non-sexual recidivism in a sample of adolescent male sexual offenders.
- Although the study failed to find any protective factors that were statistically related to sexual recidivism or desistance during the study period, Spice et al. have nonetheless begun the process of studying protective factors and sexual recidivism and have set the pace for continued research.
- Their findings suggest there may be protective factors that are specific to sexual recidivism, rather than general/non-sexual recidivism, and call for further research on both risk and protective factors in juvenile sexual offending and whether there are distinct protective factors that apply to sexually abusive youth in particular.

What Are Protective Factors?

- Protective factors, generally conceptualized only in relation to risk factors, are anything that decrease the potential harmful effect of a risk factor.
- These exist independently of risk, can be conceived of in many different ways, and fill different roles in the life of each individual and the larger community.
- However, with respect to risk in particular, protective factors serve to inhibit or restrain the emergence of risk or protect against harm.
- Like risk factors, these can be found to reside within the individual and the external environment.
- However, most of the current juvenile (and adult) risk assessment instruments do not presently include a protective factors scale.

The Nature of Protective Factors

- Religious/spiritual beliefs, moral convictions, prosocial attitudes, secure attachments/social connectedness, and a well developed sense of empathy illustrate protective factors that reside within the individual.
- Family support, prosocial peer group, positive role models, and stable living environment are examples of protective factors that exist outside of the individual.
- High levels of supervision and control (such as probation and threat of incarceration) also represent external protective factors.
- In a dynamic, and typically clinical, assessment model, protective factors will be a consideration in evaluating risk and an element of the overall assessment process, with adjustments made in light of factors that inhibit, restrain, or protect against risk.

Understanding Protective Factors

- Jessor, Van Den Bos, Vanderryn, Costa, and Turbin (1995) describe risk and protection as opposite ends of the same variables and thus highly correlated, making it difficult to fully understand the role of protection.
- Spice et al. (2012) write that the literature on protective factors for non-sexual recidivism has been criticized on a number of grounds, and in particular whether protective factors are conceptualized simply as “mirror images” of risk factors or as separate concepts.
- However, Hall et al. (2012) assert that it is possible and essential to conceptualize and define risk and protective factors as independent from one another, and support the idea of both as conceptually distinct rather than opposite ends of a single dimension.
- Protection, then, has meaning only in the presence of risk, and not simply as its polar opposite.
- For these reasons, it is difficult to estimate the role of protective factors in the assessment of risk, even though the process of risk assessment must take into account the absence or presence of protective factors.
- However, just as one risk factor is likely to signal the presence of other, often related, risk factors, it is similarly likely that the presence of a single protective factor is linked to the co-occurrence of other protective factors.
- It seems equally likely that the presence of multiple protective factors has an additive effects in helping to protect against harm, whereas a single protective factor has probably only a small effect.
Where Do Protective Factors Reside?

• Just as risk resides in different locations, within the individual, in his or her social relationships, and in the surrounding environment, protective factors also reside within these same domains.
• Residing within the individual, protective factors may include a well developed moral code, religious beliefs that prohibit certain behaviors, or a fear of getting caught and punished.
• Protective factors that reside within the social environment include family support, for example, and positive peer relationships and friendships.
• In the environmental domain within which the individual lives and functions, protection may include prosocial media messages, strong school or community values and support, or a strong community response to antisocial behavior.
• As with risk, protective factors are most typically conceptualized and evaluated within five domains: individual, family, school, peer group, and community.

What Are the Protective Factors?

Typically described themes related to protection against general delinquency include:

• A stable and warm relationship with at least one parent, closely related to secure parental attachment.
• Parental supervision.
• Close connections with other supportive, competent, and prosocial adults in the wider community.
• The development of an autonomous self, self-esteem and self-efficacy enhancing experiences.
• Positive school experiences, effective and safe school environments, academic success, and positive relationships with teachers and peers.
• Prosocial peer groups.
• Experiences that open new opportunities.
• Emotional and behavioral self-regulation.
• A positive approach to planning and problem solving.

Assessment Into Treatment

Understanding Assessments of Risk

• The assignment of risk may also be seen as a reflection of the potential for a sexual re-offense if the juvenile is not provided with an appropriate level of continuing care, supervision, and/or treatment.
• However, even an assessment of high risk does not necessarily mean that the youth will re-offend.
• Accordingly, given the weaknesses of any model of risk assessment, it may be more appropriate to understand the assessment of risk as a way of recognizing a preponderance or collection of risk factors and, in particular, factors that pertain to each individual youth and continue to represent risk for that individual.
• From this perspective, an assigned risk level represents the number and type of risk factors most pertinent to each youth, and the areas of risk that require continued treatment and supervision both during treatment and following discharge from treatment.

Risk Assessments Point to Treatment Needs

• From this same perspective, in a model of treatment and rehabilitation, and especially in the case of youthful offenders, we can understand the identification of risk factors as pointers to the form, targets, and intensity of treatment rather than a certain prediction that a sexual re-offense will or will not occur.
• Indeed, as shown in multiple studies, most youths will not re-offend sexually following treatment for sexually abusive behavior.
• Accordingly, it is important to bear in mind that although an assessment of risk does reflect the nature, preponderance, and severity of risk factors for any given juvenile, it also, and of greater importance from the treatment perspective, clearly identifies areas in need of current and continued treatment.
• This is equally true for youths assigned at both low and high levels of risk, although high risk juveniles may have greater on-going treatment and supervision needs upon discharge.
### Principles of Risk, Need, and Responsivity

- The idea that risk is or should be linked to treatment has been much cited in the work of Andrews, Bonta, and Hoge (1990) in their Risk-Need-Responsivity (RNR) model.
- The level and intensity of treatment services provided to sexual and non-sexual offenders should be linked to the level of risk they pose for a re-offense, as well as their treatment needs and their likelihood of benefiting from treatment.
- The model describes risk in both the risk principle of the model, which includes both static and dynamic risk factors, and in the need principle which focus only on dynamic risk factors and clearly recognizes the assessment of dynamic risk factors as one important basis for the provision of treatment.
- The responsivity principle is very much tied to treatment by recognizing that treatment effectiveness is in part tied to characteristics of the offender.

### Risk, Need, and Responsivity and Comprehensive Assessment

- In turn, it is obvious that in many cases both static and dynamic risk factors are directly related to the characteristics of the offender, and in the case of dynamic risk factors are the targets for treatments.
- However, whereas risk may be defined through the narrow exploration of static risk, need and responsivity can only be explored and understood through the comprehensive assessment of dynamic factors.
- Without applying a model of comprehensive assessment it is difficult to imagine how we can apply the risk, need, and responsivity model, which itself recognizes the need to gather a variety of information about the individual being assessed, beyond a checklist of static risk factors.

### Risk is Re-Assessed Over Time

- For juveniles, on-going assessments of risk are not simple repeats of past assessments.
- This is always a problem with actuarial risk assessments, or assessments based entirely on static factors.
- It is important to re-assess individuals over time, both in order to assess the impact of treatment or the passage of time, and to assess the current level of risk to re-offend.
- Whether actuarial or clinical, it is important that risk assessment procedures include a significant component by which dynamic risk factors are assessed over time.
- Dynamic risk factors are the targets for treatment.

### The Application of Risk Factors in Treatment

Risk factors, both static and dynamic, play an important role not only in the assessment of risk itself, but also in the provision and measurement of individualized treatment.

- **As Treatment Targets.** Dynamic risk factors, as well as protective factors, are the targets for treatment, both of which may be identified through the initial assessment of risk.
- **In Case Formulation.** Without understanding risk factors specific to the offense, we can neither assess the impact of the impact of those specific factors on the sexual offender, nor plan to treat those specific risk factors for that individual offender.
- **In the Assessment of Treatment Outcome.** Without understanding specific risk factors we cannot assess progress in treatment with respect to the factors that specifically contributed to the development of sexually abusive behavior in that individual.
- **In the Re-Assessment of Risk.** Without understanding risk factors specific to each individual we cannot meaningfully re-assess sexual risk, as re-assessment is essentially an evaluation of the current status of risk factors unique to that individual, in which specific risk factors are the targets of treatment.
- **In the Development of Protective Factors.** As protective factors are best and most easily understood in relationship to risk factors, without understanding specific risk factors we cannot meaningfully understand the presence or absence of protective factors in each specific case, nor meaningfully develop protective factors specific to the case.
Risk and Protection as Targets of Assessment and Treatment

Conclusions: The Best of Our Knowledge

The Best of Our Knowledge

• There is a well developed body of research into the etiology of juvenile sexually abusive behavior, and a growing literature that addresses the evaluation and treatment of sexually abusive youth, with an increasing focus on empirical studies.
• Nonetheless, in many ways research into the factors that place children and adolescents at risk for sexually troubled behavior and/or sexual recidivism is still in its infancy, as is our research into the capacity of sexual risk assessment instruments to accurately predict risk for sexual recidivism.
• Whereas, research literature has pointed us toward a better understanding of the types and classes of factors and experiences that place youth at risk for sexually abusive behavior or sexual recidivism, it is inconsistent and uneven and has provided no clear or consistently replicated or homogeneous answers regarding a definite and certain (i.e., statistically valid) set of risk factors.
• At best, we can say that our knowledge of risk factors for juvenile problem sexual behavior is well defined in that we understand the range of factors and have a clear sense of factors that promote troubled sexual behavior.

Exercising Caution and Sensitivity in Juvenile Assessment

• We must remain aware of and cautious about the developmental status and changeability of children and adolescents.
• For this reason, virtually without exception all designers and students of juvenile risk assessment agree that such evaluation should be comprehensive in design and contextual in application, and not based solely on static factors.
• That is, adolescent risk should be understood in a broader context than simply the trajectory that static factors point towards or initiate sexually abusive behavior.
• Instead, “There is a consensus in the field that assessment of risk in juvenile offenders should include a comprehensive assessment of an array of individual and contextual factors (Caldwell & Dickinson, 2009).
• In this vein, Fanniff and Letourneau (2012) recommend we focus on the social and developmental context of each juvenile, in addition to the presence of individual risk factors.
Exercising Caution and Sensitivity in Juvenile Assessment

- Rich (2011) and Spice et al. (2012) describe the need to study, not only risk factors and the accuracy of risk assessment instruments, but also the nature of risk and its management, using the risk assessment instrument as a platform for case management and treatment rather than a tool for making “passive predictions of limited practical use” (Boer et al., 1997, p. 4).
- Indeed, it is clear that for sexually abusive youth assessment is not just aimed at defining a level of risk, but aimed more at developing a deep understanding of the youth upon which to build and develop realistic, appropriate, and meaningful treatment interventions.
- We are therefore not only concerned with estimating risk for a sexual re-offense, but also, and perhaps more, concerned with preventing sexual recidivism.

The Skill of the Evaluator

- Regardless of the strength of any risk instrument, good evaluation requires well trained evaluators who don’t simply score, total, and make interpretations of tests or make important and sometimes life changing decisions based simply upon those scores.
- Described in the psychological evaluation guidelines of the American Psychological Association (Turner, DeMers, Fox, & Reed, 2001) well trained evaluators use their advanced training and knowledge of psychology, human behavior, and social interactions to draw clinical conclusions.
- Even when using an actuarial assessment tool, such as the JSORRAT-II, it will be important to apply clinical judgment under circumstances where so much is at stake.

Comprehensive and Individualized Assessment of Juveniles

- We must thus embed risk assessment instruments into a larger and more comprehensive assessment that addresses and develops a broad view of the juvenile under assessment, and build the use of the risk assessment instrument into the larger assessment process.
- Here we can recognize the role of risk assessment instruments as the basis for case management and treatment, and not simply as passive predictors of risk.

Comprehensive and Individualized Assessment of Juveniles

- Equally, we recognize the role of risk assessment instruments in gathering important information about the youth, including their capacity to recognize the presence and quantity of risk factors, and the nature of dynamic risk factors as presenting opportunities for and as targets of treatment.
- Indeed, given the inconsistent predictive validity of current risk assessment instruments, it may be as, or even most, useful to consider juvenile risk assessment as a means and process by which to identify and recognize the presence of risk factors, in terms of their type, their number, their frequency, and their combination, in light of research that highlights these factors as elements of risk for future sexual and non-sexual offenses.
- This stands in contrast to understanding and responding to a combination of risk factors as a calculation that can, with any level of statistical certainty, predict the incidence or probability of a future offense.
- It is clear from our research base so far that this capacity for a high level of predictive accuracy and utility is far from the case at the moment, or in the foreseeable future.

Risk Assessment is Complex

“Assessment remains complicated. Current measures help, but are not stand-alone instruments...

“Accurately assessing an individual client requires up-to-date knowledge of research-based risk factors, careful differential diagnosis and a well-versed developmental perspective. Despite very promising advances in developing risk assessment measures, there is still great variability across studies.”

“Professionals need to be extremely careful about assessing re-offense risk for an individual client, and take the time to obtain specialized knowledge in this area... Given the low base rates of sexual re-offense, the use of measures to guide safety, risk management, and treatment plans might be a better way to proceed than simply making statements about risk.”

-Bengis, Prescott, and Tabachnick (2012)
Recognizing Protective Factors

- As we further develop our current and develop new juvenile risk assessment instruments, it will be important to also focus on the inclusion and incorporation of protective factors, and continue to build our knowledge of both risk and protective factors, including their individual mechanisms and how they interact, not only with other risk and protective factors but with one another.
- We must thus ensure a continued focus on protective factors, and the continued development of research into protective factors and their relationship to risk.

Remaining Well-Informed

- However, only with better instruments or better trained and more evaluators can we avoid mistakes that poorly informed use of any juvenile risk assessment instrument may bring.
- Rich (2009) describes the “covenant” between the developers of risk assessment instruments and the user of such instruments, highlighting the requirement for well-designed and meaningful tools and the need for the evaluator to acquire the training and supervised experience necessary for well-informed professional practice.
- Further highlighting the responsibility of the instrument “end user,” Ward, Gannon, and Birgden (2007) write that “practitioners have obligations to always use such measures appropriately, ensure they are trained in their administration, and most importantly, make sure that the assessment process culminates in an etiological formulation that is based around the individual’s features alongside those they share with other offenders” (p. 207).
- As recently noted by Rasmussen (2013), decisions related to placement and treatment have long-term ramifications for sexually abusive youth and their families, and the tools and processes that inform these decisions must be accurate, based on our best evidence, and sensitive to age, gender, and cognitive differences in young offenders. “Likewise, treatment needs to be based on evidence-based models... with interventions tailored to the specific needs of each youth” (p. 135).
- With so much at stake, we must remain well-informed about our processes and practices, and ensure our decisions and approaches to treatment are based on the best, most current, and most accurate information available to us.

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