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Issue Brief

Assessing Risk for Inappropriate Sexual Behavior: Advice from the 2006 Mentally Ill/Problematic Sexual Behavior Program Summit

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In an unprecedented event, Laurie Guidry, Psy.D., Director of the Massachusetts Department of Mental Health Mentally Ill/Problematic Sexual Behavior (MI/PSB) Program recently organized the first summit conference of its kind to discuss best practice applications for assessing, treating and managing the MI/PSB population using a panel of state and national experts. One of the most prominent topics of conversation was how to assess risk for future problematic sexual behavior. This issue brief describes public concerns about this topic, some background of risk assessment, and expert opinions expressed at the summit about practices with the MI/PSB population.

Background

Sexual offending is a major public health concern due in part to perceptions of its resistance to treatment. Many states have enacted Sexually Violent Predator (SVP) statutes to extend the confinement of sex offenders indeterminately, and/or state sex offender registries to institute long-term tracking of released sex offenders and community notification to all residents within the proximity. However, these strategies are not always satisfactory to the public. Indeed, in Massachusetts, the Marlborough City Council tried to pass an ordinance effectively banning any sex offenders from living within the city limits. What the public fails to recognize is that most sexual offenders do not re-offend. Studies indicate that the sexual re-offense rate of the average sex offender over 5 to 6 years is 13.7%.[1]

The nature of sexual offending among the chronically mentally ill population with problematic sexual behavior is typically less severe than the average sex offender (e.g., exposing oneself in public while psychotic as opposed to committing an act of rape). Less than 1% of persons obligated to register as sexual offenders are clients of the Department of Mental Health. Nonetheless, public concerns about sex offenders have had an unfortunate impact on the release of patients within the Massachusetts mental health system who have some history of sexual misbehavior, prompting the need for risk assessment.

Demand for Risk Assessment

Sexual offenders are more likely than any other offenders to undergo psychological evaluations of their risk for re-offending. Preventive detention hearings frequently call on psychological or psychiatric experts to assess whether a person is at elevated risk for engaging in future sexual offending. This aids courts and mental health boards in their determinations about continued confinement versus release into the community. This system challenges these professions to determine with greater precision who is likely to recidivate sexually.

Actuarial Risk Assessment Instruments (ARAIs)

One approach was the development of "actuarial" risk assessment instruments (ARAIs). ARAIs often use a formal procedure to make a judgment about the statistical likelihood that a sex offender will engage in a future illegal sexual act. Typically, developers select items based on past behavior due to their statistical association with a given outcome (e.g., reoccurrence of sexual violence) in a particular development sample. For example, the most widely used sex offender ARAI[2], the *Static-99*, attempts to predict future behavior among adult males convicted of at least one sexual offense against a child or non-consenting adult by

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assigning examinees to groups characterized by factors associated with lower or higher risk.

Concerns About ARAIs With the MI/PSB Population

The predictive validity of ARAIs often depends on the characteristics of the people on which the tool was developed. Specifically, many of the tools were designed based on what variables best predicted an outcome, and in what manner they predicted, in a particular development sample. There is no way to tell how much of the observed relation between the variables and recidivism is due to unique characteristics of the development sample and how much will generalize to new samples.[3] This may be particularly problematic when dealing with the MI/PSB group for several reasons raised at the summit, some of the most important being:

- *Relevance of Development Samples to MI/PSB Group:* ARAI development samples tend to be prisoners and/or forensic psychiatric patients with major sex offenses who are often not chronically mentally ill. By contrast, many of the MI/PSB group have committed only minor sexual violations and have severely impairing, chronic major mental illnesses. This can affect the predictive power of ARAIs for an MI/PSB patient, which varies based on setting (e.g., hospital vs. prison) and offender characteristics (e.g., rapist vs. child molester).

- *Require Offense History:* For statistical reasons, ARAIs are not appropriate for use among people with no prior arrests for sex offenses – a large percentage of the MI/PSB group has never been charged with a sexual crime. Though sexual violations while under institutional care may suffice as a "prior arrest," the operational definition for this is poorly defined and difficult to apply.

- *Lack Clinical Utility:* The items on ARAIs have little to no clinical relevance, so they do not aid treatment or risk management.

Recommendations from the MI/PSB Summit

- *Use Procedures with Clinical Utility:* Tools should identify characteristics or risk factors that can be targeted for intervention to reduce a patient's risk (e.g., symptoms of mental illness, sexual deviance, permissive attitudes toward sexual violence).

- *Use Procedures that Assess Changes in Risk (Plan to Re-Evaluate Risk):* According to most ARAIs, "once a high risk, always a high risk." If the goal is to manage potential risk in the community at some point, the danger of ARAIs is that they give a score that doesn't go away. Grisso[4] called this the "tyranny of static variables" because examinees could "be doomed to perpetual commitment."

- *Include Contextual Variables/Triggers:* Use procedures that include an assessment of a patient's potential triggers and supports in the community.

- *Maintain a Database:* Develop information about the relevant risk factors unique to the MI/PSB population that can be shared more broadly.

- *Use Clinicians with Expertise in Chronic Mental Illness:* Training with the chronic mentally ill population is more important than forensic training.

In general, experts' preferred approach included assessments involving a narrative and full history of the patient with information about the community the patient may be released to, supplemented with evidence-based risk assessment tools (e.g., the *Risk for Sexual Violence Protocol*[5]) that are relevant for the particular patient. In some cases (i.e., when dealing with a patient who is also a convicted sex offender) ARAIs may be relevant but they should always be supplemented with vast clinical information.

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