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Adjusted actuarial risk assessment of sex offenders: frequency, patterns, and reasons for clinical overrides of the MnSOST-R

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**Adjusted actuarial risk assessment of sex offenders:
Frequency, patterns, and reasons for clinical overrides of the MnSOST-R**

by

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A thesis submitted to the graduate faculty
in partial fulfillment of the requirements for the degree of
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Signatures have been redacted for privacy

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INTRODUCTION

Until recently, questions concerning the utility and validity of actuarial assessments of recidivism were primarily raised in scholarly publications and courts of law. As the use of such instruments became more widespread among corrections departments and more offenders were evaluated prior to their release from incarceration, public and media interest increased. In late autumn of 2003, this interest shifted to intense scrutiny, directed at the Minnesota Department of Corrections (DOC) and their use of the Minnesota Sex Offender Screening Tool – Revised (MnSOST-R), a 16-item inventory, designed to assist in the process of identifying predatory and violent sex offenders (see Epperson, Kaul, Huot, Hesselton, Alexander, & Goldman, 1998, 2000; Epperson, Kaul, Huot, Alexander, & Goldman, 2000; Epperson, Kaul, Huot, Goldman, & Alexander, 2003).

The reason for this examination stemmed from the disappearance on November 22, 2003, of college senior Dru Sjodin and the subsequent arrest of the primary suspect in her abduction, Alfonso Rodriguez, Jr. Mr. Rodriguez had been released from a Minnesota prison less than six months earlier after his sentence for a 1980 sex offense had expired. Since September 1999, all sex offenders in Minnesota have been assessed using the MnSOST-R prior to their scheduled release from confinement. Before the scheduled release of a sex offender in Minnesota, two sequential processes take place. The first is a review to determine whether the offender should be referred for possible civil commitment. The second is a review by the End of Confinement Review Committee (ECRC) to determine the risk level assigned to an offender, which influences how much community notification and supervision the offender's release requires. In the event that the county attorney successfully pursues civil commitment, the second review by the ECRC does not take place. Decisions

made at both reviews are anchored by the offender's MnSOST-R score(s). The risk assessment report for Mr. Rodriguez, published in the Minneapolis Star Tribune on December 13, 2003, stated, "Actuarially, Mr. Rodriguez's score on the MnSOST-R places him in a pool of offenders who appear to be at high risk to reoffend sexually." Also, according to the Minneapolis Star Tribune (Haga, McKinney, & Lopez, December 13, 2003), Mr. Rodriguez had been designated a level 3 offender based on his review and corrections officials had held a civil commitment hearing more than a year prior to his release, but decided against pursuing commitment, in part because of his age, 50. Within the high risk (level 3) category of offenders, there is a subset for offenders who score exceptionally high on the MnSOST-R. For offenders with a score of 13 or above, the presumptive action is referral for civil commitment. Mr. Rodriguez's score was a 13 (Haga, McKinney, & Lopez, December 13, 2003).

The alleged abduction and murder of Dru Sjodin by Mr. Rodriguez raised the question of why the actuarial determination that he posed a high risk for reoffense was overridden, resulting in his release instead of his possible commitment to indefinite treatment. Also, of concern would be the reasons for such an override and their impact on risk assessment. The importance of such issues cannot be overstated, both because of their role in the Sjodin case specifically, and the implications for both the Minnesota DOC and public, as well as sex offenders incarcerated in that state.

According to Minnesota Department of Corrections records (personal communication, William Donnay, March 11, 2004), Mr. Rodriguez was one of 1,770 sex offenders, whose risk had been assessed using the MnSOST-R, scheduled for release into Minnesota communities beginning in September, 1999. Of those offenders, 304 scored in the

high risk level on the MnSOST-R. However, only 154 were classified as high risk by the ECRC. Within the high risk category of the MnSOST-R, a subset exists for offenders who score exceptionally high. The presumptive action for such high scoring offenders is referral for civil commitment review. There were 90 offenders with scores in this range, but not all of them were referred for commitment proceedings. In addition, of the smaller group of offenders who were referred to the county attorney, only a portion of cases were pursued. The possibility that offenders may have been incorrectly released after an override of their actuarial assessments instead of being referred for possible commitment, or may have been incorrectly released with lower levels of supervision because of an override, obviously raises concerns and requires an examination of the reasons for such decisions.

Brief Historical Overview of Risk Assessment

The risk of violence posed by criminals released from prison has been a focus of concern for the criminal justice system for decades. As Andrews and Bonta (1998) noted, “The prediction of criminal behavior is perhaps one of the most central issues in the criminal justice system. From it stems community safety, prevention, treatment, ethics, and justice” (p. 211). As a result, the legal system has long relied on psychologists and other practitioners to present assessments of risk to be used in various proceedings, such as making sentencing determinations, release decisions, and supervision guidelines among others. It is not surprising that, in light of their importance and far-reaching implications, assessments of risk have been subjected to rigorous examination.

Initially, questions were raised about the constitutionality of violence prediction, a corollary of risk assessment. This concern was predicated on the notion that predictions of future criminal behavior were so inaccurate that to give them a legal effect would violate the

due process and equal protection granted by the Fourteenth Amendment (Monohan, 1996).

However, courts throughout the United States overwhelmingly rejected this notion.

Monohan (1996) cited two cases in which the unpredictability of future behavior is dismissed as a legal concern. In *Jurek v. Texas* (1976), the likelihood of a defendant committing future crimes was determined to be an acceptable reason for imposing a death sentence, with seven justices rejecting the idea that it is impossible to predict future behavior. Similarly, in *Schall v. Martin* (1984), Supreme Court Justice Rehnquist determined that there is nothing inherently unattainable about a prediction of future criminal conduct from a legal standpoint. Despite challenges such as these, Grove and Meehl (1997) note, “. . . it seems well established that there is no constitutional impediment to using predictions of dangerousness in legal proceedings” (p. 36).

Once the legal system upheld the constitutionality of laws that relied on violence prediction, the focus shifted to how such predictions could be improved (Grisso & Appelbaum, 1992). Due to the crucial implications of decisions based on violence predictions, it is imperative that those decisions be based on the most accurate information and assessments. According to Monahan and Steadman (1994), many researchers found the development of actuarial methods to be the answer to improving the clinical predictions, which had been used previously.

The Clinical Versus Statistical Debate

Meehl's classic book, *Clinical Versus Statistical Prediction* (1954) can be seen as the starting point of the on-going debate over the relative accuracy of clinical judgment versus actuarial prediction. As in most domains, early predictions of violence relied upon clinical judgment. Grove, Zald, Lebow, Snitz, & Nelson (2000) defined clinical judgment as “the

typical procedure long used by applied psychologists and physicians, in which the judge puts data together using informal, subjective methods” (p. 19). Despite being the longest-used method for the prediction of violence, several researchers have demonstrated numerous problems with unaided clinical judgment. Douglas, Cox, and Webster (1999) cited clear and convincing findings of the inability of mental health professionals to accurately predict violence. Even more specifically, in his review of clinical prediction, Monohan (1981) found that only one in three positive predictions of violence by clinicians was accurate. Different reasons have been cited for the difficulties clinicians face when trying to make predictions. Hilton and Simmons (2001) pointed out a fundamental problem, noting that “clinicians using only unaided clinical judgment can be subject to the same errors and biases as lay persons” (p. 394). Webster, et al. (2000) also noted that humans are susceptible to many errors in clinical judgment, but further observed that many clinicians rarely receive any feedback on the accuracy of their predictions, which prevents any changes in their maladaptive methods.

In contrast to clinical judgment, “The superiority of mechanical prediction holds across many prediction domains,” (Grove, et al., 2000, p. 24) and “is well-specified” (Webster, et al., 2000, p.19). Ideally, these devices provide hard actuarial data on the probability of violence (Borum, 1996). Hart (1998) noted that possibly the most significant advantage of actuarial prediction is its improvement in the accuracy and consistency of predictions. Hilton and Simmons (2001) reiterate this, stating that “Research has shown that actuarial assessments of violence are consistently more accurate than unaided judgments by clinicians” (p. 393).

In the past decade, research has consistently supported the use of actuarial prediction over clinical judgment in decision-making across various domains (Harris, Rice & Quinsey,

1993; Grove & Meehl, 1996; Grove, et al., 2000), including risk assessment. Actuarial tools have been ruled as scientifically valid in U.S. courts and have been used in U.S. penal settings for several years (Dolan & Doyle, 2000). In his 1997 editorial, Monohan states that “Future research on the validity of predictions of violence . . . is likely to stress a reliance on actuarial approaches as the best hope to improve predictive accuracy” (p. 168).

Adjusted Actuarial Assessment

Many clinicians are hesitant to accept the superiority of actuarial predictions (Douglas, Cox, and Webster, 1999). Despite repeated research demonstrating the inaccuracy of clinical or subjective judgment, practitioners want freedom to make such judgments. According to Monohan (1996), clinicians may see reliance on actuarial methods as a criticism of their judgment or a threat to self-esteem. Hanson (1998) noted that clinicians may question the comprehensiveness of actuarial tools and “Those skeptical of actuarial predictions will always find reasons to adjust actuarial estimates” (p. 65).

Other researchers have argued that there is an overestimation of the deficiencies of clinical judgment because no distinction is made between clinical judgments based on self-reports and those based on objective reports (Westen & Weinberger, 2004). They would further posit that almost all observations involving psychology are ultimately clinical, as they involve some informal aggregation across time by someone (Westen & Weinberger, 2004). Douglas, et al. (1999) stated explicitly, “The use of actuarial tools also does not remove the necessity of clinical skill and judgment” (p. 164).

Several researchers have also raised concerns about potential reasons to adjust an actuarial assessment. Hanson (1998) argued that even the strongest proponents of actuarial prediction (Grove & Meehl, 1996; Meehl, 1954) believed that adjustments to statistical

predictions could be justified in certain circumstances. Grubin (1997) furthers this argument by contending that mechanical methods may miss rare variables in individual cases that are essential to the prediction. However, Grove and Meehl (1996) refer to this objection as the ‘broken leg case.’ In their argument, a broken leg is a clear objective fact with obvious implications, but individual cases with such variables are relatively infrequent. While such a variable may warrant overriding the actuarial findings, giving “broken leg” status to a large number of variables inconsistently applies potentially mistaken weight to such variables.

Arguments such as these have lead many clinicians to argue for the use of adjusted actuarial assessment. Quinsey, Lalumiere, Rice, and Harris (1995) explained adjusted actuarial assessment as beginning with an actuarial prediction, but allowing expert evaluators to adjust the actuarial prediction after considering potentially important factors not included in the original actuarial measure. As Douglas and Kropp (2002) note, this method is more structured than the clinical judgment approach, but more flexible than actuarial approaches. However, since this approach does not place restrictions on including, weighting, or combining factors, it still fits Grove and Meehl’s (1996) definition of “subjective, impressionistic” decision-making (p.293). Also, to date, no data have shown the reliability and validity of such a method or demonstrated empirical support for which risk factors should or should not be used to adjust risk.

Sex Offender Risk Assessment

Assessing the risk of reoffense for sex offenders in particular presents additional challenges. As Hanson and Bussiere (1998) noted, evidence indicates that sexual offending is different from other crimes and observed that this may result in many persistent sexual offenders being judged as low-risk on scales designed to predict general criminal recidivism.

Whereas criminal history was the best predictor of general recidivism, a number of additional variables were identified as potential contributors to the prediction of sexual recidivism in a range of studies. In their 1998 meta-analysis of 87 articles based on 61 data sets, Hanson and Bussiere found that in addition to general criminal history the following variables were predictive of sexual recidivism: young age, never having been married, number of prior sex offenses, victimization of a stranger, victimization of an unrelated person, victimization of a male, early onset of sexual offending, deviant sexual arousal, deviant sexual attitudes, and any sex offender treatment failure. These findings were essentially replicated in Hanson and Morton-Bourgon's (2004) updated meta-analysis, with some additional clarification of deviant sexual arousal and attitudes. As a consequence of these differences, the assessment of sexual offenders has developed into a specialized area (Becker & Murphy, 1998).

Specialization was also required as the need to assess risk in sex offenders increased dramatically with the advent of certain federal and state legislation. Unfortunately, the Dru Sjodin case was not the first incident of a recently released sexual offender committing another offense. A number of disturbing, high profile sexual crimes committed by offenders after their release from prison precipitated increased concern about repeat offenders during the 1990s. Although sex offenders as a group are unlikely to reoffend at a higher rate than other violent offenders, society seems particularly concerned about this population, at least in part due to the high number of victims who are children (Becker & Murphy, 1998). In response to increasing pressure from victims' families and their communities, lawmakers rapidly enacted statutes aimed at protecting the public from known sex offenders. The federal legislation of "Megan's Law" in 1996 required all fifty states to implement registration and community notification laws regarding released sex offenders (Epperson, et

al., 1998). Court decisions, such as *Kansas v. Hendricks* (U.S. Supreme Court, 1997), which upheld the Sexually Violent Predator Act in Kansas, opened the door for the use of civil commitment for sex offenders deemed to be a high risk for reoffense (Hanson, 1998). Obviously, to effectively implement these laws, it was necessary to identify those offenders most at risk for reoffending (Becker & Murphy, 1998). Offenders at higher risk warrant an increased amount of community notification and higher levels of supervision, including possible civil commitment. Therefore, accurate assessments of recidivism risk have become crucial, both for the sake of increasing community safety and protecting individual liberty.

MnSOST-R

In the early 1990s, most methods of sexual recidivism still relied on clinical and/or phallometric assessment. In addition to the limitations of clinical assessment previously noted, many sex offenders may not be offered or may refuse treatment and/or phallometric assessment. Therefore, methods in existence at that time were seriously limited (Epperson, et al., 1998). The need existed for a more formal and uniform process to assess violent and predatory sex offenders using a reliable and valid predictive instrument which relied only on information routinely available to corrections personnel. Epperson, et al. (1998, 2000, 2003) developed the Minnesota Sex Offender Screening Tool (MnSOST) in response to that need.

The overall goal of the MnSOST was to bring increased precision and utility to risk assessments of sex offenders and the risk management decisions based on those assessments. There were several specific goals of the MnSOST, also. First, it sought to rely fully on actuarial data. Second, it needed to be relatively brief and simple to use. Finally, it would be applicable to all incarcerated sex offenders and rely as much as possible on behaviorally anchored items.

The tool was developed from a sample drawn primarily from sex offenders released in Minnesota between 1988 and 1990. Offenders were excluded if their only sex offenses were intrafamilial and none of those offenses were the equivalent of rape. The development sample was comprised of 166 non-sexual recidivists and 90 sexual recidivists, with sexual recidivism defined as re-arrest for a “hands-on” sex-related offense. In 1998, the tool underwent a major revision, which refined empirical methods for selection and scoring. This research yielded the 16-item MnSOST-R (see Appendix A for score sheet descriptions of each item), which was presented at the 1998 annual research and treatment convention of the Association for the Treatment of Sexual Abusers (ATSA; Epperson, Kaul, & Hesselton, 1998).

The reliability of the MnSOST-R has been demonstrated repeatedly and has been shown to be generally above .80 by both internal and external studies (Epperson, et al., 2003; Langton, Barbaree, Harkins, Seto, & Peacock, 2002). Specifically, in a comparison of eight instruments, Langton, et al. (2002) reported inter-rater reliabilities ranging from .75 to .94, with the MnSOST-R having a reliability of .83. In studies of the MnSOST-R alone, interclass correlations (ICC) for relative agreement ranged from .80 to .87 (Epperson, et al., 2003). The ICC for absolute agreement in the same studies ranged from .76 to .86.

Several studies have examined the validity of the MnSOST-R. Most commonly, the results were reported as Receiver Operator Characteristics (ROC) – Area Under the Curve (AUC). The ROC curve is generated by plotting the proportion of recidivists correctly classified as high risk (sensitivity) against the proportion of non-recidivists incorrectly classified as high risk (1-specificity) for each possible cut score. For each possible cut score, offenders scoring at or above the specified cut score were classified as high risk and

offenders scoring below the specified cut score were classified as low risk. The area under the ROC curve reflects the overall accuracy of the instrument. An ROC-AUC of .50 reflects chance level accuracy. Values significantly greater than .50 are significantly greater than chance. A value of 1.0 reflects perfect accuracy. In the development sample, Epperson, et al. (1998, 2003) reported an ROC-AUC of .77 for the total sample, .79 for rapists, and .74 for molesters. In three subsequent validation studies, the ROC-AUCs for the total samples were consistently above .73 (Epperson, et al., 2000, 2003). The first of these studies used 220 incarcerated sex offenders released from Minnesota prisons in 1992. The period of time offenders were at risk for recidivism was six years. In that study, the ROC-AUC was .73. A second study examined the validity of the MnSOST-R with a North Dakota prison sample. This study used 182 sex offenders released in North Dakota between 1989 and 1998. The median risk period for these offenders was eight years. With that sample, the ROC-AUC was .76. The third study used 271 offenders placed on probation in North Dakota for a sex offense from 1989 to 1998. The median period of time offenders were at risk for recidivism was just under eleven years. In that study, the ROC-AUC was .77.

Overall, the MnSOST-R has unmistakably contributed to a more formal and uniform review process for incarcerated sex offenders. Evidence indicates that the MnSOST-R provides a reliable and accurate assessment of risk when used appropriately and in keeping with department guidelines.

The Current Study

Absent from previous research is the investigation of the impact that adjustments to actuarial assessment may have in specific instances. Cases like Alfonso Rodriguez, Jr. illustrate the potential consequences of such an override. To empirically determine the

consequences of adjusted actuarial assessment, it is necessary to evaluate the frequency of clinical overrides of an actuarial instrument and the reasons for such overrides. With this information, it would be possible to examine the impact adjusted actuarial assessment may have on predictive accuracy in a future study.

Overview and research questions

This study provides such critically needed information by examining adjustments made to risk levels determined by an actuarial tool, the MnSOST-R (Epperson, et al., 1998, 2000, 2003). In Minnesota, prior to their release from confinement, sex offenders are assessed twice using the MnSOST-R. This is done first by a psychologist to determine if the offender meets criteria for civil commitment referral. For offenders who score 13 or above on the MnSOST-R, the presumptive action is referral for civil commitment review. However, any offender in the high risk category of the MnSOST-R may be referred. In some cases the psychologist has overridden the MnSOST-R, either by referring offenders who did not score in the high risk category or by not referring offenders who scored in the very high risk subset. Then, the psychologist recommends a risk level (low, moderate, or high; see Appendix B for presumptive risk levels and associated cut scores) to be assigned based on the first MnSOST-R score. In some cases, the psychologist has overridden the MnSOST-R and recommended a different level of risk based on that override.

For offenders who are not civilly committed, the ECRC administers a second MnSOST-R and assigns the level of risk. In some cases, the ECRC has overridden the MnSOST-R and designated a different level of risk. This study seeks to determine the occurrence of clinical overrides by psychologists and the ECRC and the reasons for such adjustments in a sample of sexual offenders released in Minnesota since August 1999. The

specific research questions addressed are: First, how often are the referral decisions or risk levels determined by the MnSOST-R adjusted by DOC personnel? Second, what are the reasons for such adjustments and are they consistent with department guidelines governing clinical overrides? After these questions are examined, it will be necessary to conduct further research into whether these overrides have an impact on the predictive accuracy of the MnSOST-R.

Benefits

There are several benefits to this research. First, this study will quantify clinical overrides of the MnSOST-R within the DOC by number, direction, and type. Second, this research will determine the reasons behind these overrides and any patterns of use, either consistent with or inconsistent with established guidelines for overrides. These results will inform the process currently used by the DOC. Finally, this research lays the necessary foundation for a planned follow-up study into the impact clinical overrides have on predictive accuracy.

The planned follow-up study also has numerous potential benefits. First, to the best of the primary researcher's knowledge, no study has yet examined the effect of clinical overrides on a pure actuarial measure of sexual recidivism prediction. Without conducting such research, it is impossible to determine whether such adjusted actuarial assessment strengthens or weakens the predictive utility of an instrument. As long as the criminal justice system continues to require predictions of dangerousness, upon which decisions such as release and confinement are based, researchers must respond with the most reliable methods available. To do this, such methods must be studied using actual case data and release outcomes.

While benefits to the field of recidivism prediction, such as those discussed above, encourage academics to pursue such research, it is the practical benefits that motivate service providers. The benefits of this study and the planned future study to the DOC range from assisting the department with analyzing their own data to testing the effectiveness of current departmental practices to facilitating positive public relations. First, compiling a data set comprised of released offenders provides the DOC with an available source for department statistics about risk levels assigned. Later, this information can be compiled with corresponding recidivism data. Next, this type of research provides a means by which the DOC can either demonstrate the effectiveness of its current assessment and release procedures or show its commitment to constantly investigating and improving upon existing measures. Finally, building upon the previous idea, the DOC can demonstrate to the public its commitment to both the safety and welfare of the community and rehabilitation of released offenders.

The importance of research into the reliable prediction of sexual recidivism cannot be overstated. With the advent of legislation such as Megan's Law and its derivatives, it is imperative that risk assessments be as accurate as possible. The cost of mistaken assessment carries equally devastating outcomes to both offenders and communities. By mistakenly classifying offenders as high risk, an individual may unjustly be deprived of his liberty. On the other end, mistaken classification of a dangerous offender as low risk could result in victimization of individuals and their communities in a particularly traumatic way. Therefore, any and all efforts to improve upon predictions of recidivism should be wholeheartedly explored and supported. Before a study of recidivism may be accomplished, however, the frequency of and reasons for clinical overrides must first be established.

METHODS

Participants

The full sample for this study was an exhaustive sample of 1,770 Minnesota sex offenders released since August 1999, for whom all necessary data could be accumulated. As of September 1999, the Minnesota DOC had fully implemented the transition from the MnSOST to the MnSOST-R for possible referral for commitment reviews and for ECRC reviews. The review for possible referral occurred approximately one year before the scheduled release date, and the ECRC review occurred approximately six months before release. Consequently, all offenders in our sample have at least one MnSOST-R score in their record and the overwhelming majority have two scores, one from the reviewing psychologist and a final one from the ECRC.

In addition to the full sample of 1,770 sex offenders in this study, a second sample of almost 500 offenders was analyzed. This sample was comprised of offenders from the full sample who had had a clinical override of their MnSOST-R score at some point in the release process, either by the reviewing psychologist or the ECRC. In addition to offenders from the full sample, there are approximately 50 offenders included who were released prior to September 1999, but who had been assessed using the MnSOST-R. This sample of about 500 is referred to as the override sample and was used to examine the distribution and frequency of clinical overrides by the psychologist and the ECRC, as well as the rationales for the overrides. The full sample is an exhaustive, and therefore representative, sample of sex offenders released by the DOC. The override sample is an exhaustive, and therefore representative, sample of cases with clinical overrides of the MnSOST-R, but it is not a representative sample of all released sex offenders.

Materials and Procedure

In order to conduct this research, it was necessary to obtain data from Minnesota DOC records. Required data included initial MnSOST-R scores from the reviewing psychologist and the risk level recommended; ECRC MnSOST-R scores and the risk level assigned; rationale for any clinical overrides; and basic demographic information for the offender, such as race, age, and level of education. It is important to note that the data collected was aggregated and once matched, all identifiers were removed, rendering it anonymous. All data was collected by a trained team of researchers, including the author and a doctoral-level psychologist with graduate and undergraduate students in psychology from Iowa State University. All researchers involved in obtaining and analyzing the necessary archival data completed human subjects research training and any necessary background checks required by the DOC, further ensuring the confidentiality of any records reviewed. Before data collection began, this study received full approval from both the Iowa State University Institutional Review Board (IRB) and the DOC.

Some of the data listed above were available through computer records, although a review of paper files was also necessary. Decisions regarding commitment referral and commitment status existed in electronic DOC files. Final ECRC MnSOST-R scores and the subsequent assigned risk levels also existed in electronic DOC files. For psychologist MnSOST-R scores and recommended risk levels, it was necessary to review paper copies of their reports. Paper files of psychologist and ECRC reports were also reviewed for information regarding clinical overrides and their rationales.

RESULTS

The full sample of sex offenders was examined to investigate the overall frequency and direction of clinical overrides by DOC personnel. Analyses were conducted to determine how often referral decisions or risk levels were being adjusted by DOC personnel. Further analyses were used to determine whether overrides were occurring within a particular risk level or in a certain direction.

Analyses of the Full Sample

Overrides in civil commitment referrals

First, overrides regarding referrals for civil commitment review were analyzed for the full sample of 1,770 sex offenders released in Minnesota since September 1999. Congruent referrals are cases in which the MnSOST-R score was 13 or greater, placing the offender in the very high risk subset, where the presumptive action is referral for commitment proceedings. However, it is not incongruent for any offender scoring in the high risk range of the MnSOST-R (score = 8-12) to be referred for a commitment review. Similarly, congruent non-referrals are cases in which the MnSOST-R score was not in the high risk range (score < 8). And, it is also not incongruent if an offender scoring above 8, but below 13, is not referred because he is not in the very high risk subset. Referral overrides only exist in cases where an offender was referred for civil commitment review with a MnSOST-R score below 8. Non-referral overrides only occurred in cases where an offender had a score of 13 or greater, but was not referred for a civil commitment review. Table 1 summarizes the frequency of all commitment referrals and non-referrals, including overrides, for the full sample.

Table 1. Referral Decisions

Category	N	%
No Override		
Congruent Referral	26	1.5%
Not Incongruent Referral	22	1.2%
Congruent Non-Referral	1442	81%
Not Incongruent Non-Referral	192	11%
Override		
Override Referral	24	1.4%
Override Non-Referral	64	3.6%

It is apparent that the MnSOST-R scores anchor the referral decisions overall, with only 5% of all cases being clear overrides. There are very few upward overrides, as reflected by only 24 of 1466 offenders with scores below 8 being referred (2%). Downward overrides were more common, with 64 of 90 offenders with scores above 12 not being referred (71%).

Overrides in risk level assignment

It also is clear that risk level assignments are anchored by MnSOST-R scores. Table 2 shows the agreement of ECRC assigned risk levels with MnSOST-R presumptive risk levels. Cases where the assigned risk level was congruent with the presumptive risk level are shown on the diagonal. The overall congruence rate for the full sample was 75%. While this shows strong reliance on the MnSOST-R in decisions regarding risk level assignment, this is largely the result of a high number of congruent low risk classifications (1001 of 1116 or 90%). Congruent moderate and high risk classifications were both near 50%.

Of the 449 cases in the full sample in which a clinical override was documented, 302 (67%) were downward overrides. In contrast, only 146 (33%) were upward overrides. Two

Table 2. Risk Level Assignment

Assigned Risk Level	MnSOST-R Presumptive Risk Level		
	Low (3 & Below)	Moderate (4-7)	High (8 and above)
Low	1001 (90%)	153 (44%)	24 (8%)
Moderate	97 (9%)	166 (47%)	126 (41%)
High	18 (2%)	31 (9%)	154 (51%)
Totals	1116	350	304

level overrides, going from high risk to low risk or vice versa were rare. Only 8% of downward overrides and 12% of upward overrides were two levels.

Analyses of the Override Sample

After examining the full sample to determine the overall frequency and direction of clinical overrides by DOC personnel, analyses of the override sample were conducted. These were done to ascertain potential patterns in the number and types of overrides made by psychologists and the ECRC, as well as in the reasons for the overrides. Prior to examining their separate overrides, the agreement between the psychologists' MnSOST-R scores and the ECRC's MnSOST-R scores was investigated.

Comparison of MnSOST-R Scores from Psychologists and the ECRC

Bivariate correlational analyses were conducted to determine the level of agreement between the psychologists' and the ECRC's MnSOST-R scores. Overall, there was very strong agreement ($r = .94, p < .01$) between the two scores, which reinforced the high inter-rater reliability of the MnSOST-R discussed previously.

Despite the high amount of agreement between the psychologist and ECRC MnSOST-R scores, there were differences between psychologist MnSOST-R scores and ECRC MnSOST-R scores in some cases, and that difference was sufficiently large enough to change the presumptive risk level on occasion. In the majority of these cases, the ECRC had lower MnSOST-R scores than the psychologists. Out of the 484 cases for which both scores were available, 91 (18.8% of all cases) had a lower ECRC MnSOST-R score than the psychologist's MnSOST-R score. Of those 91 lower scores, 32 (35% of cases with lower ECRC scores) led to a lower presumptive risk level. This represents approximately 7% of the 484 cases overall. In contrast, of the 484 cases for which both scores were available, only 27 cases (5.6% of all cases) had a higher ECRC MnSOST-R score than the psychologist's MnSOST-R score. Of these, the higher score led to a higher presumptive risk level in 9 cases (33% of all cases with higher ECRC scores). This represents approximately 2% of the 484 cases. Table 3 shows the number of congruent and incongruent cases by the presumptive risk levels for the psychologist's and ECRC's MnSOST-R scores.

Table 3. Agreement Between Presumptive Risk Levels

ECRC MnSOST-R Presumptive Risk Level	Psychologists MnSOST-R Presumptive Risk Level			Totals
	Low (3 & Below)	Moderate (4-7)	High (8 and above)	
Low (3 & Below)	126	5	1	132
Moderate (4-7)	14	152	3	169
High (8 and above)	1	17	165	183
Totals	141	174	169	484

Overrides by reviewing psychologists

Reviewing psychologists within the DOC score their MnSOST-R first, then use it as a basis for recommending an appropriate level of risk. Table 4 shows the total number of overridden and congruent cases according to psychologist MnSOST-R scores and recommended risk levels. Complete data were available to evaluate overrides by psychologists in 495 cases within the override sample. Out of those cases, a total of 272 (55%) had a clinical override. Similar to the full sample, psychologists overrode cases in a downward direction more frequently than in an upward direction. Downward overrides occurred in 165 cases (61%) and upward overrides occurred in 107 cases (39%).

Differences also existed among the overrides. Like the full sample, two level overrides in either direction were relatively uncommon among the psychologists. In cases with a presumptive MnSOST-R score in the high range, only 4% were overridden to the low range. Similarly, in cases with a presumptive MnSOST-R score in the low range, only 8% were overridden to the high range. Looking at this from another perspective, psychologists made two-level overrides in only 4% of all downward overrides. They made two-level overrides in 10% of all upward overrides.

The largest percentage of clinical overrides among the reviewing psychologists was from high risk to moderate risk, with 89 cases (48%) adjusted this way. The second largest group was from low risk to moderate risk, with 64 cases (47%) being overridden in such a manner. Based on these percentages, the reviewing psychologists demonstrated a tendency to be equally likely to adjust presumptive high risk cases downward (51% of presumptive high risk cases) and presumptive low risk cases upward (55% of presumptive low risk cases).

Table 4. Psychologist Overrides

Recommended Risk Level	MnSOST-R Presumptive Risk Level		
	Low (3 & Below)	Moderate (4-7)	High (8 and above)
Low	62 (45%)	69 (40%)	7 (4%)
Moderate	64 (47%)	70 (41%)	89 (48%)
High	11 (8%)	32 (19%)	91 (49%)
Totals	137	171	187

Psychologists were twice as likely to adjust presumptive moderate risk cases downward than upward, driving the overall pattern of being more likely to make downward overrides.

Overrides by ECRC

While reviewing psychologists make a recommendation as to which risk level they think is appropriate for an offender, it is the ECRC that actually assigns the risk level to an offender prior to his release. This assigned risk level is based on a second MnSOST-R score from the ECRC. Table 4 shows the total number of overridden and congruent cases according to ECRC MnSOST-R scores and assigned risk levels. Complete data were available to evaluate overrides by the ECRC in 482 cases within the override sample. Out of those cases, a total of 359 (74%) had a clinical override, substantially more than the adjustments made by psychologists. Identical to the full sample, the ECRC overrode cases in a downward direction twice as often as they overrode cases in an upward direction.

Downward overrides occurred in 240 cases (67%) and upward overrides occurred in 119 cases (33%).

Table 5. ECRC Overrides

Assigned Risk Level	MnSOST-R Presumptive Risk Level		
	Low (3 & Below)	Moderate (4-7)	High (8 and above)
Low	51 (36%)	111 (64%)	12 (7%)
Moderate	79 (56%)	33 (19%)	117 (70%)
High	11 (8%)	29 (17%)	39 (23%)
Totals	141	173	168

Differences also existed among the ECRC overrides. Like the full sample and the overrides by psychologists, two level overrides in either direction were relatively uncommon by the ECRC. In cases with a presumptive MnSOST-R score in the high range, only 7% were overridden to the low range. Similarly, in cases with a presumptive MnSOST-R score in the low range, only 8% were overridden to the high range. Looking at this from another perspective, two-level overrides by the ECRC constituted only 5% of all downward overrides and 9% of all upward override cases.

The overall pattern of being more likely to make downward overrides was evident at all presumptive risk levels for the ECRC. The ECRC was more likely to make downward overrides on presumptive high risk cases (77% of presumptive high risk cases) than upward overrides of presumptive low risk cases (64% of presumptive low risk cases). Downward overrides of presumptive moderate risk cases occurred at more than three times the rate of upward overrides for this group (64% versus 17% of presumptive moderate risk cases).

Rationale for overrides

Once the overall patterns among clinical overrides and the agreement between psychologists and the ECRC had been determined, it was necessary to perform additional analyses to investigate the reasons for adjustments and whether the reasons were consistent with department guidelines governing clinical overrides.

Trends between MnSOST-R scores and overrides. One possibility behind the overrides was that MnSOST-R scores near cut-offs for each risk level were being overridden to the next level. For example, were scores of 4 (just above the cut point of 3 for low risk) being adjusted downward more frequently than higher scores in the moderate range, and were scores of 7 (just below the cut point of 8 for high risk) being adjusted upward more frequently than lower scores in the moderate range?

Analyses of MnSOST-R scores for both psychologists and the ECRC were completed. There was a tendency for upward overrides to increase as scores increased towards 3, the cut point between low risk and moderate risk. There was also a tendency for downward overrides to increase as scores decreased towards 8, the cut point between high risk and moderate risk. Similarly, downward overrides had a tendency to increase in frequency as scores decreased towards 4, the cut point between moderate and low risk. However, it was very unlikely for scores greater than 12, the cut point for the very high risk subset, to be overridden at all. While these trends indicated that there was some adjustment resulting from scores being near cut points, they did not account for a large portion of the override cases.

Types of reasons used by psychologists and the ECRC. Because trends in scoring did not sufficiently explain the number of overrides occurring, it was necessary to examine

the reasons given by psychologists and the ECRC for their overrides. The authors of the MnSOST-R provided several guidelines that were acceptable reasons for overriding the MnSOST-R score (see Appendix C and D; Epperson, et al., 1998, 2000). Eight of these guidelines addressed acceptable reasons to override a score on the MnSOST-R in an upward direction, as they may increase the likelihood of sexual recidivism. One guideline addressed an acceptable reason to override the MnSOST-R score in a downward direction, as it may decrease the likelihood of sexual recidivism. In addition, one other reason, low intellectual functioning of an offender, was cited by the primary author of the MnSOST-R (personal communication, Douglas Epperson, May 31, 2004) as an acceptable reason to make an upward override.

The primary author of the MnSOST-R also acknowledged two additional reasons commonly used by DOC personnel when adjusting downward (personal communication, Douglas Epperson, May 31, 2004). These reasons were when the offender had committed only an intra-familial offense or if a higher level of community notification was unnecessary due to offense circumstances. While these reasons do not affect the likelihood an offender will recidivate, they do impact the level of community notification required by an offender's release. As mentioned previously, one function of risk assessment in the DOC is to determine the level of community notification necessary, with offenders at higher risk for reoffense usually requiring broader community notification. In cases where a broader level of notification is not required due to offense circumstances, such as when an offender committed only an intra-familial offense, an offender's risk level may be adjusted downward. This imperfect relationship between risk assessment and community notification will be discussed later. For the purposes of analysis, all of the reasons previously established or

acknowledged as acceptable by the authors of the MnSOST-R are referred to as established reasons and each was quantified for the purposes of analysis. It is important to note that these established reasons do not take into account additional reasons that the DOC may recognize as acceptable rationales for overriding the MnSOST-R.

In many cases, additional reasons beyond those given as guidelines by the authors of the MnSOST-R were cited by psychologists or the ECRC. These individual reasons were grouped into appropriate categories by a Q-sort. For this study, these reasons are referred to as unestablished reasons and each was quantified for the purposes of analysis. Table 6 shows the breakdown of psychologists' use of established and unestablished reasons, as well as the number of cases where no reasons were given. Table 7 shows the same breakdown for

Table 6. Psychologists' Reasons for Overrides

Override Direction	Category of Reason Used		
	Established	Unestablished	None
Upward	74 (69%)	95 (89%)	4 (4%)
Downward	58 (35%)	122 (74%)	15 (9%)

Table 7. ECRC's Reasons for Overrides

Override Direction	Category of Reason Used		
	Established	Unestablished	None
Upward	62 (52%)	95 (80%)	13 (11%)
Downward	26 (11%)	70 (29%)	149 (62%)

reasons given by the ECRC. It is important to note that both established and unestablished reasons could be used in the same case.

Two general trends emerged in the reasons used for both reviewing psychologists and the ECRC. First, both groups were more likely to cite reasons overall for upward overrides than for downward overrides. Second, reviewing psychologists and the ECRC were less likely to use established reasons than unestablished reasons for both types of overrides. This trend was pronounced in the downward overrides by psychologists, and it was dramatic in the downward overrides by the ECRC. In addition, the ECRC was much more likely to give no reasons at all for downward overrides.

Tables 8 and 9 provide more detailed information about the patterns of reasons used by reviewing psychologists and the ECRC respectively. In both tables, information on the use of established and unestablished reasons for overrides is shown by direction and degree. Psychologists used established reasons in similar numbers for upward overrides or when making a two-level downward override (69% to 73% of cases). In cases with one-level downward overrides, psychologists used far fewer established reasons (32% and 35%). This pattern was similar, although less pronounced, for unestablished reasons, with one exception. The highest percentages of unestablished reasons were used by psychologists when making upward overrides (86% to 94%). And, in cases with one-level downward overrides, psychologists used unestablished reasons less frequently (73% and 75%). However, for two-level downward overrides, psychologists used hardly any unestablished reasons (7%). The highest percentage of cases in which reviewing psychologists did not cite any reasons was in cases overridden from high risk to moderate risk (11%).

Table 8. Psychologist Pattern of Overrides and Reasons

	RISK LEVEL PRESUMED BY PSYCHOLOGIST MnSOST-R SCORE		
RISK LEVEL ASSIGNED BY PSYCHOLOGIST	HIGH RISK (SCORE > OR = 8)	MODERATE RISK (SCORE = 4-7)	LOW RISK (SCORE < OR = 3)
HIGH RISK	<p>NO OVERRIDE CONGRUENT</p> <p>N = 91</p>	<p>OVERRIDE ↑ ONE LEVEL</p> <p>N = 32</p> <p>22 cases (69%) used established reasons</p> <p>30 (94%) cases used unestablished reasons</p> <p>2 (6%) cases used no reasons</p>	<p>OVERRIDE ↑ TWO LEVELS</p> <p>N = 11</p> <p>8 (73%) cases used established reasons</p> <p>10 (91%) cases used unestablished reasons</p> <p>0 (0%) cases used no reasons</p>
MODERATE RISK	<p>OVERRIDE ↓ ONE LEVEL</p> <p>N = 89</p> <p>31 (35%) cases used established reasons</p> <p>65 (73%) cases used unestablished reasons</p> <p>10 (11%) cases used no reasons</p>	<p>NO OVERRIDE CONGRUENT</p> <p>N = 70</p>	<p>OVERRIDE ↑ ONE LEVEL</p> <p>N = 64</p> <p>44 (69%) cases used established reasons</p> <p>55 (86%) cases used unestablished reasons</p> <p>2 (3%) cases used no reasons</p>
LOW RISK	<p>OVERRIDE ↓ TWO LEVELS</p> <p>N = 7</p> <p>5 (71%) cases used established reasons</p> <p>5 (7%) cases used unestablished reasons</p> <p>0 (0%) cases used no reasons</p>	<p>OVERRIDE ↓ ONE LEVEL</p> <p>N = 69</p> <p>22 (32%) cases used established reasons</p> <p>52 (75%) cases used unestablished reasons</p> <p>5 (7%) cases used no reasons</p>	<p>NO OVERRIDE CONGRUENT</p> <p>N = 62</p>

Table 9. ECRC Pattern of Overrides and Reasons

	RISK LEVEL PRESUMED BY ECRC MnSOST-R SCORE		
RISK LEVEL ASSIGNED BY ECRC	HIGH RISK (SCORE > OR = 8)	MODERATE RISK (SCORE = 4-7)	LOW RISK (SCORE < OR = 3)
HIGH RISK	<p>NO OVERRIDE CONGRUENT</p> <p>N = 39</p>	<p>OVERRIDE ↑ ONE LEVEL</p> <p>N = 29</p> <p>12 (41%) cases used established reasons</p> <p>27(93%) cases used unestablished reasons</p> <p>2(7%) cases used no reasons</p>	<p>OVERRIDE ↑ TWO LEVELS</p> <p>N = 11</p> <p>8 (73%) cases used established reasons</p> <p>10(91%) cases used unestablished reasons</p> <p>0 (0%) cases used no reasons</p>
MODERATE RISK	<p>OVERRIDE ↓ ONE LEVEL</p> <p>N = 117</p> <p>8 (7%) cases used established reasons</p> <p>32 (27%) cases used unestablished reasons</p> <p>78 (67%) cases used no reasons</p>	<p>NO OVERRIDE CONGRUENT</p> <p>N = 33</p>	<p>OVERRIDE ↑ ONE LEVEL</p> <p>N = 79</p> <p>42 (53%) cases used established reasons</p> <p>58 (73%) cases used unestablished reasons</p> <p>11 (14%) cases used no reasons</p>
LOW RISK	<p>OVERRIDE ↓ TWO LEVELS</p> <p>N = 12</p> <p>4 (33%) cases used established reasons</p> <p>1 (8%) cases used unestablished reasons</p> <p>7 (58%) cases used no reasons</p>	<p>OVERRIDE ↓ ONE LEVEL</p> <p>N = 111</p> <p>14 (13%) cases used established reasons</p> <p>37 (33%) cases used unestablished reasons</p> <p>64 (58%) cases used no reasons</p>	<p>NO OVERRIDE CONGRUENT</p> <p>N = 51</p>

The ECRC was more variable in their use of reasons, although the general pattern remained similar. The ECRC used established reasons in the highest percentage of cases when making upward overrides (41% to 73%) and when making two-level downward overrides (33%). They used far fewer established reasons in cases with one-level downward overrides (7% and 13%). There was a comparable pattern with unestablished reasons, as well. The highest percentages of unestablished reasons were used by the ECRC when making upward overrides (73% to 91%). In cases with one-level downward overrides, the ECRC used unestablished reasons much less frequently (27% and 33%). For two-level downward overrides, the ECRC also used very few unestablished reasons (8%). However, the number of cases in which the ECRC did not cite any reasons was much greater than for psychologists. The highest percentages of cases in which the ECRC did not give a reason were in cases with downward overrides (58% to 67%).

Use of established individual reasons by psychologists and the ECRC. Once general trends in the types of reasons used by psychologists and the ECRC were determined, the next step was to look at the individual reasons used within each type. All individual established reasons cited by psychologists for upward overrides are listed in Table 10, as well as the total number and percentage of cases in which they were used. They are also separated by type of override. The two established reasons given most frequently by psychologists when overriding the MnSOST-R in an upward direction were: Reason 2 - Release conditions have been revoked/restructured for failure to follow treatment directives, inappropriate sexual behavior, or behavior reflective of offense (37%); and Reason 6 - Offender refused, quit, or did not pursue sex offender or chemical dependency treatment during incarceration and has a pattern of repeated treatment failures (34%).

Table 10. Frequency of Established Reasons Used for Upward Overrides by Psychologist

Reason	Low to moderate	Low to high	Moderate to high	Overall
1) Offender has made statements of his intent to reoffend	0	2(13%)	0	2(2%)
2) Release conditions have been revoked/restructured for failure to follow treatment directives, inappropriate sexual behavior, or behavior reflective of offense	24(39%)	4(27%)	16(38%)	44(37%)
3) Ten or more discipline reports during incarceration	2(3%)	0	1(2%)	3(3%)
4) Five or more separate sentencing occasions for all sex/sex-related offenses, plus <u>all</u> adult non-sexual felony offenses	0	1(7%)	4(10%)	5(4%)
5) Credible evidence in file indicates offender victimized 50 or more people in hands-on sex offenses (charged or uncharged)	0	0	0	0
6) Offender refused, quit, or did not pursue sex offender of chemical dependency treatment during incarceration and has a pattern of repeated treatment failures	19(31%)	4(27%)	17(40%)	40(34%)
7) Offender has demonstrated a pattern of inappropriate sexual behavior while incarcerated, as officially documented in file	6(10%)	4(27%)	2(5%)	12(10%)
8) Current or past sex/sex-related offenses involve a significant degree of harm to victim(s)	3(5%)	0	2(5%)	5(4%)
9) Offender has a low level of intellectual functioning (e.g., his full scale IQ is less than 70)	7(11%)	0	0	7(6%)

Similarly, Table 11 lists all individual established reasons cited by reviewing psychologists for downward overrides, along with the total number and percentage of cases in which they were used. These are also separated by type of override. The two established

Table 11. Frequency of Established Reasons Used for Downward Overrides by Psychologist

Reason	Moderate to low	High to moderate	High to low	Overall
10) Offender developed an incapacitating illness or physical condition that decreased motivation or ability to sexually reoffend	0	1(3%)	0	1(1%)
11) Offender committed only intra-familial sex offenses	13(46%)	9(24%)	2(33%)	24(34%)
12) Higher level of community notification was unnecessary due to offense circumstances	15(54%)	27(73%)	4(67%)	46(65%)

reasons given most frequently by psychologists when overriding the MnSOST-R in a downward direction were: Reason 12 - Higher level of community notification was unnecessary due to offense circumstances (65%); and Reason 11 - Offender committed only intra-familial sex offenses (34%).

All individual established reasons cited by the ECRC for upward overrides are listed in Table 12, as well as the total number and percentage of cases in which they were used. They are also separated by type of override. The two established reasons given most often by the ECRC when overriding the MnSOST-R in an upward direction were the same two as those most frequently given by the psychologists, but in reversed order. They were: Reason 6 - Offender refused, quit, or did not pursue sex offender or chemical dependency treatment during incarceration and has a pattern of repeated treatment failures (46%); and Reason 2 - Release conditions have been revoked/restructured for failure to follow treatment directives, inappropriate sexual behavior, or behavior reflective of offense (33%).

Table 12. Frequency of Established Reasons Used for Upward Overrides by ECRC

Reason	Low to moderate	Low to high	Moderate to high	Overall
1) Offender has made statements of his intent to reoffend	0	2(20%)	0	2(3%)
2) Release conditions have been revoked/restructured for failure to follow treatment directives, inappropriate sexual behavior, or behavior reflective of offense	18(34%)	3(30%)	5(31%)	26(33%)
3) Ten or more discipline reports during incarceration	0	0	1(6%)	1(1%)
4) Five or more separate sentencing occasions for all sex/sex-related offenses, plus <u>all</u> adult non-sexual felony offenses	0	0	1(6%)	1(1%)
5) Credible evidence in file indicates offender victimized 50 or more people in hands-on sex offenses (charged or uncharged)	0	0	0	0
6) Offender refused, quit, or did not pursue sex offender of chemical dependency treatment during incarceration and has a pattern of repeated treatment failures	26(49%)	2(20%)	8(50%)	36(46%)
7) Offender has demonstrated a pattern of inappropriate sexual behavior while incarcerated, as officially documented in file	0	2(20%)	0	2(3%)
8) Current or past sex/sex-related offenses involve a significant degree of harm to victim(s)	1(2%)	0	1(6%)	2(3%)
9) Offender has a low level of intellectual functioning (e.g., his full scale IQ is less than 70)	8(15%)	1(10%)	0	9(11%)

Likewise, the individual established reasons most frequently cited by the ECRC for downward overrides were the same as those most often given by the psychologists, but in reversed order. They were Reason 11 - Offender committed only intra-familial sex offenses

Table 13. Frequency of Established Reasons Used for Downward Overrides by ECRC

Reason	Moderate to low	High to moderate	High to low	Overall
10) Offender developed an incapacitating illness or physical condition that decreased motivation or ability to sexually reoffend	0	1(10%)	1(25%)	2(7%)
11) Offender committed only intra-familial sex offenses	11(73%)	3(30%)	3(75%)	17(59%)
12) Higher level of community notification was unnecessary due to offense circumstances	4(27%)	6(60%)	0	10(34%)

(59%); and Reason 12 - Higher level of community notification was unnecessary due to offense circumstances (34%). Table 13 lists all individual established reasons cited by the ECRC for downward overrides, along with the total number and percentage of cases in which they were used. These are also separated by type of override.

Use of unestablished individual reasons by psychologists and the ECRC. The individual use of unestablished reasons by psychologists and the ECRC was also examined. All cases of individual unestablished reasons cited by reviewing psychologists for upward overrides are listed in Table 14. The total number and percentage of cases in which they were used is also given overall and for each type of override. There were three unestablished reasons most frequently given by psychologists when overriding the MnSOST-R in an upward direction. They were: Reason 13 - History of supervision/release failures (did not rise to the level of release revocation or restructure) (20%); Reason 15 - Nature of victim pool requires broader notification (19%); and Reason 14 - Deviant sexual orientation (18%).

Table 14. Frequency of Unestablished Reasons Used for Upward Overrides by Psychologist

Reason	Low to moderate	Low to High	Moderate to high	Overall
13) History of supervision/release failures (did <u>not</u> rise to the level of release revocation or restructure)	23(27%)	3(10%)	10(15%)	36(20%)
14) Deviant sexual orientation	16(19%)	6(21%)	11(16%)	33(18%)
15) Nature of victim pool requires broader notification	15(17%)	8(28%)	11(16%)	34(19%)
16) Evidence of extensive number of victims for which offender was not charged (less than 50)	8(9%)	5(17%)	9(13%)	22(12%)
17) Predatory offense behavior and/or high-risk grooming behaviors	8(9%)	4(14%)	8(12%)	20(11%)
18) Long history of previous sex offenses, civil commitment referral, severe violence, or extensive criminal history	8(9%)	0	11(16%)	19(10%)
19) Unlikely to have stable, well-supervised release conditions	5(6%)	1(3%)	1(1%)	7(4%)
20) Mental health and/or addiction concerns	2(2%)	0	1(1%)	3(2%)
21) Denial of index offense and/or lack of offender insight	0	1(3%)	3(4%)	4(2%)
22) Egregious circumstances during offense (e.g., gratuitous violence, injury to children)	1(1%)	1(3%)	2(3%)	4(2%)

Table 15 lists all individual unestablished reasons cited by reviewing psychologists for downward overrides. The number and percentage of cases in which they were used is also given overall and by type of override. The unestablished reasons most frequently cited by psychologists when overriding in a downward direction were: Reason 24 - Only one

Table 15. Frequency of Unestablished Reasons Used for Downward Overrides by Psychologist

Reason	Moderate to low	High to moderate	High to low	Overall
23) Currently in or successful completion of sex offender or chemical dependency treatment	8(11%)	6(7%)	0	14(9%)
24) Only one known sex offense	22(31%)	22(26%)	0	44(27%)
25) Concerns about MnSOST-R scoring or risk level assigned (i.e., questions raised about scoring or offender does not appear to rise to associated level of risk)	8(11%)	27(32%)	1(14%)	36(22%)
26) Stable and/or well-supervised release conditions	0	3(4%)	0	3(2%)
27) Sexual contact for index offense did not involve force, was non-predatory, involved an acquaintance, and/or was consensual/mutual	15(21%)	15(18%)	4(57%)	34(21%)
28) Subject's age at time of release or time elapsed since index offense	14(20%)	10(12%)	2(29%)	26(16%)
29) Indications of offender insight or rehabilitation potential	3(4%)	2(2%)	0	5(3%)

known sex offense (27%); Reason 25 - Concerns about MnSOST-R scoring or risk level assigned (i.e., questions raised about scoring or offender does not appear to rise to associated level of risk) (22%); and Reason 27 - Sexual contact for index offense did not involve force, was non-predatory, involved an acquaintance, and/or was consensual/mutual (21%).

All individual unestablished reasons cited by the ECRC for upward overrides are listed in Table 16, as well as the total number and percentage of cases in which they were used. They are also separated by type of override. The two unestablished reasons given most often by the ECRC when overriding the MnSOST-R in an upward direction were the

Table 16. Frequency of Unestablished Reasons Used for Upward Overrides by ECRC

Reason	Low to moderate	Low to High	Moderate to high	Overall
13) History of supervision/release failures (did <u>not</u> rise to the level of release revocation or restructure)	20(22%)	2(7%)	13(26%)	35(21%)
14) Deviant sexual orientation	15(17%)	6(22%)	9(18%)	30(18%)
15) Nature of victim pool requires broader notification	21(23%)	6(22%)	11(22%)	38(23%)
16) Evidence of extensive number of victims for which offender was not charged (less than 50)	2(2%)	3(11%)	3(6%)	8(5%)
17) Predatory offense behavior and/or high-risk grooming behaviors	13(14%)	6(22%)	6(12%)	25(15%)
18) Long history of previous sex offenses, civil commitment referral, severe violence, or extensive criminal history	8(9%)	2(7%)	7(14%)	17(10%)
19) Unlikely to have stable, well-supervised release conditions	7(8%)	1(4%)	1(2%)	9(5%)
20) Mental health and/or addiction concerns	2(2%)	0	0	2(1%)
21) Denial of index offense and/or lack of offender insight	2(2%)	1(4%)	1(2%)	4(2%)
22) Egregious circumstances during offense (e.g., gratuitous violence, injury to children)	0	0	0	0

same as two of the three most often cited by the psychologists. They were: Reason 15 - Nature of victim pool requires broader notification (23%); and Reason 13 - History of supervision/release failures (did not rise to the level of release revocation or restructure) (21%).

Table 17. Frequency of Unestablished Reasons Used for Downward Overrides by ECRC

Reason	Moderate to low	High to moderate	High to low	Overall
23) Currently in or successful completion of sex offender or chemical dependency treatment	16(33%)	10(25%)	0	26(30%)
24) Only one known sex offense	13(27%)	4(10%)	0	17(20%)
25) Concerns about MnSOST-R scoring or risk level assigned (i.e., questions raised about scoring or offender does not appear to rise to associated level of risk)	3(6%)	4(10%)	0	7(8%)
26) Stable and/or well-supervised release conditions	3(6%)	6(15%)	0	9(10%)
27) Sexual contact for index offense did not involve force, was non-predatory, involved an acquaintance, and/or was consensual/mutual	2(4%)	9(23%)	1(50%)	12(14%)
28) Subject's age at time of release or time elapsed since index offense	6(13%)	3(8%)	1(50%)	10(11%)
29) Indications of offender insight or rehabilitation potential	2(4%)	4(10%)	0	6(7%)

Similarly, one of the individual unestablished reasons most frequently cited by the ECRC for downward overrides was the same as one given most often by the psychologists. This was Reason 24 - Only one known sex offense (20%). However, the most frequently cited unestablished reason for a downward override by the ECRC was not often cited by psychologists. This was Reason 23 - Currently in or successful completion of sex offender or chemical dependency treatment (31%). Table 17 lists all individual unestablished reasons cited by the ECRC for downward overrides. The number and percentage of cases in which they were used is cited overall and by type of override.

DISCUSSION

The purpose of this study was to determine the frequency of and reasons for clinical overrides of the MnSOST-R by DOC staff. In summary, the results of this study demonstrated that the MnSOST-R clearly anchors the risk assessment process in the Minnesota DOC, as shown by the 75% of cases in which the risk level assigned reflects the presumptive risk level associated with the MnSOST-R score. Despite this high rate of congruence, clinical overrides occurred in a large number (25%) of cases overall. In addition, the high percentage of cases with no override was driven by the high congruence rate (90%) in low risk cases. The percentage of clinical overrides was actually much higher in cases with a presumptive risk level in the moderate range (53%) or high range (49%).

Although the reasons established or acknowledged by the authors of the MnSOST-R were used in many overrides, a much larger percentage of unestablished reasons were used by psychologists and the ECRC. For both, cases in which there was an upward override were more likely to have an established reason given (52% - 69%), as opposed to cases in which there was a downward override (11% - 35%). In many cases, the ECRC did not cite any reasons for overriding the instrument downward. These results indicated it was necessary to explore the patterns in overrides and their given reasons in greater detail.

Implications

For upward and downward overrides, adjustments were usually one level. However, downward overrides occurred twice as often as upward overrides. This is not surprising given that the high percentage of overrides in the presumptive moderate risk and high risk ranges. There are a few possible explanations for the high level of downward overrides, particularly by the ECRC. First, it is possible that the MnSOST-R may overestimate an

individual's risk to reoffend. In an attempt to offset this, clinical overrides in a downward direction may be made. However, several studies have demonstrated that the MnSOST-R is a reliable and valid measure of sexual recidivism risk (Epperson, et al., 1998, 2003; Langton, et al., 2002). Given this, it is unlikely that concerns about MnSOST-R scores and presumptive risk levels are the principle impetus for the high number of downward overrides.

Additional explanations include those in which factors other than risk of recidivism entered the picture. A second possibility is that the large number of downward overrides may partially be due to the imperfect relationship between risk level and community notification level. Risk level is conceptualized as the likelihood of an offender to recidivate. Community notification level refers to the need for members of a community to know about an offender's release. This is reflected in the two most common established reasons for overrides by both the ECRC and psychologists. There is a decreased need for full community notification if an offender committed only intrafamilial offenses (Reason 11) or other characteristics of the offense(s) and victim(s) limit the need to know (Reason 12).

Related to this imperfect mapping between risk assessment and community notification needs, it also appears that consideration of an offender's release environment may be reflected in assigned risk levels. This is indicated in the use of Reason 19 – Unlikely to have stable, well-supervised release conditions (consistent with upward overrides), and Reason 26 – Stable and/or well-supervised release conditions (consistent with downward overrides) to explain adjustments to risk levels. However, such a consideration is really a component of risk management, not a risk factor. A particular risk level is a reason for releasing an offender into a supervised setting. It is this supervision that reduces the threat

presented to the community. This may decrease the need to broadly inform the community, but it does not change the risk inherent in the individual.

Even considering overrides which may reflect the sometimes murky relationship between risk assessment and risk management, there is still another potential explanation for the high level of downward overrides. It is possible that decisions to adjust risk levels are unduly influenced by resource considerations. This possibility could explain why there are more downward overrides than upward overrides. Concerns about whether the DOC is responsible if a released offender recidivates would reflect a consideration of liability and would likely result in more upward overrides to reduce this possibility. However, concerns about whether there is enough money and personnel to adequately supervise offenders at a high risk level reflect a consideration of DOC resources.

The pattern among reasons used to justify clinical overrides seems to support the possibility that resource concerns may impact adjustments. Overall, fewer reasons were given for downward overrides than for upward overrides. If the availability of resources were the primary concern, then any use of those resources would need to be fully explained and supported. Upward overrides clearly require more resources and those are the overrides for which the most reasons were given. In contrast, if liability were the main concern, then downward overrides would need to be carefully justified and more reasons would have been used in those cases.

The pattern among the types of reasons used as a rationale for adjustments also appears to support the possible influence of resource considerations. Overall, established reasons were less likely to be used than unestablished reasons. However, this trend was most pronounced for downward overrides. This is consistent with a resource bias. Since there are

far fewer established reasons for downward overrides, fewer cases meet the criteria necessary to support adjusting risk levels downward. If resource concerns motivated more downward overrides, then it was necessary to use additional reasons in order to justify those overrides.

Similarly, there were a large number of cases (62%) in which the ECRC cited no reasons for adjusting risk levels downward. This seems to demonstrate less concern for offering any rationale for downward overrides versus upward overrides and is clearly not consistent with liability concerns. Instead, the absence of reasons in so many cases appears to support the influence of resource concerns in override decisions. It is also problematic from the standpoint of recordkeeping, because the rationales behind those overrides cannot be evaluated.

The use of unestablished reasons for overrides in either direction raises additional concerns because the relationships of those reasons with recidivism are largely unknown. However, the use of certain unestablished reasons is particularly problematic. One area of concern is the use of unestablished reasons to justify downward overrides that are already assessed by the MnSOST-R. For example, Reason 23 - Currently in or successful completion of sex offender or chemical dependency treatment, was the most frequently cited unestablished reason by the ECRC for downward overrides. This is already captured in Items 14 and 15 on the MnSOST-R (see Appendix A). It is not logical to use a factor that has already been considered in determining risk level as a rationale for modifying that same risk level. Two other unestablished reasons used by the ECRC and reviewing psychologists face the same problem. Reason 27 - Sexual contact for index offense did not involve force, was non-predatory, involved an acquaintance, and/or was consensual/mutual and Reason 28 -

Subject's age at time of release or time elapsed since index offense are both assessed using the MnSOST-R (see Appendix A).

The use of unestablished reasons for which there is little empirical support raises additional concerns. Reason 21 - Denial of index offense and/or lack of offender insight was used to justify upward overrides in some cases. However, the recent meta-analysis by Hanson and Morton-Bourgon (2004) found that denial and minimization by offenders did not predict sexual recidivism. Similarly, the presence of insight on the part of the offender (Reason 29) was used as a rationale for downward overrides, a relationship that is not empirically supported (Hanson and Morton-Bourgon, 2004).

Given that overrides of an offender's risk level by DOC personnel occur at some level in one out of every four cases, it seems important to use only reasons that have been established as "broken legs." Otherwise, clinical judgment may supercede the empirically supported actuarial measure. The degree to which this may damage the instrument's predictive accuracy is unknown. Unfortunately, the consequences of any damage could be serious for individuals put at risk and society as a whole.

Limitations and Future Research

Clearly, the primary limitation of this study is that the effect of the clinical overrides is unknown. The purpose of this study was to lay a foundation for future research into the impact adjustments to the MnSOST-R may have on its predictive accuracy. However, this impact remains to be seen. Now that it has been established that overrides of the MnSOST-R are occurring with some frequency within the Minnesota DOC and that the reasons for such overrides are not always consistent with guidelines governing them, future research into

recidivism must be undertaken. This can establish whether adjusted actuarial assessment enhances or impedes the predictive accuracy of a specific actuarial tool.

A second limitation of this study was the use of archival records. Because data in this study were obtained solely through file review, information was limited to the written record the process investigated. Therefore, it was not possible to fully examine the entire decision-making process behind the clinical overrides. As part of a future recidivism study, it may be possible to collect further information and conduct more thorough analyses.

Conclusion

A necessary first step into the investigation of adjusted actuarial assessment has been completed. It is now established that adjustments to MnSOST-R risk levels have been made in a significant percentage of cases since the full implementation of the MnSOST-R in 1999. Furthermore, it is clear that a large portion of these overrides were not made in accordance with guidelines established by the authors of the MnSOST-R. As important as it is to develop guidelines to account for the rare instances (“broken legs”) that warrant an actuarial adjustment, it is just as crucial to ensure that there is adherence to those guidelines. This is made especially salient when deviation from such guidelines may result in significant losses.

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APPENDIX A: MnSOST-R SCORE RECORDING SHEET
(Epperson, et al., 1998, 2000)

<p>Historical/Static Variables</p> <p>1. Number of sex/sex-related convictions (including current conviction): _____</p> <p>One0</p> <p>Two or more+2</p> <p>2. Length of sexual offending history: _____</p> <p>Less than one year-1</p> <p>One to six years+3</p> <p>More than six years.....0</p> <p>3. Was the offender under any form of supervision when they committed any sex offense for which they were eventually charged or convicted? _____</p> <p>No.....0</p> <p>Yes.....+2</p> <p>4. Was any sex offense (charged or convicted) committed in a public place? _____</p> <p>No.....0</p> <p>Yes.....+2</p> <p>5. Was force or the threat of force ever used to achieve compliance in any sex offense (charged or convicted)? _____</p> <p>No force in any offense.....-3</p> <p>Force present in at least one offense0</p> <p>6. Has any sex offense (charged or convicted) involved multiple acts on a single victim within any single contact event? _____</p> <p>No.....-1</p> <p>Yes.....+1</p> <p>7. Number of different age groups victimized across all sex/sex-related offenses (charged or convicted): _____</p> <p>Age group of victims: (check all that apply)</p> <p><input type="checkbox"/> Age 6 or younger</p> <p><input type="checkbox"/> Age 7 to 12 years</p> <p><input type="checkbox"/> Age 13 to 15 years and the offender is more than five years older than the victim</p> <p><input type="checkbox"/> Age 16 or older</p> <p>No age group or only one age group checked0</p> <p>Two or more age groups checked+3</p> <p>8. Offended against a 13- to 15-year-old victim and the offender was more than five years older than the victim at the time of the offense (charged or convicted): _____</p> <p>No.....0</p> <p>Yes.....+2</p> <p>9. Was the victim a stranger in any sex/sex-related offense (charged or convicted)? _____</p> <p>No victims were strangers-1</p> <p>At least one victim was a stranger +3</p> <p>Uncertain due to missing information 0</p>	<p>10. Is there evidence of adolescent antisocial behavior in the file? _____</p> <p>No indication-1</p> <p>Some relatively isolated antisocial acts0</p> <p>Persistent, repetitive pattern.....+2</p> <p>11. Pattern of substantial drug or alcohol abuse (12 months prior to arrest for instant offense or revocation): _____</p> <p>No.....-1</p> <p>Yes.....+1</p> <p>12. Employment history (12 months prior to arrest for instant offense): _____</p> <p>Stable employment for one year or longer-2</p> <p>Homemaker, retired, full-time student, or disabled/ unable to work.....-2</p> <p>Part-time, seasonal, unstable employment0</p> <p>Unemployed or significant history of unemployment..... +1</p> <p>File contains no information.....0</p> <p align="right">.....Historical/Static Subtotal: _____</p> <p><u>Institutional/Dynamic Variables</u></p> <p>13. Discipline history while incarcerated (does not include discipline for failure to follow treatment directives): _____</p> <p>No major discipline reports or infractions0</p> <p>One or more major discipline reports+1</p> <p>14. Chemical dependency treatment while incarcerated: _____</p> <p>No treatment recommended / Not enough time / No opportunity.....0</p> <p>Treatment recommended and successfully completed or in program at time of release.....-2</p> <p>Treatment recommended but offender refused, quit, or did not pursue.....+1</p> <p>Treatment recommended but terminated by staff.....+4</p> <p>15. Sex offender treatment history while incarcerated: _____</p> <p>No treatment recommended / Not enough time / No opportunity.....0</p> <p>Treatment recommended and successfully completed or in program at time of release.....-1</p> <p>Treatment recommended but offender refused, quit, or did not pursue.....0</p> <p>Treatment recommended but terminated+3</p> <p>16. Age of offender at time of release: _____</p> <p>Age 30 or younger+1</p> <p>Age 31 or older.....-1</p> <p align="right">.....Institutional/Dynamic Subtotal: _____</p> <p align="right">TOTAL SCORE (static+dynamic): _____</p>
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APPENDIX B: RISK LEVELS AND ASSOCIATED MnSOST-R CUT SCORES
(Epperson, et al., 2003, p. 24)

Presumptive Risk Level	MnSOST-R Score
1 (low)	3 and below
2 (moderate)	4 to 7
3 (high)	8 and above

Refer for county attorney ^a	13 and above

Note. ^aThe referral group is a subset of the high risk group.

APPENDIX C: MnSOST-R SPECIAL CONSIDERATIONS
(Epperson, et al., 1998, 2000)

Special Concerns That May Increase Likelihood of Sexual Recidivism

1. The offender has made statements, as documented in file, indicating an intent to reoffend.
2. The offender's release conditions have been restructured or revoked for failure to follow treatment directives, inappropriate sexual behavior, or behavior reflective of offense dynamics.
3. Ten or more major discipline reports during the current incarceration modestly increases the likelihood of sexual recidivism (approximately equivalent to a one-point increase in MnSOST-R score).
4. Five or more separate sentencing occasions for all sex/sex-related offenses (juvenile sex offenses, gross misdemeanor or felony sex offenses) *plus* all adult non-sexual felony offense may modestly increase likelihood of sexual reoffending (Document actual number, including current sentencing occasion).

Sentencing occasions are *distinct* court appearances when the offender was sentenced for criminal convictions. The number of charges, counts, or convictions is irrelevant because only distinct sentencing occasions are counted.

5. Credible evidence in the file indicates that the offender has victimized an extraordinarily high number of people (50 or more) in hands-on sex offenses (charged or uncharged).

For example, an offender reports over 70 victims of hands-on sex offenses, and this self-report is documented in the file and deemed credible.

6. The offender refused, quit, or did not pursue sex offender or chemical dependency treatment during the current incarceration (items #14 and #15 on the MnSOST-R) *and* has a pattern of repeated prior treatment failures (being terminated from treatment, quitting treatment, and/or sexual re-offending after completing treatment).

7. The offender has demonstrated a pattern of inappropriate sexual behavior while incarcerated, as officially documented in the file.

Examples of inappropriate sexual behavior would include discipline reports for masturbation, exposing, sexual activity, or sexual assault; collection of inappropriate sexual material; grooming of targeted victims; and other sexual activity that violates institutional rules.

8. The current or past sex/sex-related offenses involved a significant degree of harm in the form of physical injury or death to the victim(s).

This item reflects the *seriousness* of the risk involved rather than the *likelihood* of risk. Therefore, this item does not increase the likelihood of reoffending, but it may increase their risk level because of the increased potential of serious physical harm to victims.

APPENDIX D: MnSOST-R SPECIAL CONSIDERATIONS
(Epperson, et al., 1998, 2000)

Special Concerns That May Decrease Likelihood of Sexual Recidivism

1. The offender has developed an incapacitating illness or physical condition that decreases motivation or ability to sexually offend (e.g. later stages of a terminal illness, etc.)

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