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Should Actuarial Risk Assessments be Used with Sex Offenders who are Intellectually Disabled?

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Background Objective actuarial assessments are critical for making risk decisions, determining the necessary level of supervision and intensity of treatment (Andrews & Bonta 2003). This paper reviews the history of organized risk assessment and discusses some issues in current attitudes towards sexual offenders with intellectual disabilities.

Method We present two risk assessment tools (RRASOR and STABLE-2000) that appear to have practical utility with this population. Data are presented from a community sample of 81 sexual offenders who are intellectually disabled suggesting that the RRASOR may provide a useful metric of risk for this population. Dynamic risk is assessed using the STABLE-2000. This tool, based on 16 areas empirically associated with sexual recidivism, samples the individuals' current behaviour, skill deficits and personality factors. Change in these factors serves to flag the supervisor to changing risk levels.

Conclusions In addressing the question of whether we should seek special risk measures normed on people with intellectually disabilities, given the current lack of alternative tools, we conclude that it is reasonable to make use of the risk assessments that have been validated on the general sex offender population.

Keywords: developmental, intellectual disability, risk, sex(ual) offenders

The treatment of people with intellectual disabilities in conflict with the law is different from the way in which 'normal' offenders are treated (Hingsburger *et al.* in press). Assessment of risk to reoffend is one of the most obvious and controversial differences. Non-intellectually disabled offenders are routinely assessed with a wide range of actuarial risk assessment tools (see Appendix). Based upon measurable factors in the offender's past, these risk assessment tools have now reached a level of accuracy where they should be used as a matter of course (Barbaree *et al.* 2001; Sjöstedt & Långström 2001; Doren 2002). Routine use of these tools allows us to determine the level of risk each offender presents and apply treatment and supervision resources accordingly (Andrews & Bonta 2003).

But are these tools appropriate for use with sex offenders who are intellectually disabled? The application of these tools should occur only if there is reasonable expectation of benefit to this population. Some commentators have understandable fears that the use of actuarial measures will only increase the stigmatization of this population. On the other hand, we must consider if the lives and liberty of intellectually disabled sexual offenders are being unjustly restricted because some practitioners are reluctant to adopt formalized risk assessment.

History of Risk Assessment

Bonta (1996) describes the historical progression of risk assessment, starting with the 'first generation' of risk assessment, usually described as 'clinical judgement.' Clinical judgement is a subjective process based upon theory and practical clinical experience. Some staff working with individuals with an intellectual disability who have sexually offended believe risk assessment is best based solely on the staff's knowledge of the individual and the individual's current behavioural patterns. Even though multidisciplinary teams are now often involved in the overall direction of the assessment and treatment, these teams rarely use structured risk assess-

ment and front line staff are often forced to make independent risk-relevant decisions, such as, 'can Robert go to the mall on Friday night'. This is problematic as each staff member who interacts with the client will have their own perception of risk, based upon their own unique experiences, their knowledge of the literature, and their depth of familiarity with the individual. This often leads to inequitable treatment of the individual even within the same agency.

Clinical judgement includes no objective criteria and often puts considerable weight on factors that have been shown not to be related to risk of sexual re-offence (such as denial of the sexual offence), while ignoring other factors that have been shown to predict sexual re-offence (such as holding attitudes that support sexual offending). For a concise review of the factors that do and do not predict sexual re-offence refer Hanson & Morton-Bourgon (2004).

This lack of an observable process makes judgement replication and accountability almost impossible. Processes of this nature have been shown to be open to idiosyncratic individual interpretation and do not perform well in comparison to more structured risk assessment methodologies (Menzies *et al.* 1994; Andrews & Bonta 2003; Hanson *et al.* 2003). By not taking into account those risk factors identified in research (Hanson & Morton-Bourgon 2004) it is easy to misjudge the person's risk and potentially expose them to a risk situation for which they are not prepared or, conversely, restrict someone's liberty without just cause.

The 'second generation' of risk assessment assigns either points or a weighted score to factors that have been shown in the literature to predict sexual recidivism, creating a scale or metric of risk. These metrics are then compared with follow-up recidivism data to determine a valid and reliable measure of risk (within reasonable margins of error). This type of assessment is generally referred to as 'actuarial assessment'. It is called 'actuarial' because, much like auto insurance rate estimation, it calculates levels of risk based upon past performance to make a prediction of future performance. This method of risk estimation is justified as it relies upon one of the strongest and never violated rules in psychology, that the 'best predictor of future behaviour, is past behaviour' (Thorndyke 1911). Early versions of these tests have most commonly contained only 'static factors' (see box text) that, once accurately assessed, estimate long-term sexual recidivism risk (see Appendix).

Because these tests contain only historical, static variables they are generally insensitive to changes in risk level. This insensitivity means that they cannot be used to assess changes in risk over time or gauge the success (pre–post) of treatment regimes. As a result, when some people have assessed individuals with intellectual disabilities only with static based measures they assume that the assessed level of risk is a non-changeable fact. In several cases to our knowledge this has led administrative authorities, often with the best intentions, to attempt to protect the public by severely, unethically, and possibly illegally, imposing behavioural and environmental restrictions that compromise quality of life and individual freedom.

> *Static Risk Factors*, are historical, generally unchangeable indicators of risk that have been seen in the literature to correlate with sexual reconviction or re-offence in adult males. These factors generally represent behaviours or conditions that have happened or existed in the persons past. Examples of useful static risk factors are the perpetrator's age, number of past sexual offences committed, and preferential choice of victim.

The 'third generation' of risk assessments include dynamic factors, factors that have been shown to be associated with sexual recidivism but, unlike static factors, can be seen to change over time and with effort. 'Stable' dynamic factors are intermediate-term attitudes and skill deficits that indicate treatment needs. These stable dynamic predictors can be influenced by treatment or other intervention and, if repeatedly assessed over time, can track changes in the offender's risk level, for better or worse.

Dynamic risk assessments should be used in conjunction with a static, actuarial measure to provide both a baseline risk appraisal (static factors) and an appraisal (dynamic) that can track changes in risk level over time. In short, stable dynamic assessment points the way to treatment intervention in a way that clinical opinion or static actuarial assessment cannot. A commonly used static and stable measure will be reviewed later.

Current Attitudes and Approaches to Sex Offenders With Intellectually Disabilities

People with disabilities are regarded by some as asexual. As such, when sexual behaviour occurs, whether appropriate or inappropriate, it is reacted to as problematic – behaviour that must be reduced. Normative sexuality and the appropriate adult sexual expressions of those in our care has never been directly addressed, accepted or acknowledged within some agencies. Only recently have agencies begun to develop policies that

allow or facilitate adults with disabilities to form healthy sexual relationships. In some community-based organizations policies supporting client rights to sexual expression and practical guidelines to assist staff and caregivers in helping their clients fulfil these basic human needs do not yet exist. The systemic denial of any sexual life for this population, in our view, leads to a climate where all sexual expression is seen as deviant and, as such, is repressed. For people with lives that are often externally controlled, it is possible that blocked age-appropriate and socially appropriate sexual expression may lead to inappropriate sexual behaviour.

Within agencies the inability to appropriately label and describe risk may well prevent appropriate intervention on those issues that will get the person back into sexual trouble. It sometimes happens, that because of the presence of a seemingly 'over-riding' diagnostic concern (Intellectual Disability) the significance of the individual's problem behaviours are not recognized, not diagnosed, and as a result, are not treated. Reiss *et al.* (1982) have described this as 'diagnostic overshadowing'. We have all experienced this when sexually deviant behaviour in this population is explained away as 'he just doesn't know any better' or when sexual behaviour is blamed on the disability as in, 'that's what they're like'. In individuals with sex offending histories, non-recognition of the gravity of the sexual behaviours may result in the individual being denied treatment and supervision resources that would normally be available if the person did not have a diagnosis of intellectual disability.

In addition, because standard risk evaluation measures have been neglected with this population the staff that work in this area have a severely limited vocabulary for describing risk and risk factors. There is no general agreement among staff and caregivers of what constitutes 'high' risk, never mind 'low' risk. This leads to an unfortunate tendency to 'err on the side of caution'. As a result, it is our experience that, many more of those in our care are labelled 'high risk' than need be.

Within the group of professionals that work with people with intellectual disabilities there is often a tendency to see the population of people with intellectual disabilities as 'different' and hence no measures developed on other populations can be used. In addition, there is a natural reluctance to apply risk measures developed on 'criminals' to individuals within our care. Identification of risk or labelling the person as being at risk of a certain criminal behaviour is a double-edged sword. Labels have been used against this population to restrict their lives and liberty and to enhance their feeling of 'otherness'. On the other hand, if seen as problem identification, labels can sometimes open doors to services and much needed community based resources that would otherwise be denied to people with intellectual disabilities.

However, as has occurred historically, labelling a person at risk because he is intellectually disabled does not help us to address the factors that will get him back into trouble, for although we are effective at teaching skills, we can only minimally treat or remediate intellectual disability. We can, however, treat sexual behaviour problems (Hanson *et al.* 2002) and specifically those of people with intellectually disabilities (Ward *et al.* 1992; Hingsburger *et al.* 1999; Tough & Hingsburger 1999; Haaven & Coleman 2000).

With these 'pros' and 'cons' of risk assessment in mind we must carefully consider the following question, 'If we do not generalize techniques that are in common usage within a normal population, do we deny potential benefit to people with intellectual disabilities?' Our position is that it would not be helpful to adopt any tool or technique that does not offer specific benefits to individuals with intellectual disabilities.

Should We Have Our Own Measures?

It could be argued that we should not use actuarial measures developed on sexual offenders of normal intelligence for individuals with intellectual disabilities who display sexually inappropriate behaviours. However, the simple truth is that nobody has developed a reliable static actuarial measure specifically for the population of people with intellectual disabilities. There is no scientific reason to believe that static and stable factors that reliably predict risk for a normal offender will not reliably predict risk for offenders from the intellectually disabled population. Indeed, what data exists (Tough 2001a,b) suggests that these same factors predict quite well within the intellectually disabled population.

For example, the STABLE-2000 (Hanson & Harris, 2000) assesses six areas of stable dynamic risk. Few would argue that a sexual offender who is intellectually disabled with an impulsivity problem is less risky than one without or that a sexual offender who is intellectually disabled who holds attitudes that support the sexual assault of children is less risky than one who does not hold such attitudes. There are no published reports in the literature to substantiate the position that there are different risk predictors for individuals who are intellectually disabled. Hence, until someone demonstrates that risk for sexual re-offence is different in the intellectually disabled population it is reasonable to

apply measures that are used in the general, non-intellectually disabled population.

Static Actuarial Assessment of People With Intellectual Disabilities

One specific practice group, Behaviour Management Services (BMS) of York Central Hospital, has routinely been using both static and dynamic risk prediction methodologies. This sample consists of 81 intellectually disabled sex offenders showing a range of intellectual disability (28% borderline, 40% mild and 24% moderate). At this time BMS supports these 81 offenders in the community, and has done so for an average of 7.7 years (SD = 5.0) (minimum follow-up = 0.4 years; maximum follow-up = 22.75 years). Behaviour Management Services uses the RRASOR (Hanson 1997) as its standard measure of static risk. This is a four-item actuarial scale that assigns offenders to one of six risk levels, each with associated risk estimates for sexual recidivism, stated as percentages at 5 and 10 years. Figure 1 presents the percentage of these 81 people at each level of risk.

From Figure 1 it can be seen that most individuals being supported in the community are in the low- and moderate-risk categories. Although a score of up to 6 is possible on the RRASOR, no one in this community sample scored above 4.

As a result of using an objective risk assessment tool such as the RRASOR, BMS can aim its resources where they will do the most good (see box text of Andrews & Bonta). Instead of pouring resources into all these individuals with the supposition that all are high risk, BMS can portion out resources in a way that acknowledges the risk principle. BMS can supervise low-risk offenders with a low intensity of supervision, moderate with moderate and the higher-risk individuals with the most intense treatment and supervision.

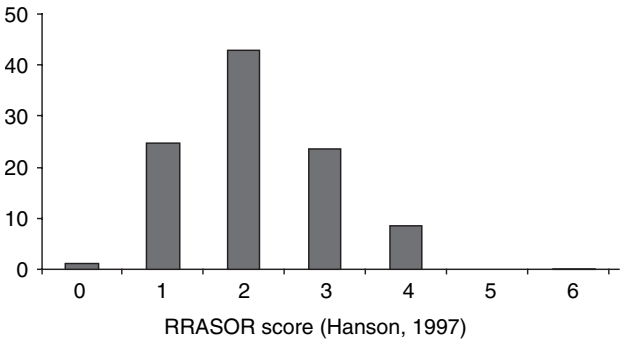

Figure 1 Percentage of offenders at each risk level ($n = 81$).

Andrews & Bonta: The Risk Principle

The risk principle (Andrews & Bonta 2003) tells us that the most effective use of treatment resources targets truly high-risk offenders and applies lower levels of resources to lower risk offenders. The greater the assessed risk, the higher the levels of intervention and supervision; the lower the assessed risk, the lower the levels of intervention and supervision. Indeed, research has suggested that offenders may actually be made worse by the imposition of higher levels of treatment and supervision than is warranted given their risk level.

But this still begs the question, 'Of what real benefit is this to the individual with an intellectual disability?' Objective and valid risk assessment allows most BMS clients to benefit by being considered for lower levels of supervision, more adequately tailored to their needs. This frees resources for individuals at higher risk of re-offence to benefit by having access to more targeted treatment and supervision resources, improving their chances of not reoffending. In addition, individuals who are not high risk can generally undergo treatment in the community while living with only the amount of supervision they truly require. This means that rather than living 'under house arrest' by virtue of an overly cautious view of their risk, they live with the freedom that their risk category allows. Before the regular imposition of static risk assessment the staff had no valid or reliable means to sort low-risk offenders from high-risk offenders.

Stable Dynamic Risk Assessment

An associated study, the Dynamic Predictors Project (Hanson & Harris 2001) has stable dynamic data on a sample of 52 sex offenders who have a significant intellectual disability. Parole and probation officers are supervising these gentlemen across all jurisdictions within Canada. These men were assessed using the STABLE-2000 (Hanson & Harris 2000) that assesses 16 areas of stable dynamic risk that have been empirically associated with the risk of sexual recidivism. Stable dynamic risk factors are personality characteristics and skill deficits that have been directly linked in the literature to sexual recidivism and these risk factors should be assessed about every six months. Stable dynamic factors, when changed through treatment should lead directly to a reduction in recidivism risk. This means a reduction in risk to the community and

a reduction in risk to the individual that he/she will be charged with another sexual offence or jailed. These areas of stable dynamic risk are divided into six major risk areas: significant social influences, intimacy deficits, sexual self-regulation, attitudes supportive of sexual assault, co-operation with supervision and general self-regulation.

Areas of STABLE Dynamic Risk

1 Significant social influences
2 Intimacy deficits
- Lovers/intimate partners
- Emotional identification with children
- Hostility towards women
- General social rejection/loneliness
- Lack of concern for others

3 Sexual self-regulation
- Sexual pre-occupations/sex drive
- Sex as coping
- Deviant sexual interests

4 Attitudes supportive of sexual assault
- Entitlement attitudes
- Attitudes supporting sexual assault – adults
- Attitudes supporting sexual assault – child molester attitudes

5 Co-operation with supervision
6 General self-regulation
- Impulsive acts
- Poor cognitive problem solving
- Negative emotionality/hostility

Appropriately trained parole and probation officers in the community can reliably assess these 16 risk areas. We propose that, in the absence of better validated tools normed on an intellectually disabled population these risk factors can be used to guide risk decisions, supervision and treatment in the community by those who care for individuals with intellectually disabilities. While the static risk level will never go down because of the historical nature of static assessment, the stable dynamic risk level can be re-evaluated as the individual finishes courses of treatment (decreased risk) or begins to associate socially with other people who have sexual offending behaviours (increased risk). It should be kept in mind that stable assessment, at this point in its development, has not been statistically validated. Stable assessment should be regarded as 'empirically informed guided judgment'. While not perfect, stable dynamic assessment remains the best option available at this time for the community supervision of all sexual offenders.

Conclusion

If we are going to support the rights of people with intellectual disabilities as full citizens we must address in our services and our care all aspects of their sexuality. This must include the rational and empirical contemplation of how to assess and treat individuals when they display sexually inappropriate behaviours.

One of the great benefits of valid and reliable risk assessment is that it gives everyone a metric of risk, a common language to describe and discuss the level of danger that a given individual presents. By having words and terms that describe specific risk areas and treatment needs, staff are able to engage in an individualized, informed debate concerning the support needs of their clients. Clinical staff can then make service, supervision and treatment decisions based upon replicable and justifiable assessment.

It is important to emphasize that the assessment of risk and the use of the assessment instruments require training. The scoring of actuarial measures looks deceptively simple. Unfortunately, for already financially stretched service agencies this entails training costs and staff development activities removed from direct service provision. As a result, generally, the completion of risk assessment tools and risk evaluations should be done only by trained clinical staff who then work collaboratively with front-line staff on treatment and supervision decisions.

Comprehensive dynamic assessment allows an evaluation of risk over time. The individual is no longer locked into a state of perpetual risk. The team can enhance support and supervision if the person presents more risk and increase personal liberty and independence when the person's risk diminishes. It is worth pointing out that when an individual is locked into a permanent risk state without benefit of dynamic re-evaluation, we as clinical supports are also locked into the same state with no opportunity to adjust our services relative to changes in risk over time.

Finally, we regard not doing risk assessment with this population as ethically suspect. Not assessing individual risk, needs and developing a personal treatment plan for these individuals could be seen as indicative of an attitude that sees those with sexual offending behaviours as monolithic. Perhaps, even as a group that does not deserve service. In all other areas of service delivery we strive to enhance and support the individual. Those in our care who exhibit sexually offending behaviours deserve no less.

Notes

RRASOR, STATIC-99, the Coding Manual for the STATIC-99, and the new Hanson and Morton-Bourgon Meta-analysis (2004) can be downloaded from the website of Public Safety and Emergency Preparedness Canada: http://www.psepc-sppcc.gc.ca. Click on 'Corrections Publications'; see years 1997, 1999, 2003 and 2004.

'Word' versions of the STATIC-99, the Coding Manual for the STATIC-99 and the Coding Manual for the STABLE-2000/ACUTE-2000 can be requested by e-mailing Andrew Harris at either harrisaj@csc-scc.gc.ca or harrisa@psepc-sppcc.gc.ca.

The views expressed are those of the authors and do not necessarily represent the views of Public Safety and Emergency Preparedness Canada or York Central Hospital.

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