



Research Bulletin: Clinical and Structured Assessment of Sex Offenders



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During the summer of 2006, the Division of Probation and Correctional Alternatives (DPCA) conducted a survey of local Probation Departments to assess sex offender management practices. Among the resulting recommendations was that DPCA draft and disseminate a series of research bulletins on issues related to sex offender management so that probation officers in the field would have the latest information.

This bulletin represents the second in a series expected to be completed by the end of 2007 that will examine issues specific to managing sex offenders in the community including assessment, pre-sentence investigation, treatment, supervision strategies to reduce risk, the use of technology such as the polygraph, Global Positioning Systems (GPS) and forensic computer searches.

A copy of the survey and results can be found at :

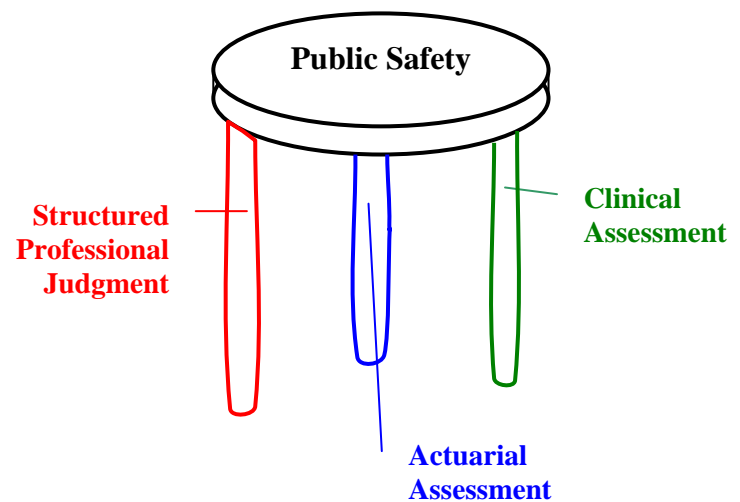
<http://www.dPCA.state.ny.us>

This research bulletin will build upon the first¹ by introducing concepts related to structured assessment and instruments that foster collaboration among probation officers, clinicians and treatment providers². While the instruments are referred to as clinical or structured, many of them are also actuarial in that they predict violent and/or sexual recidivism, and most have been cross-validated with a community corrections sample. The assessment instruments presented here can be administered by a clinician or a probation officer under certain circumstances (e.g. with access to results of recent examinations), and some include the results of other established clinical assessment instruments. However, they all require training, some clinical, on their specific development and application.

Assessment is best considered as a three-legged stool. The top represents public safety: risk management and victim protection. Victims include known and potential victims.

Supporting public safety are:

1) actuarial assessment methods to determine the potential for both short and long term risk; 2) structured clinical assessment methods to evaluate historical and current situational factors that may affect amenability to treatment and risk of offending while under supervision; and 3) structured professional judgment which in many ways mirrors the continuous assessment done by probation officers in the field. All strategies are based on empirical evidence regarding risk and protective factors.



¹ <http://www.dPCA.state.ny.us/pdfs/somgmtbulletinmay2007.pdf>

² Although the instruments presented here are considered to be based on structured judgment, most are limited to relatively static variables. Two contain a number of dynamic variables: the Acute and Stable and the Treatment Progress Scale.

The clinical (actuarial) assessment instruments included in this bulletin are limited to the Violence Risk Appraisal Guide (VRAG) and the related Sexual Offense Risk Appraisal Guide (SORAG). The Hare Psychopathy Checklist (PCL) will be included in a subsequent bulletin because while it may be predictive of reoffending, it is one-dimensional as opposed to the multi-dimensional clinical instruments and those based on structured professional judgment discussed here; including the Acute 2007 and Stable 2007, Sexual Violence Risk-20 (SVR-20), and the Sex Offender Treatment Needs and Progress Scale (TPS).

Overview of Assessment Methods

Recent meta-analysis comparing the predictive accuracy of four types of assessment provides short descriptions of assessment approaches along with comparisons of their predictive accuracy (Hanson and Morton-Bourgon, 2007):

1. the “empirical actuarial approach” in which “items are selected based on observed relationships with outcome, and explicit rules are provided for combining items into an overall evaluation of risk” (e.g. SORAG, Static-99³);
2. the “conceptual actuarial approach” where “the final judgment is determined by explicit rules, but the items are selected based on theory” (e.g. Acute and Stable, and TPS);
3. structured professional judgment, defined as requiring “evaluators to rate a list of pre-determined items, but the final evaluation is left to professional judgment...[and is] promoted as providing clinically meaningful case formulations while avoiding the dismal predictive accuracy associated with the unstructured clinical approach”; and
4. unstructured professional judgment in which “risk factors are not specified in advance, nor is the method of combining the risk

factors into an overall evaluation of risk.” (p. 3).

The observed recidivism rates in the meta-analysis cited above were: 12.4% sexual recidivism, 17.5% violent (including sexual), and any recidivism was 30.1% (Hanson and Morton-Bourgon, 2007).

In comparing assessment approaches, the empirical actuarial measures ($d = .70$, CI⁴ of .64 to .75)⁵ performed better in predicting sexual recidivism than unstructured professional judgment ($d = .43$, CI of .28 to .58), but there was little difference in predictive accuracy between the empirical and conceptual actuarial measures ($d = .66$ and .66, respectively, CI of .56 to .75). Structured professional judgment was shown to be in the middle ($d = .42$, CI of .25 to .60) (Hanson and Morton-Bourgon, 2007)⁶.

It should be noted that research into predictive accuracy with structured professional judgment has until now been considered preliminary due to methodological issues (small samples, variation across studies in methods, low base rates, statistical techniques) hence low explanatory values in meta-analyses. However, recent research has indicated strong predictive ability of at least one of the instruments (e.g. Knight and Thornton, 2007)

While unstructured judgment (opinion) is relevant in many contexts, it is not when it comes to risk assessment due to its inaccuracy in predicting reoffending, lack of structure, and potential for bias in the risk factors considered. Structured assessment

⁴ A confidence interval is the probability that scores will fall within the range provided, usually set at 95%.

⁵ Briefly, the d statistic is a standardized measure of effect size capturing “...the average difference between the recidivist and the non-recidivist, and compares this difference to how much recidivists are different from other recidivists, and how much non-recidivists are different from other non-recidivists.” It is less influenced by base rates than correlation coefficients. Values of .20 are considered small, values of .5 are considered medium and values of .8 or greater are considered large. Hanson and Morton-Bourgon (2004, p. 6-8).

⁶ Scores for structured professional judgment presented are with the removal of an outlier; with the outlier the scores are $d = .57$, 95% CI of .41 to .73. The nature of the outlier data is unknown.

³ Hanson and Thornton (1999). Static 99: Improving Actuarial Risk Assessments for Sex Offenders. Department of the Solicitor General of Canada.

is more accurate than unstructured assessment, but less accurate than actuarial assessment. Finally, adjusted actuarial assessment refers to the practice of completing an actuarial assessment, but allowing for overrides based on clinical (sometimes empirical) knowledge. Doren (2002) suggests three circumstances under which adjustments may be made:

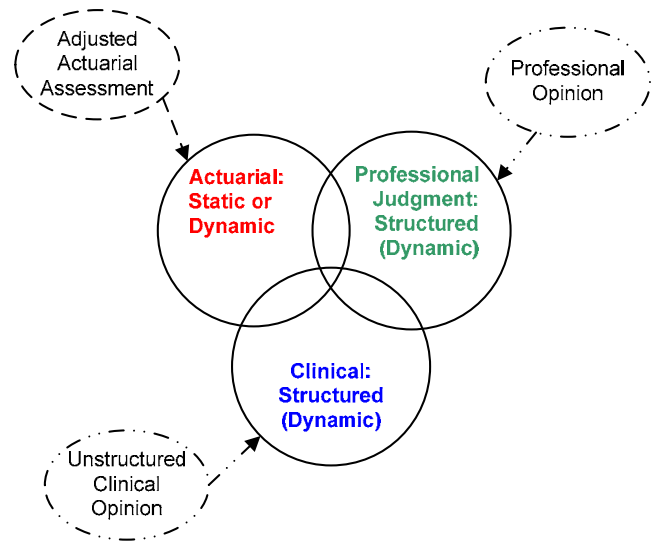
1. “When research has demonstrated the information to add incrementally to the actuarial instruments’ predictive (or postdictive) accuracy [for example, a specific measure of deviant sexual tendencies not captured in the instrument.]
2. When the information (or set of case characteristics) is clearly beyond the actuarial scheme [for example, female or developmentally delayed offenders]
3. When there is a rare characteristic in the case for which there is also an obvious degree of associated risk or protection even if never researched” (p. 164, internal quotes omitted.) [for example, a violent sexual offense resulting in serious physical injury or death.]

Recent research indicates that overrides judgment may lead to a *decrease* in predictive accuracy (Hanson, Harris, Scott and Helmus; in press). Therefore, modifying a resulting score can nullify the assessment.

In most instances, actuarial assessment does not allow for adjustment of the scores, whereas clinical assessment and structured professional judgment allow for incorporation of experience and practice within established professional guidelines but do not provide probabilities of reoffense. When probation officers encounter any of the three situations identified by Doren (above), it is best to forgo actuarial assessment altogether in favor of a structured assessment to gather information on risk factors, but refrain from providing any reference to risk.

As illustrated in figure one, ideally actuarial, clinical and structured professional judgment all contribute to an overall profile of risk. Inferior methods should be disregarded, as represented by the dotted and dashed lines in figure one. The research into the adjusted predictive abilities of the actuarial adjustments to the SVR-20 are promising, therefore the concept of adjusted actuarial assessment is represented in the figure below by the oval with the dashed line.

Figure One: Integration of Assessment Strategies



A somewhat different way to look at these interrelated concepts is to place them on a tri-level continuum, with the least accurate assessment methods to the left and the more accurate on the right:

Figure Two: Accuracy of Assessment Methods

| | | | |
|-----------------------------------|----------------------------------|--|--|
| Opinion | Clinical or Professional Opinion | Clinical Assessment or Professional Judgment | Actuarial or Actuarially-based Clinical Assessment |
| Dynamic | | Static or Dynamic | |
| Unstructured | | Structured | |
| Low accuracy <----->High Accuracy | | | |

Structured Assessment

The issue of structured assessment requires discussion because it can mean different things for clinicians and probation officers.

In his book on evaluating sex offenders for civil commitment, Dr. Dennis M. Doren⁷ presents guidelines developed by a group of practitioners representing ten states that had recently enacted a civil commitment law requiring clinical evaluation. Several of these guidelines may be useful to probation officers at the pre-sentence investigation and supervision stages, and are excerpted below (Doren, 2002, for the entire list see pages 28-30):

- Persons performing the assessment must have an “identified competence with all procedures employed”;
- The assessment must include a face-to-face interview if the subject is willing;
- A variety of resources should be used and self-reports shall be verified to the extent possible;
- All procedures are “in accord with the ethical principles of one’s own relevant professional organization”;
- The evaluator, under most circumstances, must “use some set of actuarial instruments, these being derived through scientific methods, where instruction is obtainable... Exceptions... need to be based on reasoned scientific argument, such as the lack of applicability of the available instruments to a specific case”;
- The evaluator has the responsibility to keep up-to-date with scientific knowledge as it relates to assessment methods and instruments;
- “Where there is empirical support to conclude that there are multiple dimensions to be assessed, then the evaluator needs to cover each of the relevant dimensions through the instrumentation chosen”; and
- The presentation of opinions related to risk should not be presented through the use of specific percentage of likelihood of reoffending.

The last point is of particular value. While the instruments presented here have demonstrated ability to statistically predict reoffending, not all of the authors provide tables showing reoffense rates over time or by risk level, instead they rely on the AUC/ROC statistical methodology to validate predictive ability. Similarly, it would be expected that the results of clinical evaluations would present offenders as high, moderate or low risk, or some combination thereof, rather than a statement to the effect of “...the probability of rearrest [re-offense] for this offender is...” Such statements are not only incorrect, but they may provide a false sense that a method exists to determine the actual odds of a particular offender recidivating when in fact, all we have done is compare this offender to similar ones who did recidivate, who are in turn being compared to like offenders who did not recidivate.

In contrast, the Association for the Treatment of Sexual Abusers (ATSA) released a position statement on assessment⁸, which is defined as “...the process of identifying the probability or likelihood of future dangerousness or harm...” but acknowledges that an assessment “...will always involve some degree of uncertainty about the truth of actual prediction...” and that “...the task of risk assessment is to strike a scientific and ethical balance among the identification of offenders, while optimizing public safety.” The organization has also created standards and guidelines for the treatment of adult male sexual abusers⁹, and a set of ethical guidelines that all clinicians involved in the evaluation or treatment of sex offenders should adhere to.

⁸ <http://www.atsa.com/ppAssessment.html>

⁹ These guidelines include: evaluation; intervention (relapse prevention, cognitive restructuring, empathy enhancement, interpersonal skill training, emotional management, sexual arousal control, family and other support networks, generalization); risk management; collaboration; and appendices on phallometry, viewing time measures, the polygraph, and medications. These guidelines will be referenced throughout this bulletin series where appropriate. Copies are available for purchase from www.atsa.com.

⁷ Dr. Doren is the Evaluation Director at Sand Ridge Secure Treatment Center, Mauston, Wisconsin.

The guidelines released by ATSA include that the purpose of and standards for a psychosexual evaluation¹⁰ are to:

“...determine a client’s risk to reoffend, identify dynamic risk factors, and develop appropriate treatment and supervision plans...[and to] provide guidance to others...in making decisions affecting a client’s future and whether the client’s risk can be managed in a community setting.”

“The psychosexual evaluation should include clear statements regarding the client’s dynamic risk factors, risk for reoffending, specific treatment needs, strengths, amenability to treatment, recommendations regarding the intensity and type of intervention that is required, and risk management strategies...a comprehensive description of the client’s abusive and nonabusive sexual behavior...address issues that could affect a client’s responsibility to treatment such as culture, ethnicity, age, IQ, learning style, neurophysiological disorders, personality style, mental and physical disabilities, medications, and motivation...” (ATSA, p. 11)

Structured Professional Judgment

A comparable approach is based on structured professional judgment, similar to research-guided clinical assessment discussed by Doren (2002), and speaks more to probation practice. The premise is the same: an empirically-based list of risk and protective factors is developed pertaining to a single topic, which may include subscales; scoring is typically based on the degree to which the item

¹⁰ Specifically, the psychosexual evaluation should include information from multiple sources on: community supports; access to potential victims; criminal or other antisocial behavior and values; developmental history and family background; deviant sexual interest and arousal; education and employment histories; history of aggression or violence; history of sexually abusive behavior (victims, tactics and circumstances); insight into precursors and risk; level of cognitive functioning; level of self-disclosure and accountability; medical and mental health history; official and unreported history of sexual and nonsexual crimes; peer and romantic relationship history; relevant personality traits; sexual history (including fantasies, urges and behavior); sexual relationships; masturbation and intercourse frequency; functioning and unusual sexual interests or behavior that are not sexually deviant or illegal (such as cross dressing); substance use; and use of sexually arousing materials (ATSA, p. 11-12).

applies to a case; and scores are usually weighted and/or summed in some manner.

Since probation officers in New York tend to not be clinicians, the structured professional judgment (SPJ) model promulgated by Dr. Kevin Douglas¹¹ and Dr. P. Randall Kropp in the area of domestic violence seems more appropriate (2002). It is important to note that the authors consider SPJ guidelines, rather than assessment:

Guidelines must reflect “current theoretical, clinical, and empirical knowledge about violence...provide the minimum set of risk factors that should be considered in every case...[and includes] recommendations for information gathering (i.e. the use of multiple sources and multiple methods), communicating opinions, and implementing violence prevention strategies...[and] does not impose any restrictions for the inclusion, weighting, or combining of risk factors (p. 626)...which risk factors to consider, as well as operational definitions for the scoring of the factors...Structured professional judgment does not abrogate the professional responsibility and discretion and visibility of risk judgment...By systematically identifying risk factors – particularly dynamic or changeable risk factors – relevant to a case, management strategies can be tailored to prevent violence...[t]he structured professional approach allows for a logical, visible, and systematic link between risk factors and intervention, in addition to the ability to identify persons who are at higher or lower risk for violence.” (Douglas and Kropp, 2002, p. 627).

“A prevention-based paradigm for risk assessment includes evaluating persons on a comprehensive domain of established violence risk factors and selecting an appropriate risk level based partially on the number and nature of factors present, as well as on the anticipated degree of intervention, management, and preventive action required to stem the occurrence of violence...the risk factors that comprise the assessment also provide the basis for the preventive measures...there should be management and treatment options available that flow directly from the assessed risk factors.” (Douglas and Kropp, 2002, p. 631)

¹¹ In the first version of the first research bulletin, this study was erroneously cited without reference to Dr. Kevin Douglas. The error has been corrected in subsequent copies.

The concept of structured professional judgment offers a complimentary component to actuarial assessment in a manner consistent with both evidence-based and probation practices. The concept is flexible, and can be applied in a range of different methods. One option is to develop a list of theoretically relevant dimensions and provide guidelines on how those factors relate to supervision and risk. Another option is to select a comprehensive theoretically-based dynamic assessment instrument such as the SVR-20, Acute 2007 and Stable 2007, or TPS that have the added benefit of also functioning as actuarial assessments.

Dynamic Risk Factors

Risk factors can be static or dynamic; and dynamic factors can be further divided into stable dynamic factors that have the potential to change over time (and indicate what to address), and acute dynamic factors that can change in a much shorter period of time (weeks, days, hours, minutes; and indicate when to intervene)¹². These concepts deserve more attention since they drive the instruments in this bulletin and require more attention from an assessment perspective than static factors.

Dynamic risk factors are important to probation officers because many of the decisions made on a daily basis, such as supervision strategies, filing violations, or requesting modification of orders and conditions of the court are in fact made on acute and stable dynamic factors. Also, dynamic factors, when addressed, show the potential to reduce risk of reoffense. The research on these factors is still under development, but decades of multi-national work by prominent researchers and clinicians has brought the level of knowledge to a state where the information is highly relevant and useful to community supervision of a population whose offending has immense effects on the victims. Hanson and Harris' (2000) developmental research for the Sex Offender Needs Assessment Rating (SONAR; Hanson and Harris, 2001) that has evolved into the Acute and Stable contributed significantly to the identification and understanding

of dynamic risk variables. The important findings of Hanson and Harris (2000) are that recidivists:

- Viewed themselves as being at little risk, and took few precautions to avoid risk ($r = .38, p < .001$);
- Tended to be disengaged from supervision and treatment ($r = .30, p < .001$), were more likely to attempt to deceive officers ($r = .29, p < .001$), miss appointments ($r = .22, p < .001$), and be generally non-compliant just before reoffending ($r = .22, p < .001$);
- Displayed attitudes such as showing little remorse or concern for the victims and justification, as well as an entitlement to "express their strong sexual drive" ($r = .28, p < .001$ and $r = .29, p < .001$, respectively);
- Have access to victims ($r = .26, p < .001$)
- Have an antisocial (chaotic) lifestyle ($r = .26, p < .001$) and an uncontrolled release environment ($r = .17, p < .001$)
- Were more likely to engage in socially deviant but not necessarily illegal activities ($r = .20, p < .001$) but there was no noticeable increase in behavior prior to reoffending;
- Were equally likely as non-recidivists to display psychological symptoms during supervision, but the recidivists' mood decreased just before committing a new offense ($r = .20$ for anger $p < .001$, $r = .16$ $p < .01$ for negative mood, and $r = .11$ for general psychiatric symptoms, $p < .05$);
- Were more likely to abuse drugs or alcohol ($r = .17, p < .01$) and the abuse increased just before recidivating ($r = .16, p < .01$);
- Were more frequently unemployed ($r = .10, p < .05$), but neither a loss of employment nor problems with the type of employment were a significant risk predictor;
- Had more intimacy problems as measured by conflict or lack of a partner ($r = .10, p < .05$);

¹² For thoughtful discussion on issues in using dynamic variables to predict risk, please see Quinsey, Harris, Rice and Cormier (2006, p. 43-45).

- Had more negative social environment as measured by positive and negative influences as perceived by the supervising officer (quoted and paraphrased from p. 22-26).

Meta-analysis of 95 different studies of more than 31,000 offenders with about 2,000 risk predictions indicates the robustness of several dynamic predictors of sexual recidivism (Hanson and Morton-Bourgon, 2004¹³):

- Measures of deviant sexual interest: any deviant sexual interest ($d = .31$), sexual interest in children ($d = .33$) and paraphilic interest ($d = .21$);
- Sexual preoccupation ($d = .39$);
- General self-regulation problems ($d = .37$), and impulsivity/recklessness ($d = .25$);
- Intimacy deficits: conflicts in an intimate relationship ($d = .36$) and emotional identification with children ($d = .42$);
- Attitudes tolerant of sexual crime ($d = .22$).

The initial meta-analysis indicated a correlation between failure to complete treatment and recidivism of $r = .17$ (Hanson and Bussière, 1998). The update found a very small relationship between poor progress in treatment ($d = .14$), and non-compliance with supervision was a better predictor ($d = .62$), without addressing the issue of treatment failure (Hanson and Morton-Bourgon, 2004).

Other Dynamic Factors

Early studies that rejected treatment as effective were based on outmoded treatment methods¹⁴ and suffered from serious methodological flaws. A

¹³ This was an update to Hanson and Bussière. (1998).

¹⁴ For a user-friendly overview of the history of sex offender treatment and other treatment-related issues, see Prentky and Schwartz. (December, 2006). Treatment of Adult Sex Offenders. Harrisburg, PA: VAWnet. http://new.vawnet.org/Assoc_Files_VAWnet/AR_SexOffendTreat.pdf. Retrieved June, 2007.

meta-analysis of the effects of *current* treatment methods (i.e. cognitive-behavioral or systemic modalities started in the late 1980s to 1990s) indicates a reduction in risk: the weighted average of results corresponds to a recidivism rate of 17.4% for untreated subjects and 9.9% for treated subjects, a reduction in risk of 7.5% (Hanson, et al., 2002).

It should be noted that including treatment as a predictor of risk assumes that: a) treatment is effective at reducing the risk of reoffending, along with all its complexities; b) an evidence-based treatment model(s) exists (e.g. the nexus between treatment efficacy and reoffending has been identified and validated by empirical research within the model(s)); and c) effective treatment is implemented with fidelity to the model(s). These issues are highly relevant to the supervision of sex offenders and will be explored in a subsequent bulletin¹⁵.

Examining risk from a different perspective, a study on the effect of social controls on sex offenders on probation who were participating in the Minnesota Community-Based Sex Offender Program Evaluation Project tested a desistance model that contained a small number of dynamic risk factors: job and marital stability (informal social control), orders and conditions of the court¹⁶ (formal social control), and substance abuse. In the final predictive model, stable employment histories¹⁷ and a court ordered treatment condition interacted with each other to reduce offending (Kruttschnitt, Uggen and Shelton, 2000). However, the presence of an order and condition to attend treatment does not always equate with actually receiving treatment, as evidenced by the Sex Offender Management Survey

¹⁵ Janice Marques, who created the Sex Offender Treatment Evaluation Project in California in the 1980s comments that in addition to asking "Is there a treatment effect?" other relevant questions include "Is there an effect for either rapists or child molesters?", "Do groups differ in terms of severity of reoffenses?", "How does risk change over time?", "How does treatment affect risk over time?", "How do our participants change during treatment?", and "Which offenders have responded best to our treatment?" Marques (1999).

¹⁶ Measured as whether drug testing, avoiding contact with minors and treatment were ordered by the court as a condition of probation.

¹⁷ Measured as working for the same employer for at least six months prior to the pre-sentence investigation.

Report and Recommendations¹⁸ finding that access to treatment varies greatly by county across New York State. Still, the finding that employment and treatment are associated with a reduction in recidivism is important.

Some debate does exist regarding whether assumed dynamic factors are, in fact, dynamic. For example, Hanson, Harris, Scott and Helmus (2007) consider deviant sexual interests to be both acute (sexual preoccupation) and stable (deviant sexual preference); while Seto, Harris, Rice and Barbaree (2004) argue that deviant sexual interests are a static variable:

“In our view, anomalous sexual interest cannot be assumed to be a dynamic risk factor until there is evidence that change scores, derived from assessments conducted at least two different times, add to the prediction of recidivism after initial scores are considered.” (p. 465).

A Few (More) Notes on Assessment

An item from Supervision of the Sex Offender, written by researchers/practitioners Georgia Cumming and Robert McGrath illustrates both the complexity of risk assessment and the need for clinician - treatment provider - probation officer collaboration:

Risk Assessment: Five Critical Questions (p. 23-26):

1. What is the probability of reoffense?
2. What degree of harm would most likely result from a reoffense?
3. What are the conditions under which a reoffense is most likely to occur?
4. Who would likely be the victim of a reoffense?
5. When is a reoffense likely to occur?

These are questions that cannot be answered by static or dynamic actuarial assessment alone, and probation officers can make a substantial contribution to the answers to these questions because the necessary information can often be obtained through supervision practice. For example, the following information is necessary to try to answer the questions listed above:

1. Ongoing longitudinal research on recidivism with large and representative samples has and will continue to inform us of the probability of reoffense;
2. Consideration of past and future victims on a case-by-case basis by persons familiar with the offense, and the victim, as well as offending dynamics can inform us of the degree of harm were a new offense to occur;
3. Professionals who supervise or treat sex offenders must have an understanding of the etiology and theories of sexual offending, as well as risk factors, to be able to identify pre-offending behavior and to effectively identify situations where public safety is at risk;
4. Determination of offending preferences (e.g. gender, age, relationship) can be done through reliable and valid psychometric means, and home visits and collateral contacts help to identify access to victims and shed light on potential victims and risky employment or residential situations; and
5. Structured and dynamic actuarial assessment instruments and structured professional judgment can assist probation officers to understand and identify situations where offending may occur, and to supervise accordingly.

One criticism of actuarial assessment instruments based on static factors is that they are considered atheoretical because they were generally derived from existing data sources (i.e. official records) and items were selected because they predict recidivism, rather than explain it. The assessment instruments presented here *are* derived from theory, albeit

¹⁸ <http://www.dPCA.state.ny.us/pdfs/somanagementsurveyreport.pdf>

theories that are still in the later stages of development and confirmation. Decades of multi-national research have provided a theoretical foundation and the empirical evidence associating sex offender-specific risk factors with recidivism.

It is important to stress that dynamic factors typically cannot be drawn from or reasonably inferred by official records. They must be assessed in an interactive environment with the sex offender, whether by a probation officer or clinician. This often takes more than one office visit and requires gathering information from multiple sources.

The main difference between these instruments and the shorter actuarial instruments such as the Static-99 is that these instruments require far more information and time to score; not only the richness of the information obtained, but the process of assessing the offender can provide a solid foundation for the pre-sentence investigation and subsequent supervision planning. Such thorough and ongoing assessment can also lend credibility to violation proceedings (see Stalans, Juergens, Seng and Lavery, 2004.)

These assessment instruments require not only training, and in some cases clinical proficiency, but careful attention to detail in gathering information and scoring of the items. Knowledge of the theoretical foundations of sex offending is extremely important to understanding how the instruments work because many of the dimensions measured have developed from or contributed to theories of sexual offending and the understanding of its origins (etiology).

The assessment instruments presented here have also shown predictive ability in several recently published well-defined and methodologically-sound research studies (Knight and Thornton, 2007; Langton, Seto, Barbaree, Peacock, Harkins and Hansen 2007; Hanson, et al., in press).

Clinical Assessment: Brief Overview

It is not uncommon to encounter assessment instruments that incorporate other assessments into their scoring. Most common are a diagnosis from the Diagnostic and Statistical Manual of Mental Disorders-IV Revised (American Psychological Association, 1994), the Minnesota Multiphasic Personality Inventory (MMPI, copyright held by the University of Minnesota) or the Psychopathy Checklist (Hare, 2004), which will be discussed in a separate bulletin due to their one-dimensional nature. Instead, this section will focus on a variation of the most widely used and validated clinical violence assessment instrument: the Violence Risk Appraisal Guide.

VRAG: Violence Risk Appraisal Guide and the SORAG: Sexual Offense Risk Appraisal Guide

The VRAG and SORAG¹⁹ were developed by clinical researchers at the Mental Health Centre in Penetanguishene, Ontario, Canada, and have been validated (Harris, Rice and Quinsey, 1993) and cross-validated numerous times (Harris, Rice and Cormier, 2002)²⁰.

The instruments are completed by a clinician after a thorough document review, collateral contacts and extensive clinical interview. Scoring non-violent (p. 285) and violent offenses (p. 289) is based on the Cormier-Lang weighting system, and offenses range from one to seven points, and two to 28²¹ respectively. Interpretation of both instruments is based on nine scoring categories (Quinsey, et al., 2006).

¹⁹ Quinsey, Harris, Rice and Cormier. (2006). Violent Offenders: Appraising and Managing Risk. Second Edition. Washington DC: American Psychological Association.

²⁰ See also Grant, Harris, Quinsey, Lalumière, Boer and Lang. (2003). A Multisite Comparison of Actuarial Risk Instruments for Sex Offenders. Psychological Assessment. 15(3), 413-425.

²¹ The highest ranking violent offense was homicide, at 28 points; the next weighted offense is 15 points for aggravated sexual assault, sexual assault causing bodily harm (Quinsey, Harris, Rice and Cormier, 2006, p. 289).

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| VRAG and SORAG Dimensions: | VRAG | SORAG |
|--|-------------|--------------|
| Lived with biological parents => age 16 | ● | ● |
| Elementary school maladjustment | ● | ● |
| History of alcohol problems | ● | ● |
| Marital status | ● | ● |
| Prior non-violent convictions or charges | ● | ● |
| Prior violent convictions or charges | | ● |
| Prior convictions for offenses known to be sexual (includes hands-off) | | ● |
| History of offenses against girls < age 14 (incl. scoring rule for age difference) | | ● |
| Failure on prior release (incl. probation) | ● | ● |
| Age at index offense | ● | ● |
| Victim injury | ● | |
| Any female victim (index offense) | ● | |
| Meets DSM-III criteria for any personality disorder | ● | ● |
| Meets DSM-III criteria for schizophrenia | ● | ● |
| Phallometric test results | | ● |
| Hare PCL-R score | ● | ● |

As shown in table one below, the VRAG and SORAG are similarly predictive of recidivism, so either may be used. It is recommended that the SORAG be used since it has higher predictive accuracy for sex offenders than the VRAG initially and over time. Furthermore, the SORAG requires information that is more relevant to sexual offending than the VRAG.

Table One: AUC Values for Serious Sexual Charges (Confidence Intervals in parentheses: Knight and Thornton, 2007, Table Five, p. 122.)

| Scale | 3 Years | 10 Years | 15 Years |
|--------------|------------------------|------------------------|-----------------------|
| VRAG | .645*** (.564-.725) | .631*** (.559-.703) | .606 (.505-.707) |
| SORAG | .671*** (.591-.752) | .673*** (.603-.742) | .638** (.540-.736) |

* p. < .05; ** p < .01; *** p < .001

Much of the information used to score the SORAG is often obtained during the pre-sentence investigation by a probation officer, and could be used to supplement a clinician’s completion of the instrument. Appendix L contains a Problem Identification Checklist that covers psychotic behaviors, inappropriate pro-criminal social behaviors, mood problems, and social withdrawal symptoms (Quinsey, et al., 2006, p. 379-382.)

Appendix N includes a Dynamic Risk Appraisal Scale consisting of 29 items, 16 of which are scored by “frontline staff” not defined by the authors, with the rest completed by a clinician (Quinsey, et al., 2006, p. 385-390). It is reasonable to assume that frontline staff could include any professional involved in the supervision, treatment or management of sex offenders, from probation officers to clinicians to social workers. The Dynamic Risk Appraisal Scale could function as a framework for treatment team meetings with clinicians, probation officers and other stakeholders.

Structured Professional Judgment and Dynamic Assessment

Structured professional judgment should not be considered a risk assessment *per se*, even though all of the instruments listed here have shown predictive ability. Instead, for now, it should be considered as a set of empirically-based factors that are known to be associated with recidivism. The goal of using these instruments is to guide the probation officer in assessing the case in association with a range of supervision activities rather than providing an actual estimate of risk, which would be difficult in the absence of a sample of probationers from New York on which recidivism rates can be derived. Until then, any probabilities of reoffense associated with resulting scores should be viewed with caution and not necessarily be presented to decision-makers such as a judges at this time²² but can contribute significantly to supervision and case planning.

Acute 2007 and Stable 2007

The Acute and Stable instruments represent an impressive long-term collaborative research effort by the Canadian Department of Corrections. The resulting instruments grew out of the former Sex Offender Needs Assessment Rating (SONAR), which contributed significantly to the understanding of dynamic risk factors (Hanson and Harris, 2000). Initial validation (Hanson and Harris, 2001)

²² Ideally, implementing any risk assessment instrument should include a judicial education component so that judges have a meaningful context in which to consider assessment results.

demonstrated a moderate correlation ($r = .43$) and good predictive ability (AUC/ROC = .74).

In a major update and cross-validation study referred to as The Dynamic Supervision Project (DSP; Harris and Hanson, 2003) AUC values for the Stable instrument were .67 (CI .59 to .74) for sexual recidivism (all crimes that were sexually motivated, including self-reports where there was no arrest) and .69 for sexual recidivism and “breaches” (sexually motivated violations of supervision). The Acute instrument was able to distinguish recidivists from non-recidivists: the AUC value for sexual crime was .74 (CI .61 to .86) and sexual recidivism and breaches was .65 (CI .60-.84) based on the most recent Acute rating (Hanson, Harris, Scott and Helmus; in press).

The Static-99 should be used within the first month of supervision (which was created by the authors of this instrument and Dr. David Thornton of Wisconsin), the stable assessment should be completed within three months, and the acute assessment every six months thereafter (Hanson, Harris, Scott and Helmus; in press).

The authors were also concerned with the reliability and validity of having community supervision officers assess sensitive personal characteristics, such as deviant sexual interests. Community correction officers attended a two day training session conducted by the principal investigators (i.e. Hanson and Harris) or other approved trainers. Interrater reliability correlations²³ were .91 ($k = 88$) for the Static-99, .89 ($k = 87$) for the Stable 2000 total score, and ranged from .64 to .95 (median of .90, $k = 75$) for the Acute items, demonstrating that community corrections officers who are trained in the instrument can reliably code the sensitive items (Hanson et al., in press).

Acute and Stable Dimensions

Acute:

- Victim access
- Hostility
- Sexual preoccupation
- Rejection of supervision
- Emotional collapse
- Collapse of social supports
- Substance abuse

Stable:

- Significant social influences
- Capacity for relationship stability
- Emotional identification with children
- Hostility towards women
- General social rejection
- Lack of concern for others
- Impulsive
- Poor problem solving skills
- Negative emotionality
- Sex drive/sex preoccupation
- Sex as coping
- Deviant sexual preferences
- Co-operation with supervision

This research demonstrates the ability to improve risk assessment by the addition of acute and stable risk factors to the static factors assessed in the Static-99. The Dynamic Supervision Project differs in that the assessments were conducted prospectively by trained supervision officers in the field, whereas most other validation research was conducted with retrospective case file reviews. The data also included offenders on community supervision in the US (Alaska and Iowa) as well as Canada, whereas most research has been conducted on non-US populations.

The authors note that more research on the instrument is warranted because although the factors incrementally increase predictive accuracy, the authors concluded that *changes* in such scores were not related to recidivism risk. Data on interventions such as treatment were not recorded, and it may well be that the factors thought to be acute are less so than originally believed. The acute portion of the assessment was a better predictor when a number of assessments were averaged over time rather than as assessed once.

²³ Measured using the Interclass Correlation Coefficient (ICC).

Sexual Violence Risk – 20

Known as the SVR – 20²⁴, this instrument was developed by Canadian clinical researchers associated with Simon Fraser University and Correctional Services of Canada. It is a structured assessment of the risk of sexual violence and includes twenty factors empirically associated with reoffending. The strength of this instrument is its dimensional comprehensiveness and incorporation of structured clinical assessments (PCL score and DSM diagnosis), which may be culled from existing documents or a relatively recent evaluation to enable a probation officer to complete the assessment without a referral.

Most risk factors can in theory be assessed by a probation officer with training on the instrument, and a small enough caseload to be attentive to the subtle clues and hues of sex offending behavior required to score the instrument.

The initial validation research for the SVR – 20 indicates several domains that have been shown in other studies to be associated with sexual recidivism (Demptser and Hart, 2002; p. 128):

- Past supervision failure ($r = .50^{***}$)
- Psychopathy ($r = .46^{***}$)
- Past nonviolent offenses ($r = .42^{***}$)
- Employment problems ($r = .34^{**}$)
- Past nonsexual violent offenses ($r = .32^{**}$)
- Substance use problems ($r = .32^{**}$)
- Physical harm to victim(s) ($r = .30^*$)
- Lacks realistic plans ($r = .24^*$)

* $p < .05$; ** $p < .01$; *** $p < .001$

A comparison with the Static-99 on a sample of treated sex offenders in the Netherlands revealed a higher AUC value for the summed SVR – 20 Score (.80 $p < .001$) and adjusted actuarial score determined by the assessor (.83 $p < .001$) than the Static-99 (.71 $p < .001$). Interestingly, the correlation with sexual recidivism rose from $r = .50$ to $r = .60$ ($p < .01$ for both) between the summed (actuarial) score and the final (adjusted actuarial) score as determined by the assessor, and was still

higher than the Static-99 $r = .38$ ($p < .01$; de Vogel, de Ruiter, van Beek and Mead, 2004). However, the reader must be cautioned that the findings require replication before they can be accepted. The authors also suggest that coding the sexual deviance dimension needs clear and objective criteria and suggest that using the SVR – 20 as an instrument of judgment is superior in its predictive accuracy than using it as an actuarial assessment (i.e. summing the scores). Perhaps screening tests of deviant sexual preferences can be substituted, such as the polygraph.

SVR – 20 Dimensions:

1. Sexual deviation
2. Victim of child abuse
3. Psychopathy (PCL)
4. Major mental illness (DSM-IV)
5. Substance use problems
6. Suicidal/homicidal ideation
7. Relationship problems
8. Employment problems
9. Past nonsexual violent offences
10. Past nonviolent offences
11. Past supervision failures
12. High density sex offences
13. Multiple offence types
14. Physical harm to victim(s) in sex offences
15. Use of weapons or threats of death in sex offences
16. Escalation in frequency or severity of sexual offences
17. Extreme minimization/denial of sex offences
18. Attitudes that support or condone sex offences
19. Lacks realistic plans
20. Negative attitude towards intervention

Other Considerations: acute mental disorder, recent loss of social support network, frequent contact with potential victims or poor attitude towards intervention.

Items are generally scored as:

- **Yes** = Evidence that an important, case specific risk factor is present
- **?** = Possible or partial evidence that an important, case-specific risk factor is present.
- **No** = No evidence that an important, case-specific risk factor is present.

In a recent meta-analysis of sex offender assessment instruments, researchers noted that “the measure with the largest association with sexual recidivism was the SVR – 20 professional judgment, but this

²⁴ Boer, Hart, Kropp and Webster. (1997). Sexually Violent Recidivism – 20. British Columbia: The Mental Health, Law & Policy Institute, Simon Fraser University.

finding was based on only three studies ($n = 245$) and showed significant variability.” (Hanson and Morton-Bourgon, 2007, p. 9). However, data from an original and representative sample provided by Knight and Thornton (2007) indicate that the SVR – 20 has predictive accuracy comparable to other similar instruments, and the accuracy maintains significance over time. AUC values reported: .655 (CI .538-.726) at three years; .682 (CI .620-.749) at ten years, and .676 (.582-.771) at fifteen years ($p < .001$ for all values.)

Sex Offender Treatment Needs and Progress Scale

Most commonly referred to as the TPS²⁵, this instrument was developed by practitioners Robert McGrath, Vermont Department of Corrections Clinical Director; and Georgia Cumming, Program Director at the Vermont Center for the Prevention and Treatment of Sexual Abuse.

The TPS was created to aid clinicians, correctional caseworkers, and probation and parole officers in case management; and has been validated with an initial sample for use with the Vermont Assessment of Sex Offender Recidivism (VASOR) or the Static-99. The 22 questions measure both acute and stable dynamic risk factors, though not explicitly identified as such. The authors suggest that it can be used to identify the offenders who are most likely in need of treatment when availability is limited.

Scoring the instrument is recommended at intake and then at six month intervals. Preliminary research indicates that scores on the TPS can be reduced significantly at the end of participating in a treatment program; and that it has predictive accuracy for sexual reoffending (AUC = .72; CI .62-.82) and violations of probation (AUC = .79, CI .76-.81; McGrath, Cumming and Livingston, 2005).

Sex Offender Treatment Needs and Progress Scale Dimensions:

Sexual Deviancy

- Admission of offense behavior
- Acceptance of responsibility
- Sexual interests
- Sexual attitudes
- Sexual behavior
- Sexual risk management

Criminality

- Criminal and rule breaking attitudes
- Criminal and rule breaking behavior

Self-Regulation

- Substance abuse
- Emotional management
- Mental health stability
- Problem solving
- Impulsivity

Treatment and Supervision

- Stage of change
- Cooperation with treatment
- Cooperation with community supervision

Lifestyle Stability

- Employment
- Residence
- Finances

Social Supports

- Adult love relationship
- Social influences
- Social involvement

Scoring:

- 0 = minimal or no need for approval
- 1 = some need for improvement
- 2 = considerable need for improvement
- 3 = very considerable need for improvement

Structured Risk Assessment-7

The SRA-7²⁶ is a relatively new instrument that has recently been cross-validated and demonstrated good predictive ability with an AUC statistic of .648 (CI .576-.721, $p < .001$) over three years, .682 (.615-.750 $p < .001$) over five years, and .676 (CI .582-.771 $p < .001$) over 15 years (Knight and Thornton, 2007).

²⁵ McGrath and Cumming. (2003). Sex Offender Treatment and Needs Progress Scale. Research Version. Center for Sex Offender Management. <http://www.csom.org/pubs/SexOffTreatScale.pdf>

²⁶ Craig, Thornton, Beech and Browne. (2007). The Relationship of Statistical and Psychological Risk Markers to Sexual Reconviction in Child Molesters. Criminal Justice and Behavior. 34(3), 314-329. A more thorough analysis of the instrument could not be completed as the instrument and its coding manual were not available for review.

This approach is described by its authors as:

“Static Risk Assessment, Initial Deviancy Assessment (IDA), an evaluation of progress based on treatment response, and risk management based on offense specialization and acute risk factors. The Static Risk Assessment is an actuarial classification using the Static-99 risk assessment scale...The IDA considers empirically derived dynamic

psychological and behavioral factors. Deviance is defined in terms of the extent to which the offender’s functioning is dominated by the psychological factors that contribute to his offending. Here, high deviancy means that the dynamic risk factors underlying offending are relatively intense and pervasive.” (p. 315).

Table Two: Overview of Static, Stable Dynamic and Acute Dynamic Risk Factors (reproduced from Craig, Browne, Stringer and Beech, 2005).

| Static Risk Factors (p. 67) | | | |
|--|--|---|---|
| Developmental Factors | Sexual Interest Factors | Forensic Factors | Clinical Factors |
| <ul style="list-style-type: none"> Juvenile sexual offenses Poor family background Victim of sexual abuse | <ul style="list-style-type: none"> Male victim Paraphilias (atypical sexual outlets) Extra-familial victims | <ul style="list-style-type: none"> Past criminal history Past sexual convictions Past violent convictions Time spent in custody Non-contact offenses Stranger victims Multiple victims | <ul style="list-style-type: none"> Age of offender (negatively correlated) Lower IQ Marital/relationship history Discontinuation in community treatment programs Psychopathy |
| Stable Dynamic Risk Factors (p. 70) | | | |
| Sexual Interest Factors | | Clinical Factors | |
| <ul style="list-style-type: none"> Deviant sexual urges Sexual deviance-children (PPG) Attitudes tolerant of sexual assault | | <ul style="list-style-type: none"> Cognitive distortions Lack of victim empathy Low self-esteem Anger Substance abuse Impulsivity Personality disorder | |
| Acute Dynamic Risk Factors (p. 71) | | | |
| Sexual Interest Factors | Treatment Behavior Factors | | Clinical Factors |
| <ul style="list-style-type: none"> Frequency of sexual fantasies | <ul style="list-style-type: none"> Delinquent behavior during treatment Deterioration in dynamic risk during treatment Poor treatment cooperation Deterioration in awareness of high risk situations and relapse prevention strategies Short duration of treatment and program Poor cooperation with supervision | | <ul style="list-style-type: none"> Isolation Unemployment Deviant social influences Chaotic lifestyle Poor social support Affective disorder Substance abuse |

Summary

One may note that these instruments seem to consist of similar dynamic risk factors. They often do, and there are subtle differences between the instruments which must be taken into account when evaluating them for implementation. Table two above, excerpted from a review of static and dynamic risk predictors by researchers from the United Kingdom serves to bring all those risk factors together into a coherent manner (Craig, Browne, Stringer, and Beech, 2005).

It is clear that both sexual interest and clinical factors span static, stable-dynamic and acute-dynamic types of factors. For example, dimensions of sexual interest factors are both static and dynamic, but at the stable stage they may be managed through treatment and supervision (i.e. urges, attitudes). However, they may be more relevant to immediate risk of reoffense if they become acute (i.e. deviant sexual urges as a dynamic risk factor may become acute when they involve a high frequency of sexual fantasies.)

Assessment may be improved by being broken into multiple tasks that lend themselves to the Comprehensive Approach to sex offender management (not particularly in this order):

1. Short-term risk of recidivism as measured by a short, static assessment instrument (such as the Static-99);
2. Long-term risk of recidivism measured by a thorough psychosexual clinical evaluation (pre-sentence) and comprehensive structured/actuarial assessment administered by probation officers (such as the TPS or Acute 2007 and Stable 2007);
3. Ongoing assessment as measured by periodic dynamic assessments (such as the TPS or Acute 2007 and Stable 2007) and supervision tactics that includes extensive collateral contacts and unannounced home visits as well as regular meetings with treatment practitioners;

4. Polygraph to determine sexual history, victim preferences, monitoring behavior and maintaining relapse prevention efforts;
5. A clinical evaluation of psychopathy and deviant sexual preferences.

Discussion and Comparison of Instruments

“Given the weight of evidence supporting them, we believe actuarial risk tools should be a major consideration in the evaluation of recidivism risk potential...For the prediction of sexual recidivism, there is strong evidence supporting the reliability and validity of the Static-99, Mn-SOST-R and the Risk Matrix – 2000 Sexual. The VRAG and SORAG both have demonstrated strong associations with violent (including sexual) recidivism...For those wishing to understand their cases...the most well established measure for understanding cases are the SVR-20...and ... [the] Structured Risk Assessment” (Hanson and Morton-Bourgon, 2007, p. 16).

Multiple validated structured assessment instruments exist that can assist probation officers, clinicians and treatment providers to better manage sex offenders in the community. While the SORAG has a solid base of research on which to base recidivism estimates (e.g. multiple replications), the structured judgment instruments typically do not²⁷. Even with more current research demonstrating their predictive accuracy through AUC/ROC statistics, the probation officer may be left with assessment results that may be difficult to interpret in relation to actual risk.

Therefore, rather than artificially attaching results to an estimate of risk, probation officers can use the results in terms of relative risk (e.g. the offender poses a high, moderate or low risk) and use that general knowledge to supervise offenders. Similarly, it would not be recommended at this time that the instruments be used at the pre-sentence investigation to justify an evaluative analysis unless completed within the context of a psychosexual

²⁷ Part of this problem is due to the low base rate issue. For a thorough and user-friendly discussion, see Doren (2002) Chapter 6: Recidivism Base Rates.

evaluation completed by a qualified clinician. Assessment should be part of an overall investigation that justifies recommendations on sentencing, and orders and conditions imposed by the court.

The utility of these assessments goes far beyond the determination of likelihood of reoffending because they offer consistent, theoretically and empirically-based methods to gather and make sense of information that is necessary for the proper evaluation, treatment and supervision of the offender. Often, this information is routinely collected or encountered by probation officers as well as clinicians and treatment providers.

Recommendations

In-depth clinical and structured assessments can provide valuable information to professionals who manage sex offenders in the community. They also require more time, training and attention to detail than a short instrument such as the Static-99 or Risk Matrix 2000. In order to optimize probation officers' time, it may be desirable to create policies by which offenders who score high on initial assessments should then be considered for a more in-depth assessment. However, given the nature of the offense, potential for substantial harm to victims, and the deceptiveness of sexual offending, it would be advisable to complete a comprehensive assessment of all sex offenders so that officers have critical information on which to base sentencing recommendations, requested orders and conditions of the court, supervision plans and violation proceedings.

All of these instruments require extensive training lasting two or three days, often including a period of supervised administration of the instrument, which is an established clinical training method. It is not clear whether the clinical elements required to score the dynamic instruments will be routinely available on all offenders because access to qualified clinicians is limited in some areas of the state, and whether clinicians that are available adhere to the ATSA standards is unknown at this time.

Future Considerations:

- Build on anticipated Static-99 training by pilot testing several dynamic risk assessment instruments.
- Extend an invitation to judges to attend any assessment training provided by the Division.
- Convene a work group of probation practitioners to evaluate the dynamic risk assessment instruments included here for use in probation departments.
- Partner with the State Office of Mental Health to encourage localities to develop treatment team approaches to assessment.
- Explore cross-training options with the State Office of Mental Health and Division of Parole on any instrument selected for implementation.

Thanks to: Dr. Andrew J. R. Harris and Dr. Karl Hanson, Public Safety and Emergency Preparedness Canada; Robert McGrath, Vermont Department of Corrections; and Dr. Raymond Knight, Brandeis University.

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| <p>This bulletin was researched and written by Jami Krueger, Community Correction Representative II. Comments or clarifications may be directed to jami.krueger@dpc.state.ny.us or 518-457-5275.</p> |
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Published August, 2007.