

Risk Assessment: **A Short Introduction – Part I**

Sex Offender Risk Assessments are professional opinions about the likelihood of a particular individual committing another sex offense, other violent offense or general criminal offense within a particular time frame. Often they also include recommendations for managing and mitigating conditions that contribute to that risk. This article we will briefly explore the current state of the Sex Offender Risk Assessment art. In the next issue of Perspectives, we will look at procedures and instruments we can use to gather the information needed for a thorough risk assessment.

Obviously, opinion accuracy varies inversely with time frame length. It's easier to estimate reoffense likelihood for the coming week than the coming year. Whatever the time frame, the opinion can be based on:

- Traditional clinical observations and impressions
- Empirically guided information
- A structured risk assessment protocol
- An actuarial risk assessment tool
- A structured risk assessment protocol that includes an actuarial tool

Clinicians relying on traditional clinical methods generally utilize an unstructured combination of record information, interview impression and personality assessments like the MMPI-2, Rorschach, Millon Inventories, etc. This approach is faulty because:

- Although history is extremely important, clinicians relying on clinical opinion do not necessarily weigh the historical factors appropriately.
- Clinicians are no better than lay people at quickly judging an individual's character from relatively brief conversations. This makes them vulnerable to being charmed by clever con artists, judging people they dislike overly harshly, and simply being successfully lied to about relevant facts.
- Personality assessment instruments often describe an offender's personality quite accurately, but general personality characteristics and Axis I conditions do not correlate well with sexual reoffense potential.

Thus, although traditional clinical opinion is still widely used for conducting sexual offender risk assessments it is easily the least accurate method. Studies going back to the 1950's show that left to their own devices, mental health professionals, fearing false negatives (i.e. failure to identify a serious re-offender), tend to grossly over-estimate risk[1]. This results in large numbers of false positives. (Incorrect classifications of high reoffense risk.) False positive errors result in increased restrictions, including higher than necessary supervision levels and unnecessary incarceration. In addition to concerns over unnecessary restriction of liberty, this wastes scarce tax dollars that could be put to more beneficial uses.

Empirically guided clinical opinion relies on empirical research to focus on areas that are truly related to reoffense risk. For example, clinicians using empirical guidance know that psychopathy as measured with the PCL-R[2] correlates strongly with increased reoffense risk. Anti-social personality is less important and many mental illnesses like schizophrenia or bi-polar disorder are unrelated to reoffense likelihood except in cases where it can be shown they were instrumental in the conviction offense. (e.g., a statement that “*Mr. Jones’ thinking is intact and he evidences no signs of psychosis*” has little to do with his risk level.) Clinicians relying solely or primarily on empirical research for risk classification are likely to produce more accurate opinions than clinicians opining from traditional clinical information.

Structured risk assessment schemes are essentially information checklists. They are useful because they can help clinicians avoid missing potentially important information, and they provide a way of organizing clinical thinking. They are however, only as good as the information they include. Until recently, structured instruments were the best available option for improving unstructured clinical opinion. (e.g. The Peters and McGovern Rating Scale) However, these early instruments utilized a “current best practices” approach and were not empirically tested. They are now out-of-date, having been supplanted by actuarial scales and structured risk assessment tools that include actuarial information.

Currently available actuarial instruments like Static-99[3] and VRAG/SORAG[4] rely on a limited set of discrete pieces of information that are statistically combined to produce a numerical risk statement like; “42% of men in the XXX development population with characteristics similar to Mr. Jones committed a sexual reoffense within 7 years of institutional discharge.” Such instruments resemble insurance tables in that they tell us what proportion of a particular group is likely to manifest the characteristic of interest (reoffense) within a particular time frame but tell us nothing about which individuals within the group will be the ones to manifest the characteristic.

It is important to note that empirically supported risk factors fall into two groups: static and dynamic. Static factors cannot be modified. (date of birth, legal history, marital history, etc.) Dynamic factors are subject to modification over time. (alcoholism, personality traits, social skills, etc.) Dynamic factors can be divided into “acute” and “stable” categories. Acute dynamic factors (drunkenness, mood) correlate with immediate reoffense risk (moments - days) while stable dynamic factors (alcoholism, mood disorder) correlate with intermediate term reoffense risk (weeks – months). Static factors are used to classify long term risk. (years)

At this writing, all empirically validated actuarial instruments rely on static factors because, being immutable, they are more dependable than dynamic, or changeable factors. (i.e., an alcoholic may resume drinking after a 10-year remission but a 30-year-old man will never be 25 again.) However, static instruments have two disadvantages:

1. Because they identify unchangeable features, they do not offer opportunities for intervention.
2. Although they accurately estimate long-term risk (e.g., 25% of men in a pool will reoffend within 5 years) they give no hint about which of these men will be the reoffenders or when reoffense is becoming imminent for a particular individual.

For this kind of information, we have to rely on dynamic factors. For example, when we see a particular individual becoming more depressed and socially isolated, we have reason for concern that dynamic reoffense risk is increasing. If some of his previous offenses were committed under the influence of alcohol and we know he recently lapsed by drinking two beers, we have that much more to be concerned about. However, if he was never alcoholic and drinking was not part of his offending pattern, alcohol use might serve as a protective factor by mitigating stress that could potentially contribute to increased risk.

Thus, static factors are best suited to long-term risk classification. They are generally used to help determine which individuals are suited for community placement and appropriate supervision levels for those people. Dynamic factors help supervisors target the most important factors to monitor for a particular individual, help clinicians focus their treatments and alert us when an individual appears to be moving closer to reoffending. At present we have no fully validated actuarial schemes based on dynamic factors but one, the Sex Offender Needs Assessment Rating (SONAR) [5] has been partially validated and, pending further work, is ready for cautious use.

Some professionals argue that actuarial risk classification using static factors is already so superior to other methods that the risk estimates these instruments produce should be used without considering other, more case specific information[4]. And it is true that no group of clinicians, regardless of training and experience, has ever outperformed a task-appropriate actuarial tool.[6]

Nonetheless, most practicing clinicians are not prepared to rely on actuarial scales alone, arguing that these instruments reflect limited information sets that omit important variables. For example, Static 99, probably the most popular actuarial instrument in current use, does not include sexual interest/arousal information because that information is often difficult to come by. Instead, Static 99 relies on sexual arrest history as a proxy variable for sexual deviance. However, deviant sexual arousal is well established as the single most important factor predicting sexual reoffense[7] and it is entirely possible for an individual with a deviant sexual arousal system to have no arrest history. Thus, if plethysmography data is available and indicates significant deviant arousal it makes sense to adjust actuarial risk estimates upwards when arrest history does not reflect the measured level of deviance. Similarly, an individual with an extensive sexual arrest history for rape-like crimes may have recently become wheelchair bound, thereby lowering what would otherwise be a very high likelihood of further rape-like crimes.

Recent structured risk assessment protocols generally include an actuarial instrument but modify actuarial risk in a structured way using information not included in the actuarial tool. (e.g. SRA) Whether or not a structured protocol is used, the best currently available approach to sex offender risk assessment involves:

- Using an actuarial instrument like Static 99 to establish baseline risk.
- Considering as many other empirically supported risk factors as possible to *conservatively* modify baseline risk when indicated. (e.g. psychopathy, sexual deviance, available supervision level, likely treatment motivation, etc.)
- Measuring dynamic risk factors with the best tool currently available for that purpose, the semi-actuarial “SONAR,” to monitor ongoing risk and target relevant dynamic factors with specific treatment interventions.

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