

**The Integrated Risk Assessment and Treatment System (IRATS) Model of Sexual Offending:
A Case Study**

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Abstract

The present article describes the Integrated Risk Assessment and Treatment System (IRATS) Model of offender therapy. The model was developed for use with sexual offenders though we have argued elsewhere (e.g., Abracen and Looman, 2016) that the model may be easily adapted for use with violent non-sexual offenders. Although this model has been described in detail elsewhere, the present manuscript presents an illustration of the clinical uses of the model as applied to a particular client. This client has been included in the various outcome studies that the authors have completed on high-risk high-need sexual offenders seen in both institutional and community settings. Following a discussion of the case of GW we review some of the outcome research which we have completed in support of the model.

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Our team has recently outlined a new model for the treatment of sexual offenders. Although we initially viewed the model as an update to Andrews and Bonta's^{1,2} (e.g., 1998, 2010) influential model, often referred to as the Risk Need Responsivity (RNR) Model of criminal behaviour, we now view our perspective as being quite different from the original statements made by Andrews and Bonta. In keeping with our view of the model, we are no longer calling the model the Integrated RNR Model and have currently adopted the name the Integrated Risk Assessment and Treatment System Model (IRATS; Abracen & Looman³, 2016; Abracen, Looman & Ferguson,⁴, In press; Looman & Abracen,⁵2017).

The most recent version of the model incorporates three core features as well as internal and external pressures which interact with the core features of the model to moderate risk. Although we have previously outlined research which supports this model and why available models (e.g., the Good Lives Model) may not be sufficient to meet the treatment needs of moderate and high-risk sexual offenders (Abracen & Looman³, 2016; Looman & Abracen⁶, 2013) we have yet to provide a case study showing how these various features work together. We hope that by discussing an individual offender some of the features of the model may be more easily understood from a clinical perspective. As well, we argue that effective treatment begins with a comprehensive assessment. Based on the results of the initial assessment clinicians will need to address a number of inter-related factors in a series of programs that are designed to meet the complex needs with which moderate and high-risk sexual offenders present. Treatment involves some combination of individual and/or group based approaches.

Before discussing the case of GW we will first briefly present the IRATS Model. Following the discussion of GW's case we will describe at least a few of the long-term outcome studies that we have produced in support of the model. That is, rather than relying on a case study to describe the utility of the model the case of GW is presented to illustrate a few features of treatment that follow from the model. It is our view that long-term outcome studies using appropriate comparison groups are required to establish the efficacy of existing programs and that case studies and/or theoretical arguments regarding one or another approach are not sufficient to demonstrate the utility of a particular model. To the best of our knowledge no contemporary treatment theory of sexual aggression has been subjected to more outcome research than the IRATS.

IRATS Model

With reference to core features, the IRATS lists three factors that should be assessed. The first relates to criminal history and lifestyle variables. These elements were first comprehensively described in the RNR model (Andrews & Bonta²; 2010). Andrews and Bonta² (e.g., 2010) suggested that criminal behavior can be understood by assessing for and providing interventions related to eight core features. These eight criminogenic needs included such factors as criminal thinking, personality, associates, substance abuse, and poor choice of leisure activities as well as issues associated with school and work (e.g., inability to find or keep a job). Andrews and Bonta argued for the use of empirically grounded measures to assess risk using an actuarial approach; noting that clinical judgment is typically a poor means to assess an offender's actual level of risk. Last, Andrews and Bonta argued that treatment should be provided in a

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manner that meets the client's needs most effectively. Typically treatment should be offered using cognitive-behavioral approaches in a structured and concrete manner. Although Andrews and Bonta (2010) argued that issues associated with the therapeutic alliance are important, this aspect of their model has received very little attention either in their own writings or in the peer reviewed literature related to their model.

The second major component of the IRATS model is serious mental illness and the related issue of complex trauma. Andrews and Bonta² (2010) specifically argued that mental illness is not related to criminal recidivism. Rather than discuss the concept of mental illness directly, however, they discussed research related to personal distress. Unfortunately, Andrews and Bonta never define the concept of personal distress in any detail and it is not clear from their writings whether personal distress refers to such conditions as minor levels of anxiety and/or serious mental illness (e.g., such as a diagnosis of psychosis). Our team has argued that issues associated with serious mental illness (SMI) have been shown to be associated with increased rates of general and violent recidivism in numerous studies (See Abracen & Looman, 2016³; for review); and thus that contemporary theories of criminal behavior need to take such issues into account. Related to the concept of SMI, we argue, is having had a history of trauma and, in this regard, the research on complex trauma is certainly of relevance (e.g., Courtois & Ford⁷, 2009; Levers⁸, 2012). Of note is the strong association between having had a history of trauma and the presence of numerous mental health diagnoses; in particular substance abuse and diagnoses related to negative emotionality (Courtois and Ford⁷, 2009).

With reference to sexual offending in particular issues associated with complex trauma, and, in particular, a history of sexual

victimization, may be related to the development of deviant arousal and consequent diagnoses related to having one or more paraphilic conditions. Deviant sexual interests is the third major component of the IRATS model. As there is ample evidence in the empirical literature linking deviant arousal to sexual offending that research will not be repeated here. Interested readers are referred to Abracen and Looman³ (2016) for a discussion. We have included a copy of the IRATS in Figure I to help the reader see, at a glance, the elements included in the IRATS Model. In order to help contextualize this information we will present the case of GW. We have changed several details of GW's life in order to protect his anonymity. Although a few details of GW's life have been changed, it should be stressed that the presentation below is hardly an exaggeration. In fact, quite the opposite is true as we have left out several details regarding GW's life that would have further highlighted just how complex his actual history is. We hope to demonstrate that although groups of high-risk sexual offenders may present with a daunting list of issues that need to be addressed in treatment, a comprehensive approach to assessment and treatment, guided by an empirically supported model, may well result in the effective management of such populations.

The Case of GW

GW was initially assessed at the Regional Treatment Centre Sex Offender Treatment Program (RTCSOTP). The comprehensive assessment battery that was employed at the RTCSOTP was administered to GW (See Abracen & Looman³, 2016 for a complete description of the assessment battery). Among other issues, the assessment battery includes a phallometric assessment (i.e., a physiological assessment of arousal to both normal and deviant stimuli using a mercury-in-rubber strain gauge which measures for changes in tumescence). Paper and pencil measures

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related to personality assessment, alcohol and drug use, criminal thinking, attachment pattern, and interpersonal relations are also included in the RTCSOTP assessment battery. Overall, the pre-treatment assessment typically requires approximately two weeks to complete given the range of measures administered. As well, the psychologist assigned to the case administered a semi-structured interview which allowed for the completion of a variety of actuarial risk assessment measures. The interview also allowed for a detailed discussion of the client's upbringing, social history, history of mental health problems and sexual offending.

GW evidenced three conviction dates related to sexual offences, two involving children. The details of those offences as well as some other background information will not be presented here in order to ensure the anonymity of GW. GW is typical of clients attending the RTCSOTP who present with an average of greater than two sexual offences on their officially recorded criminal history. GW also had a record of non-sexual offending listed on his official record. A review of GW's psychiatric history revealed a history of paraphilic diagnoses. That being said, the pre-treatment assessment at RTCSOTP did not provide sufficient information to corroborate such paraphilic diagnoses (e.g., sexual sadism). Nonetheless, GW did report being sexually aroused by female children at least at the time he had committed one of his sexual offences. Pre-treatment assessment at the RTCSOTP indicated that GW's phallometric results were too low to interpret. This may have been due either to intentional efforts to hide evidence of inappropriate arousal, or as secondary to one of several medical conditions from which the client suffered and that are known to cause difficulties in the area of erectile functioning. GW was noted to have had a history of substance abuse which is typical of clients attending the RTCSOTP. As well, GW scored as being at the high end of the moderate risk

range on an actuarial measure of risk designed to assess risk of sexual offence recidivism.

A variety of reports on file indicated that GW suffered from mild to moderate cognitive impairment. As a result it was decided that it would be best for GW to attend only individual therapy sessions at first. GW attended 10 months of individual therapy sessions (he attended two sessions a week). Prior to his leaving RTCSOTP GW attended two months of the group based program. After 10 months of individually based therapy it was thought that GW would be able to participate in the group based format without feeling overwhelmed by the information presented. As well, GW did not experience an adequate level of rapport with staff initially to trust that they would help him out if he felt overwhelmed in the group based format. Following completion of the institutionally based treatment program GW was seen in individual therapy in the community by the first author (JA) for a number of years until he reached the end of his sentence. A description of GW's participation in the community based program will follow a discussion of some general information about GW's background and his progress in the institutionally based program.

GW reported that he had felt somewhat isolated and lonely for most of his life. He described having had a head injury after which he found it difficult to relate to age appropriate peers. He noted that he developed a problem related to drinking in his late adolescence and early adult years. His existence was fairly marginal in that he could manage to keep jobs that involved manual labor until such time as his activities resulted in his being charged with one or another crime and his being incarcerated. GW reported some level of social support from his immediate family and reported one relationship of two years or more, however difficulties were noted with reference to his relationships with both family members and his

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past wife (they have been divorced for quite a number of years at present). GW reported being close with his father but also described his relationship with his father as being one in which some level of neglect/abuse was common.

GW presented as being unmotivated for treatment when he first began the RTCSTP. The report from RTCSTP describes GW requiring quite a bit of time to become comfortable with the process of therapy. We have found that this type of presentation is very common with lower functioning clients, especially those with a history of abuse/neglect. This is likely due, at least in part, to attachment difficulties and a sense of concern for one's personal safety in a federal institution. With time, GW became more comfortable with the psychologist whom he was seeing at the RTCSTP and began to believe that she was on his side and not trying to use whatever information he offered against him. The fact that GW was living on an inpatient unit where professional staff spent at least part of each shift interacting with clients likely also contributed to this sense of safety. It should be emphasized that, for clients attending the RTCSTP some form of attachment insecurity is typical. Our data suggest (See Abracen & Looman³, 2016) that the majority of clients attending the RTCSTP have experienced some type of abuse or neglect during their formative years, typically by persons who were responsible for their safety or wellbeing. It is therefore not surprising that it would take some time for such clients to trust treatment staff, especially when many of our clients have typically had adversarial relationships with correctional staff in the past. It is our view that such resistance is to be expected in the clients with whom we work and that it will take time for such clients to develop trust with their primary therapist. This is in keeping with the views of Yalom⁹ (1995) who noted that much of the work of therapy isn't simply done during sessions but

also between sessions, when clients have an opportunity to reflect on the material that was discussed.

Once rapport was established, GW and his therapist completed an abridged version of the assignments that are typically completed in the full treatment program. GW began by completing an autobiography with the help of his therapist. The autobiography included discussion of both the periods where he had managed to remain offence free as well as the periods associated with his criminal behavior. As part of the autobiography GW was asked to provide his version of what happened during the three sexual offences for which he was convicted. This aspect of treatment, which we have simply termed the disclosure phase, is typically associated with some level of minimization or denial on the part of clients who we see. As is typically the case, GW admitted to having committed a sexual offence against one of his child victims but denied having committed the other two sexual offences on his record. In one case he simply stated that the allegation was false. In the other case he admitted to having had sexual relations with the adult victim but claimed that these relations were consensual in spite of there being ample evidence that this was not the case. Rather than adopting a confrontational approach with GW regarding the one offence that he denied and the other that he minimized it was decided to start working with him regarding having committed at least one sexual offence. Over time GW began to take responsibility for the offence against the adult victim but never fully took responsibility towards the victim he denied having sexually assaulted.

A number of sessions were spent addressing issues of negative emotionality with GW. Prior to beginning such discussion, however, GW was provided with a list of emotions and drawings of the facial expressions associated with those emotions. Many of the

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clients treated at the RTCSOTP have a very limited range of emotions of which they are aware. Clients are first encouraged to become familiar with a wider range of emotions and begin using these emotional terms in everyday conversation. Clients are also encouraged to understand that there is a link between the way someone thinks about a situation and the associated emotions. Clients are then encouraged to talk about their feelings and not “keep it in.” As well, clients begin to learn that they can think through their feelings by changing the way that they think about a situation. For example, if a client feels angry, it may be that he is misinterpreting information that is being presented to him. In this way, if he engages in active listening and checks out if his perceptions are correct, he may discover that he misinterpreted what is being said. Even if he has not misinterpreted what is being said, having this discussion with the other person might allow him to have some insight regarding the other person’s perspective. Clients also learn to develop skills in the area of empathy. For example, discussions occur regarding what empathy is and what it is not (e.g., mind reading-assuming what the other person is feeling). As a lack of empathy and negative emotionality can be risk factors for clients like GW this area typically is discussed for quite a few sessions. Clinicians should not assume that clients will be able to integrate this information quickly as emotions management and empathy may be skills that clients have never effectively developed.

Several sessions are also spent addressing issues associated with cognitive distortions. For example, while at RTCSOTP GW learned that some of his attitudes were associated with cognitive distortions which increased his risk of committing a sexual offence. For example, GW appeared to believe that “mature” children might be able to consent to sexual activity with an adult. Rather than being confrontational about the matter GW and

his therapist discussed how adults are in a position of authority over children and therefore children cannot consent to such activity. The fact that children simply don’t understand sexuality in the same way that adults do is also discussed with clients.

Aside from addressing issues associated with the autobiography GW and his therapist completed a self-management plan. The self-management plan included a list of internal (i.e., thoughts and feelings) and external (persons, places or situations) high-risk situations as well as a plan for how to manage these situations should they be encountered in the future. Time was spent developing a set of realistic ways in which GW could address high-risk situations in the future. This required quite a bit of time as GW presented with a number of cognitive distortions which interfered with his ability to develop positive plans. For example, GW noted that the “system” has acted in a particularly harsh manner towards him given his sentence length. He noted that, as he had served time for his previous offences these earlier offences should not have any impact on either his current sentence or any restrictions placed upon him when he was released to the community. Although a great deal of effort was put into addressing these distortions institutionally, it was felt that problems in this domain were unresolved when he completed the institutionally based treatment program.

GW was referred for additional treatment in the community both to address issues associated with cognitive distortions as well to help him apply his self-management plan in the community. GW was initially housed at a Community Correctional Centre (CCC: See Abracen, Axford & Gileno,¹⁰ 2012 for a more detailed discussion of CCCs). The CCC provides clients with a structured setting to live when first released to the community. All CCCs are operated by Correctional Services Canada (CSC) and include a staffing

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complement that includes security and parole staff. In the case of the Keele CCC where GW was first placed when released to the community, parole, psychology, nursing and psychiatric staff were also available to see clients on site. Clients typically have restricted access to the community when first released to a CCC but are quickly given additional sign out privileges unless inappropriate behaviour is suspected or observed. The psychology department as well as parole staff are housed in the same building as the CCC to facilitate communication regarding the management of the high risk offender populations who typically live at the CCC.

GW first attended community meetings with JA starting in 2003. As with all clients, the process began with a comprehensive assessment which includes a semi-structured interview and the scoring of several actuarial risk assessment measures. At the time that GW was first released to the community, he was still married and was hoping to move back home even though there were several young children present in the house. Although the fact that he could not live in an environment where children were present would certainly have been discussed with him at the RTCSTP, such selective memory is very common with the clients who we see in the community. It illustrates why there is a need to follow up with community based therapy, even though clients may have completed an institutionally based treatment program. It may be difficult to understand why someone with GW's history would initially state that there is no reason why he couldn't live with his wife (and the children who were present in the home) given the treatment he had received; however, for a client who anticipated being lonely and isolated, the thought of being in close proximity to people who he cared about would be very appealing. GW appeared to believe that he would not offend again and that therefore there was no reason for him to live anywhere other than with

his wife. The issue of high-risk situations was again reviewed with him and he quickly understood why this would represent a high-risk situation. It should be noted that had a more confrontational approach been taken in discussing these matters with GW he might well have distanced himself from the process of therapy. As it turned out, however, GW appreciated someone being honest and forthright with him but, at the same time, being able to be sympathetic as to why, at least in theory, he wanted to live at home with his wife.

When his wife later wanted to divorce him, GW and JA spent a number of sessions discussing the matter. Although he was quite sad about the divorce, he eventually began to understand why his wife might not want to be with him anymore. As well, GW became somewhat more confident that he did not need to be as isolated as he had been in the past. GW continued to use JA and other CSC staff as part of his social network (he would, for example, show up at unscheduled times just to say hello). As well, GW was able to form a relationship with an older lady living in the community. Although this lady also led a somewhat marginal existence their relationship did offer GW a source of support and was considered positive although not without its problems.

After living at the Keele CCC for several years GW managed to find a place to live independently in the community. He was able to support himself through disability benefits which he received. He was encouraged to develop a larger social network. Although GW never set up a network that members of his case management team were entirely satisfied with, he was able to establish at least some minimal level of social contact with prosocial members of the community. At the end of his sentence, GW still presented with some level of cognitive distortions however these appeared to be far less disruptive than when he first entered treatment. As well, GW understood that he

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must avoid areas where children congregate and should not be in unsupervised contact with children. GW also understood that he should not drink again as his ability to control his behavior was diminished when drinking. GW still comes to visit staff with whom he interacted while on conditional release just to say hello. He has remained offence free since being released to the community in 2003.

Discussion

It might reasonably be asked whether GW is typical of the high-risk clients who we have managed both at the RTCSTP and in the community. We have conducted a number of outcome studies both with those clients treated at the RTCSTP as well as those attending our community based programs. GW has been included in the datasets that we have compiled in both settings. We have recently produced a text that describes the outcome research which we have completed institutionally and in the community (Abracen & Looman, 2016³). These studies, which have included either matched untreated comparison groups and/or comparisons with expected rates of recidivism for a variety of actuarial instruments (e.g., the Static-99R), have demonstrated significantly lower than expected rates of recidivism among treated subjects. For example, Looman, Abracen and Nicholaichuk¹¹ (2000) followed a group of clients treated at the RTCSTP and a matched group of untreated sex offenders for approximately a 10 year period. Results indicated significant differences between treated and untreated subjects, with the treated subjects recidivating sexually at approximately half the rate of untreated subjects.

We have also completed a number of community based studies. For example, Abracen, Gallo, Looman and Goodwill¹² (2015) demonstrated a linear association between the number of individual therapy sessions completed with a psychologist in the

community and recidivism. In comparison to those clients who received no treatment or who were only assessed, those clients who received the most individual therapy (defined as over 20 sessions) were approximately 12 times less likely to recidivate. This study included both sexual offenders and non-sexual violent offenders among the treated group. With reference to sexual offenders specifically, Gallo, Abracen, Looman, Jeglic, and Dickey¹³ (2016) demonstrated that treated sexual offenders recidivated at substantially lower rates than would be predicted based on Static-99R scores. In fact, only one treated sexual offender recidivated sexually over an extended follow-up period.

In summary, we hope that some elements of the IRATS model may become more meaningful when discussed in the context of a particular client's history. The case of GW illustrates that high risk sexual offenders can be safely managed in the community even though a number of treatment issues may never be completely resolved. It is our view that having a case management approach in place where staff from several disciplines become involved likely contributes to successful outcomes. As well, the role of the therapeutic alliance cannot be overstated. It is our view that GW and the clients with whom we have been fortunate enough to work would not be open to the challenges that we make in therapy if not for the fact that they feel that their therapist is "on their side." Whenever possible clients are maintained in the community rather than incarcerated even when they present with behavior that is a source of concern (e.g., discussing the presence of a deviant fantasies). If we routinely punish clients for discussing thoughts that may be problematic, this likely serves the function of convincing clients to pretend that all is well and not to reveal any thoughts that they know or suspect that their therapist will object to. Although there will be occasions when clients need to be suspended

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(i.e., returned to a more secure setting) it is our view that this can be avoided in many cases. If a positive approach is adopted when working with clients we may be better able to safely integrate the clients with whom we work into community settings and allow these individuals to feel that they are more than simply sex offenders who are expected to fail.

Perhaps a statement we invariably make to all clients with whom we work is most illustrative of our perspective-we note that we may not approve of some of the behaviors in

which they have engaged, but simply by virtue of the fact that they are human beings they are entitled to respect and have the ability to change. From a more quantitative approach, we have observed very low rates of sexual offending in the subjects that we have treated relative to either predicted rates of recidivism or in comparison to matched untreated comparison subjects. The language used may differ but the implications are clear for those of us tasked with working with such challenging groups of clients.

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Figure I: The Integrated Risk Assessment and Treatment System (IRATS) Model

