A Structured Method of Assessing Dynamic Risk Factors Among Sexual Abusers With Intellectual Disabilities

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Abstract

The nature and severity of dynamic risk factors among a group of 87 adult male sexual abusers with intellectual disabilities were examined as was the psychometric properties of a new scale designed to measure these risk factors. The Treatment Intervention and Progress Scale for Sexual Abusers with Intellectual Disabilities (TIPS-ID) is composed of 25 dynamic risk factors linked to sexual reoffense. Data analyses indicate support for the item composition and reliability of the scale. Ratings from this scale differentiated participants on several clinical variables related to problem severity but not on a measure of static risk. These results are discussed in terms of their clinical and research implications.

Persons with intellectual disabilities who commit sexual abuse are a small, but increasing concern of the criminal justice and social service systems (Lindsay, 2002; Lund, 1992). The prevalence rate of sexual offending among persons with intellectual disabilities appears to be at least as high as among the nondisabled population (Day, 1994; Hodgins, 1992; Lindsay, 2004), and treatment programs for sexual abusers with intellectual disabilities are proliferating (McGrath, Cumming, & Burchard, 2003). However, a recent descriptive analysis of 31 studies indicates that treatment evaluation efforts with this population are at an early stage (Courtney & Rose, 2004).

In the absence of a solid research base about what constitutes effective treatment with this population, service providers for sexual abusers with intellectual disabilities arguably should follow principles of intervention that have proven effective with the general offending population. Two best practice principles that form the cornerstone of correctional intervention programs in numerous jurisdictions throughout the world are those of risk and need (Andrews & Bonta, 2003; Hollin, 2002). The *risk principle* means that the level of services provided should correspond to the risk level of the offender. Those at higher risk are allocated to higher intensity treatment and supervision programs and those with lower risk, to lower intensity programs. The *need principle* means that treatment interventions should focus on changeable problems causally linked to the offending behavior, commonly called *dynamic risk factors.*

Application of the risk–need model requires that both an offender's risk level and treatment needs be identified, ideally through validated assessment instruments. Some of these instruments

are comprised solely of *static* risk factors (i.e., unchangeable historical variables, such as the number of prior sexual offense convictions); others, only *dynamic* risk factors (i.e., potentially changeable offense-related aspects of an individual's functioning, such as pro-offending attitudes), and still others combine both. Although correctional researchers have designed most risk and need instruments with the general criminal population in mind, a few investigators have assessed the efficacy of these instruments for use with offenders who have intellectual disabilities.

In terms of static risk assessment instruments, the Rapid Risk Assessment for Sexual Offense Recidivism–hereafter called Rapid Risk Assessment (Hanson, 1997)–is a commonly used actuarial risk-estimation instrument for adult sexual offenders and has been found to have moderate predictive validity in multiple replication studies (Doren, 2002), one of which was composed entirely of sexual offenders with intellectual disabilities (Tough, 2001). More recently, the Violence Risk Appraisal Guide (Quinsey, Harris, Rice, & Cormier, 2006), an extensively studied actuarial risk instrument used for predicting violent reoffending, has been found to have moderate predictive accuracy among general criminal offenders with intellectual disabilities (Quinsey, Book, & Skilling, 2004).

Static risk instruments are effective in predicting the long-term reoffense risk of offenders, but, because they are composed of unchangeable risk factors, do not provide direction about how to reduce that risk. In contrast, dynamic risk instruments are useful for identifying key targets for treatment and supervision, measuring client progress in these areas and predicting when an individual is at increased risk over the short-term. Unfortunately, research on dynamic risk instruments for use with sexual abusers with intellectual disabilities has been limited.

Green, Gray, and Willner (2002) adapted a dynamic sex offender risk assessment instrument, the Structured Anchored Clinical Judgment protocol (Hanson & Thornton, 2000), for use with men who have intellectual disabilities who had engaged in inappropriate sexual behavior. Because this was a preliminary effort, the authors did not examine the instrument's interrater reliability, ability to assess treatment progress, or predictive validity among this population. In a recent study, Webster et al. (2006) found that considerable training and clinical experience may be required to score this protocol reliably.

A promising dynamic risk instrument used with the general adult sexual abuser population is the Sex Offender Need Assessment Rating (Hanson & Harris, 2001), which is composed of nine dynamic risk factors and designed for use by probation and parole officers supervising sexual abusers in the community. In the scale's development sample, the total score showed moderate ability to differentiate between sexual and nonsexual recidivists. Because items selected were limited to those most highly correlated with sexual recidivism in the development study, it does not include all of the factors that potentially are legitimate targets of treatment in sexual abuser rehabilitation programs.

Finally, the Sex Offender Treatment Needs and Progress Scale (McGrath & Cumming, 2003) was adapted for use in the present study. This scale is a provider-administered dynamic measure designed to aid clinicians and probation and parole officers in identifying and monitoring the treatment needs, supervision needs, and progress of adult male sex offenders. It is composed of 22 dynamic risk factors empirically or theoretically linked to sexual offending. Preliminary reports indicate that it can be scored reliably and predicts sexual reoffending with moderate accuracy (McGrath, Cumming, & Livingston, 2005).

The lack of established dynamic risk instruments for sexual abusers with intellectual disabilities and concerns that some of the characteristics and life circumstances of this population were not addressed by the best existing instruments motivated development of the present scale, the Treatment Intervention and Progress Scale for Sexual Abusers With Intellectual Disabilities (TIPS-ID). First, the senior author facilitated work groups in which developmental services case managers and treatment staff identified factors that their field experience had led them to believe were related positively or negatively to reoffending among sexual abusers with intellectual disabilities. The list of factors identified by the work groups corresponded closely to factors measured by the Sex Offender Treatment Needs and Progress Scale (McGrath & Cumming, 2003). As a result, this scale was adopted as a framework and modified to create the current scale.

Three major modifications were made. Because sexual abusers with intellectual disabilities, compared to their counterparts with no intellec-

tual disabilities, commonly lack accurate information about sexuality and sexual boundaries (Coleman & Haaven, 2001), we added a sex knowledge item. Second, because many sexual abusers with intellectual disabilities have few social contacts outside of the home and family support can be very important, we added a family influence item. Finally, a global risk management item was broken into two items: risk knowledge and risk application.

The 25 dynamic risk factors listed in Table 1 comprised the final scale. Each risk factor and scoring criteria were described using a 6-month recency time frame. Items were scored on a 4-point scale ranging from *minimal to no need for improvement* to *very considerable need for improvement.* Scores were recorded on a scoring sheet and summed to yield a total score.

In the present study we examined the reliability and validity of this scale as well as score distribution and item endorsement patterns in the hope that these data would provide a profile of the types and severity of treatment needs evident in this population.

Table 1. Means, *SD*s, and Endorsement Patterns of Treatment Intervention and Progress Scale for Sexual Abusers With Intellectual Disabilities (TIPS-ID) Items ($N = 87$)

				Percentage item endorsement[a]				
TIPS-ID risk factor		Mean	*SD*	0	1	2	3	Missing
1.	Admission of offense behavior	1.20	1.06	31.0	33.3	18.4	16.1	01.1
2.	Acceptance of responsibility	1.29	1.06	26.4	35.6	18.4	18.4	01.1
3.	Sexual behavior	0.85	1.02	47.1	33.3	06.9	12.6	00.0
4.	Sexual attitudes	1.51	1.00	17.2	33.3	28.7	19.5	01.1
5.	Sexual interests	1.67	1.04	13.8	34.5	23.0	28.7	00.0
6.	Sexual knowledge	1.51	0.91	12.6	40.2	31.0	16.1	00.0
7.	Criminal and rule-breaking behavior	1.10	0.95	31.0	36.8	23.0	09.2	00.0
8.	Criminal and rule-breaking attitudes	1.16	0.91	28.7	32.2	33.3	05.7	00.0
9.	Substance abuse	0.05	0.26	96.6	02.3	01.1	00.0	00.0
10.	Emotion management	1.51	0.82	06.9	49.4	29.9	13.8	00.0
11.	Mental health stability	0.91	0.86	36.8	40.2	18.4	04.6	00.0
12.	Problem-solving	1.84	0.81	04.6	27.6	47.1	20.7	00.0
13.	Impulsivity	1.55	0.85	08.0	43.7	33.3	14.9	00.0
14.	Employment/school	1.10	0.95	31.0	36.8	23.0	09.2	00.0
15.	Money management	1.64	1.16	24.1	18.4	26.4	31.0	00.0
16.	Residence	0.52	0.82	64.4	24.1	06.9	04.6	00.0
17.	Social influences: Peers	0.90	0.80	34.5	42.5	19.5	02.3	01.1
18.	Social influences: Family	0.86	0.92	44.8	28.7	21.8	04.6	00.0
19.	Social involvement	1.66	1.02	16.1	26.4	33.3	24.1	00.0
20.	Adult love relationship	2.52	0.97	10.3	03.4	06.9	79.3	00.0
21.	Cooperation with treatment	0.92	0.97	42.5	31.0	18.4	08.0	01.1
22.	Cooperation with supervision	0.87	0.79	34.5	46.0	14.9	03.4	01.1
23.	Risk management knowledge	1.72	0.92	09.2	28.7	35.6	20.7	05.7
24.	Risk management application	1.79	1.29	23.0	19.5	05.7	46.0	05.7
25.	Stage of change	1.67	1.03	13.8	28.7	26.4	25.3	05.7
	Total	31.98	11.78					

[a]Item endorsement values are: 0 = minimal or no need for improvement, 1 = some need for improvement, 2 = considerable need for improvement, and 3 = very considerable need for improvement.

Method

Participants

Participants were 87 male sexual abusers with intellectual disabilities age 18 or older who were living in the community and received supervision and supports funded by the Vermont Department of Disabilities, Aging and Independent Living between July 1, 2003, and December 31, 2004. This department is the single state-funding agency for people with intellectual disabilities. All participants lived in the community in their own homes or supervised residences; Vermont closed its only institution for individuals with intellectual disabilities in 1993 and began operating a totally community-based system of services. Data on 10 other individuals who met the above criteria were not available, and these individuals were not participants in this study.

The definition of *intellectual disability* we used was the same as the *Diagnostic and Statistical Manual of Mental Disorders—DSM-IV-TR* criteria for mental retardation (American Psychiatric Association, 2000). The term *sexual abuser* was defined as someone who is known to have committed a sexual misbehavior that, if prosecuted, would constitute a criminal sexual offense in Vermont. The population included 16 offenders committed to the custody of Vermont Department of Disabilities, Aging and Independent Living after being found not competent to stand trial (18%); 19 individuals on probation or furlough or who had maxed out of sentence (22%); 15 individuals substantiated for sexual abuse by child or adult protective services (17%); and 37 individuals known to have committed sexual offenses and for whom no legal finding of guilt was made (42%). Other participant characteristics are reported in the *Results* section.

Measures

Rapid Risk Assessment for Sexual Offense Recidivism. This assessment, developed by Hanson (1997), is a 4-item actuarial risk measure used to aid in assessing sexual recidivism risk among convicted adult male sex offenders. Rapid Risk Assessment items are (a) number of prior charges or convictions for sexual offenses, (b) age at date of assessment, (c) whether there were any male victims, and (d) any unrelated victims. Scores fall into one of six levels reflecting the probability of sexual reoffending at 5- and 10-year intervals. Because sexual abusers with intellectual disabilities frequently are not criminally charged for known incidents of offending, adapted scoring criteria were used (Harris, Phenix, Hanson, & Thornton, 2003, p. 17). Namely, sex offenses substantiated by formal or informal investigations that resulted in noteworthy sanctions, such as residential moves or school suspensions, were counted as both a sex offense charge and conviction.

Procedure

The senior author provided a one-day training to staff at the state's 14 developmental service agencies and focused on teaching the skills necessary to complete demographic, treatment progress, and offense coding sheets used in the study and to score participants on the TIPS-ID. Developmental services staff submitted to Vermont Department of Disabilities, Aging and Independent Living demographic and offense data, a treatment progress rating and at least one TIPS-ID rating for the 87 study participants. The treatment progress rating involved evaluating each participant's overall treatment progress for the previous 6 months as *significant, some,* or *none.* Two independent TIPS-ID and progress ratings were available for 40 (46%) of the 87 study participants. The TIPS-ID scorers ($N = 39$) were primarily case managers. The first and second authors computed Rapid Risk Assessment scores from data that service coordinators provided.

Results

Participant Characteristics

The mean age of the sample members was 34.4 years ($SD = 12.5$, range = 18 to 70). Consistent with Vermont's lack of racial diversity, all but 5 participants (6%) were White. Based on definitions established by the Association for the Treatment of Sexual Abusers (Gordon et al., 1998), the sample was composed of 23 rapists (26%), 14 noncontact sex offenders (15%), 10 incest offenders (12%), and 40 child molesters (46%). Of the 40 child molesters, 26 had molested at least one boy (30%) and 14 molested girls only (16%).

Two thirds of participants (66%) were under 24-hour supervision, and one third (34%) received less that 24-hour supervision. Most participants (69%) resided in supervised residences. Thirteen (15%) were working full- or parttime without supports, 44% were working full- or parttime with

supports, 6% were students, and about one third (36%) were neither employed nor in school.

The mean IQ of the sample was 61.9 (SD = 6.4, range = 45 to 74). At the time of the study, 75% of the sample was receiving treatment designed to address their sexually abusive behavior and 25% were not. Time in treatment data were not available. In terms of Rapid Risk Assessment scores, 35% of participants were categorized as low risk (score = 0 or 1); 56%, moderate risk (score = 2 or 3); and only 9%, high risk (score = 4 or 5).

Descriptive Statistics

The mean score and *SD*s for individual TIPS-ID items and the total score are presented in Table 1. The endorsement pattern for TIPS-ID items in this table depicts the range of types and severity of treatment needs evident among participants. The total mean score of 31.98 (SD = 11.78) was almost identical to the median (32.00) and the modal scores (32.00). Divided into quartiles, 25% of individuals scored 0 to 24; 28%, 25 to 32; 23%, 33 to 39; and 24%, 40 to 60.

Reliability

For 40 participants in the sample (46%), two independent ratings were available from pairs of service providers. Because these pairings were random, we used the one-way, random-effects ANOVA model intraclass correlation coefficient (ICC) to compute interrater reliability (Shrout & Fleiss, 1979). As shown in Table 2, the total scale ICC for a single rating (ICC_1) was .81 (95% CI, .68–.90) and for the average of multiple independent ratings (ICC_2), .90 (95% CI, .81–.95), $F(39, 40) = 9.75$, $p < .001$. For single scale items, data in Table 2 show that 80% of the items had reliabilities at least .63 for a single rating; all of the items had reliabilities of .64 or above for averaged ratings.

The scale also showed acceptable internal consistency. Cronbach's alpha for the total score was .91 and the Gutman split-half reliability was .91. The item-total correlations were .30 or above, $p < .01$, for all but two items, 9: substance abuse, $r = .12$, and 20: adult love relationship, $r = .22$, $p < .05$. The standard error of measurement (SEM) using the total score ICC_1 and ICC_2 were 5.14 and 3.73, respectively, both at the 68% confidence level.

Table 2. Interrater Reliability (ICC) for Each Treatment Intervention and Progress Scale for Sexual Abusers With Intellectual Disabilities (TIPS-ID) Item and Item Totals (N = 40)

TIPS-ID risk factor	ICC_1	ICC_2
1. Admission of offense behavior	.48	.65
2. Acceptance of responsibility	.64	.78
3. Sexual behavior	.79	.89
4. Sexual attitudes	.77	.87
5. Sexual interests	.75	.86
6. Sexual knowledge	.52	.68
7. Criminal and rule-breaking behavior	.71	.83
8. Criminal and rule-breaking attitudes	.55	.71
9. Substance abuse	.66	.80
10. Emotion management	.63	.78
11. Mental health stability	.72	.83
12. Problem solving	.77	.87
13. Impulsivity	.70	.82
14. Employment/school	.77	.87
15. Money management	.65	.79
16. Residence	.74	.85
17. Social influences: Peers	.62	.76
18. Social influences: Family	.61	.75
19. Social involvement	.47	.64
20. Adult love relationship	.94	.97
21. Cooperation with treatment	.67	.80
22. Cooperation with supervision	.63	.78
23. Risk management knowledge	.73	.84
24. Risk management application	.83	.91
25. Stage of change	.69	.82
Total	.81	.90

Note. ICC = interclass correlation for a single rating (ICC_1) and for averaged ratings (ICC_2). For all ICCs, $p < .001$.

Validity

Because the scale was newly developed, participant reoffense data were not available to examine its predictive validity. Given this circumstance, predictive validity might be inferred if individuals with a large number of static risk factors, as evidenced by higher Rapid Risk Assessment scores, were to score higher on the TIPS-ID than would individuals with a few or no static risk factors. An ANOVA test did not detect significant differences between mean TIPS-ID scores of participants with low, moderate, and high Rapid Risk

Assessment scores, $F(2, 84) = 1.40$, $p = .25$ (see Table 3). Similarly, the correlation between total TIPS-ID scores and individual Rapid Risk Assessment scores was not significant, $r = .13$, and no pattern of relationship was found when a scatter plot of these scores was examined.

Other analyses that might provide support for the validity of the scale examined the relationship between mean TIPS-ID scores and three clinically related variables: level of supervision, a *DSM-IV-TR* diagnosis of a paraphilia, and provider ratings of participant treatment progress. These variables, albeit subjective, were considered proxies reflecting different levels of treatment need. *T* tests revealed that TIPS-ID scores were significantly higher for individuals under 24-hour supervision as compared to less than 24-hour supervision, $t(85) = 2.81$, $p < .01$, and for individuals with a diagnosis of paraphilia, $t(85) = 2.95$, $p < .01$. An ANOVA test found significant differences in TIPS-ID scores across individuals with varied levels of treatment progress $F(2, 69) = 9.98$, $p < .001$ (see Table 3). Post hoc analyses using the Bonferroni correction indicated that individuals with *significant* progress had lower scores than those with *some* progress, $p < .001$, and those with *none*, $p < .001$. There were no significant differences between individuals with some progress and those with none.

Table 3. Relationship of Treatment Need Indicators to Mean Treatment Intervention and Progress Scale for Sexual Abusers With Intellectual Disabilities (TIPS-ID) Scores

Treatment need variable	*n*	Total TIPS-ID score	
		Mean	*SD*
Rapid Risk Assessment score			
Low (0,1)	30	30.87	10.62
Moderate (2,3)	49	31.59	12.74
High (4,5)	8	38.50	8.40
Supervision level			
Less than 24-hour	30	27.27*	10.45
24-hour	57	34.48	11.77
Diagnosis of paraphilia			
No	55	29.25*	11.76
Yes	32	36.66	10.43
Treatment progress			
Significant	21	22.86**	9.17
Some	38	33.79	11.66
None	13	38.00	10.37

*$p < .01$. **$p < .001$.

Discussion

In the present study we examined the nature and severity of dynamic risk factors among a group of sexual abusers with intellectual disabilities and conducted an initial psychometric evaluation of a scale designed to measure these risk factors. The nature of this sample was noteworthy because it was comprised of the near exhaustive population of identified sexual abusers with intellectual disabilities in a well-defined geographic area (the state of Vermont) during a prescribed time period. Participants were easily identified because one state agency funds their services.

The TIPS-ID showed good overall interrater reliability, comparing favorably with other similarly constructed forensic clinical rating scales (Hare, 2003; Webster et al., 2006; Worling, 2004). This was significant given that several of the items were inferential in nature, and many of the scorers had minimal experience working with persons who have committed sexual offenses. This suggests that most of the scoring criteria for items are relatively straightforward and that the scoring instructions are adequate.

Some individual items, however, had less than optimal interrater reliability (Items 1, 6, 8, and 19). Of these, Item 1 (admission of offense behavior) and Item 19 (social involvement) have relatively objective scoring criteria, so we suspect that problems here were related to scorers having differing amounts of knowledge about clients' offending histories and social contacts. Item 6 (sexual knowledge) and Item 8 (criminal and rule-breaking attitudes) are comparatively more subjective, indicating that improved scoring instructions or training efforts may be needed to improve scoring consistency.

Although not a psychometric necessity, predictors of recidivism on most risk assessment instruments are at least mildly intercorrelated with each other, and this was the case with the TIPS-ID, with two exceptions. With respect to Item 9 (substance abuse), most participants did not have alcohol or drug problems and those who did lived in supervised settings, which limited their access to these substances. Item 20 (adult love relationship) had low correlation with other items, reflect-

ing the fact that very few participants lived with or had an adult lover. The lack of correlation for these two items most likely reflects the limited social networks of most Vermonters with intellectual disabilities who receive developmental services.

Endorsement patterns suggested participants had considerable or very considerable treatment needs in 11 of the 25 areas assessed (defined by a mean item score of 1.50 or above). Whether these and the other factors assessed on the TIPS-ID will be found to be closely linked to sexual offending among sexual abusers with intellectual disabilities remains an empirical question. However, following development of the scale, the results of what is currently the largest meta-analysis of dynamic risk factors among the general sexual abuser population became available (Hanson & Morton-Bourgon, 2004, 2005), which supports the relevance of most TIPS-ID items as important treatment targets. Similarly, recently published research by Lindsey, Elliot, and Astell (2004) with a small sample of sexual abusers who have intellectual disabilities lends support to the scale's item composition.

Preliminary findings in the current study provide some optimism for the validity of the scale. Participants who were supervised at the most intense level, diagnosed as having a paraphilia, or judged to have made poor treatment progress had statistically significant higher TIPS-ID scores than did those who were not. Participants who had these characteristics arguably could be expected to have multiple and elevated dynamic risk factors and they did indeed, as measured by their TIPS-ID scores. Although mean TIPS-ID scores were not statistically significantly related to a measure of static risk, they were in the expected direction. Future research on the scale's predictive validity should involve follow-up periods of 5 years or more. This is because the base rate of sexual reoffending is quite low over the short-term (Hanson & Bussier, 1998), and, therefore, it can be difficult to find statistically significant results when conducting recidivism research with sexual abusers using short follow-up periods (Barbaree, 1997).

Whether or not total mean TIPS-ID scores are eventually found to predict sexual reoffending in follow-up studies, examination of score profiles may prove valuable. For example, we hypothesize that individuals who have considerable treatment needs in the areas of sexual behavior, attitudes, and interests (Items 3, 4, 5, and 13) will be at higher risk for sexual reoffending than individuals who have a similar total mean score but whose primary problems concern lifestyle instability (Items 14, 15, and 16). Individuals with high treatment needs in both of these broad areas, sexual deviancy and lifestyle instability, may be at highest risk. Future researchers should include cluster analytic methods and examine differential weighing of risk items.

Despite encouraging results in the present study and other recent research in the field, risk assessment with this population is quite new. Nevertheless, providers on a daily basis must assess the likelihood that individuals under their care will commit new offenses, and program managers must assess the efficacy of costly treatment interventions. These are critically important assessments, informing decisions on placement, supervision, and treatment. General guidance from the research literature is at least clear that structured, evidence-based, risk-assessment approaches are much more accurate than unaided clinical approaches (Andrews & Bonta, 2003; Hansen & Bussiere, 1998).

Based on this best-practice guidance, we have some recommendations about how to approach risk assessment with sexual abusers who have intellectual disabilities. First, assessors should establish a general risk level using a validated static risk instrument. This will provide a moderately accurate long-term prediction of the individual's risk to sexually reoffend. Currently, the Rapid Risk Assessment (Hanson, 1997) appears to be the best choice (Tough, 2001). Second, assessors should use a structured method of evaluating the presence and severity of dynamic risk factors in order to adjust this risk level, if necessary, and identify relevant targets of treatment and supervision. For this purpose, the current scale is a possible measure. Third, staff members or therapists should periodically readminister the chosen dynamic instrument to reassess the client's progress and the efficacy of treatment interventions and adjust the risk level, supervision plan, treatment targets, and treatment focus accordingly. When scores on a particular item are consistently high for a population group (as here for adult love interest), focus may need to shift from individual treatment to systemic changes. Finally, evaluators must consider relevant risk factors not commonly accounted for by structured risk instruments, such as expressed intent to reoffend or disability that limits access to potential victims.

The results of this study must be considered

preliminary. Independent use of total scores to make clinical or legal decisions is not warranted by the current findings. Providers may most productively use the TIPS-ID as a structured method of periodically examining client progress against a relatively comprehensive list of clinically and empirically derived risk factors thought to be closely linked to sexual reoffending. These results, we hope, will motivate further examination of the instrument and increase our knowledge about how to successfully treat individuals with intellectual disabilities who have sexually abused others.

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