



The use of the RSV-20 in a Forensic Sample: A Research Note

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Abstract

The assessment of sexual offenders commonly requires the use of structured assessment tools or actuarial devices. The current study reports on 27 defendants assessed on the Sexual Violence Risk-20 protocol, 18 of whom were found guilty or pleaded guilty. Nine of the 20 variables making up the SVR-20, significantly discriminated between the guilty and not-guilty defendants. The RSV-20 was not designed to provide aggregate scores or to be used as a dimensional measure. However, when computing aggregate scores the RSV-20 did not discriminate between the groups and none of the 3 broad clusters of behaviours discriminated between the groups. It is noticeable that static factors, in general, were more predictive than dynamic factors, between the two groups.

Keywords: Sex-offenders; Risk-assessment; Clinical assessment

INTRODUCTION

The potential harm caused by sexual offenders is immense, and the accurate assessment of risk is a major requirement for the clinician. This is despite the fact that in most private clinicians case loads, sex-offenders represent a minority of referrals.

Forensic assessment is, fundamentally, about decision making under uncertainty (Mellers, Schwartz, & Cooke, 1998). Traditionally, risk assessments occurred via clinical reasoning, a practice criticised on empirical grounds as highly flawed (Blackburn, 1993; Hanson, 1998). In order to curb emotional and artifactual influences on risk assessment, a tendency over the last 15 years has been to develop and utilise actuarial and structured risk assessment devices. Examples of actuarial risk predictors include the Static-99 and the RRAISOR index (Hanson, 1998). Examples of structured risk assessment devices are the Risk of Sexual Violence-20 (Kropp et al., 1995).

A detailed examination of the strengths and weaknesses of various assessment approaches can be found in Hanson, (1998) and Blanchette (1996).

In essence, actuarial approaches assign weights to variables that have been established by empirical studies as likely to predict offending behaviour. An individual is assessed on each of these variables, his or her score "weighted" and the resultant variable string added. Should a specific cut off score be obtained a suitable risk rating is applied. There are arguments for and against actuarial approaches, (Blackburn, 1993; Mellers et al., 1998) however, essentially, actuarial approaches appear to be an improvement on unstructured clinical assessment. There are a number of difficulties with actuarial approaches. The first is their static nature – actuarial devices cannot incorporate new data without having to be completely re-computed. Actuarial devices are reliant on local normative samples that may make the generalisation of cut-off scores unreliable. Finally, clinicians may develop

A variation of this paper was given at the 1st National Forensic Psychology Conference, Sydney, February, 2001.

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over-inflated confidence in what appears to be a scientific tool, and assign too much importance to a device that is both a probabilistic measure and frequently accounts for less than 50% of the variance of whatever it is predicting (Mellers et al., 1998). None the less, actuarial devices play an important role in current risk prediction. Actuarial devices can be contrasted against structured or guided clinical assessment protocols (Hanson, 1998).

The RSV-20 is an example of a structured risk assessment tool that seeks to identify an offender's standing on a set of static risk factors, criminogenic needs, and sex-offender specific variables. Structured clinical assessments also use variables identified on the basis of research as indicating risk of recidivism. Like actuarial assessments, structured clinical assessments utilise both static and dynamic risk indicators. Hanson (1998) argues that such an approach, whilst worthy of merit has shortcomings because there is no explicit decision rule about what variables or what loadings on variables may be important. It does however, have the advantage in that it forces the clinician to carefully consider each of the variables research has found to be important in predicting recidivism. Structured risk assessments also provide the clinician with an opportunity not only to assess risk but to assess needs that can be addressed through either treatment or management (Andrews & Bonta, 1994). Needs assessments, and the resultant treatment plan, can then modify the offender's risk. It is expected that an assessment approach that incorporates both static and dynamic risk factors should provide for a more holistic assessment. Given that forensic assessments have a wider remit than just assessing risk, and that readers of such reports could include probation officers, treatment specialists, review boards, as well as judges and juries, the broader assessment base provided by structured clinical assessments is an important consideration in any such assessment.

The development of one such approach, the RSV-20 (Kropp et al., 1995) is well described in its manual and is briefly described below. (A more detailed discussion can be found in Boer, Wilson, Gauthier & Hart, 1997). The development of the instrument was exhaustive and the rationale for it well developed. It is part of the general thrust of research emanating from the Canadian Corrections Department.

At the moment there is no proposal to convert the RSV-20 into an actuarial device (Boer, personal communication). Independent research into the RSV-20 is still minimal as it is a new instrument,

but it appears that the need to complement actuarial devices with a structured clinical assessment device is needed (Boer et al., 1997).

Present Study

The following research explores the use of the RSV-20 within a convenience sample derived from my private forensic practice. Within my practice I see clients who plead guilty to sexual offences, who plead not guilty and are found guilty and who plead not-guilty and are found not-guilty. The current study provides data on the RSV-20 items for offenders who are guilty of an offence, and defendants found not-guilty. Although a descriptive study, it is hoped it will provide some useful information about the RSV-20 and provide some guidance to the continuing use of the instrument.

METHOD

Participants

A total of twenty-seven males with an average age of 38.17 years, (s.d. 18.17, range 16-68) referred between 1998 and 2000 were used for this study. This is not a full data set, as some offenders referred to me did not have known completed court outcomes or were awaiting appeal, and for others adequate information was not available. The analysis is conducted with 18 proven or pleaded guilty subjects and 8 proven not guilty and 1 not proceeded with subject (for health reasons and treated as not-guilty¹).

For all 27 subjects, data are available from my clinical interview, file data including police facts, in most cases expanded witness accounts, cognitive assessment, and personality assessment (either the MMPI-2 or the SCL-90R). In most cases collateral information was available in the forms of other reports, probation and parole reports, and interviews held by me with other family members or partners. For all cases there are multiple sources of data.

The subjects in this study were charged with multiple offences. Seventeen were charged with various offences against children or adolescents; 8 were charged with sexual assault of adults; and 2 charged with lesser offenses of sexual harassment (involving allegations of assault associated with sexual harassment). The median number of alleged victims was 2, for each offender, however, two cases reported a very large numbers of unidentified victims (more than 30). Fourteen of the sample had prior criminal records for non-sexual crime and of these 10 had prior convictions for sexual violence.

Measures

The Risk of Sexual Violence-20

The RSV-20 consists of 20 items divided into three broad sections. It is not an actuarial device in that no beta weights are assigned to each of the variables and no normative data is supplied. It is not a psychometric instrument in that it is not designed as a summative scale and assessments of reliability are confined to inter-rater reliability. Validity studies of the RSV-20 are only now being under-taken. The RSV-20 assesses risk across three broad dimensions of psychosocial risks, sexual risks, and future plans.

Psychosocial risks items include sexual deviation, being a victim of child abuse, psychopathy, major mental illness, substance use problem, suicidal/homicidal ideation, relationship problems, employment problems, past non-sexual violent offences, past non-violent offences, and past supervision failure.

Sexual offending variables refer to a history of high density sex offences, multiple sex offences, physical harm to victim(s), the use or threats of weapons, escalation in frequency or severity, the occurrence of extreme minimization and /or denial, and attitudes supportive of or condoning of sex-offending.

Finally, two variables make up the *future plans* section. These include realistic plans for the future and a positive response to treatment. Each variable is assigned a score of either 2 (definite evidence of the behaviour), 1 (probable evidence) and 0 (definitely no evidence).

The RSV-20 allows a section for the clinician to add in variables that might have specific reference to the person under assessment or drawn from a specific population.

In using the RSV-20 the clinician is exhorted to obtain multiple sources of information on the multiple domains of functioning and to use multiple methods to gather such information. In completing the RSV clinicians are urged to gather information on static and dynamic (needs) risk factors, to evaluate the accuracy of the information gathered, and to repeat assessments at regular intervals (dynamic factors change).

Procedure

All subjects were seen for an extensive clinical interview that in most cases included cognitive assessment and personality assessment. One subject received no psychometric assessment and literacy problems prevented self-report personality assessment with 4 subjects. The RSV-20 was completed following the assessment and file review. The RSV-20 was completed by myself and independently by a research assistant with psychological training who was not experienced in sexual assault matters and who used the file data only to complete ratings. This was not an attempt to establish inter-rater reliability (no correlation coefficient was computed), but rather a check on the ratings I assigned. A process of discussion resolved any differences.

RESULTS

Analysis of the data proceeded by both item analysis and by investigating whether a "total score" and component scores could be used to separate the guilty from the not guilty groups. This is a rather crude approach to classification, but allows a comparison of the three broad sections. The analysis was conducted on aggregated data and the Kruskal Wallis median test used. An alpha of .05 was set for all significance levels, however no category score achieved significance. That is, neither an overall score, or sub-category scores of sexual risk, psychosocial risk or future plans aggregate scores predicted whether an offender was in the guilty or not guilty group.

The clinical use of the RSV-20 is primarily in the examination of each risk item. For this purpose a series of 2 by 3 tables were computed, and in most cases bi-variate histograms to inspect the data. However, a number of categories resulted in polarised ratings (either no or high risk; or moderate and high risk) and chi-square analyses suffered from having low cell numbers. To compensate for this, chi-squares were recomputed on most cells, contrasting high risk against the aggregate of no and moderate risk. The ratings for each variable are shown in Table 1. To read this table, the Chi square on the first line represents the analysis across all three cells, while the second line represents the analysis on a 2x2 table.

Table 1
Rankings on Each Variable of the RSV-20 for Guilty and Not-Guilty Subjects

| Variable | Description | X ² |
|-------------------------------------|--|--|
| 1. Sexual Deviation | Two thirds of the not-guilty group but only 22% of the guilty group report no sexual deviations. | X ² =5.63 p = .059 X ² =39.29, p<.001 |
| 2. History of Sexual Abuse | Seven (78%) of the not-guilty participants but only 5 (28%) of the guilty participants reported no history of sexual abuse as a child. | X ² =6.37, p<.05 |
| 3. Psychopathy | 50% of the not guilty sample had no ranking of psychopathy, whilst 33% of the guilty sample had no ranking. (p<.01, X=9.47) | X ² =3.9, p=.41 X ² =9.47, p<.01, |
| 4. History of Mental Illness | Four (44%) of the not guilty sample and 7 (39%) of the guilty sample had no current or life time diagnosis of mental illness. | Chi-square not significant. |
| 5. Substance Abuse | 5 (55%) of the not guilty group and 5(27%) of the guilty group had a low substance abuse rating, but 33% of the guilty group and 22% of the not guilty group had a high substance abuse rating. | Chi-square not significant. |
| 6. Suicide or Homicide | Seven (78%) of the not guilty group and 9 (50%) of the guilty group denied any life time threats or actions of homicide or suicide. | X ² = 3.76, p=.43 X ² =15.82, p<.001 |
| 7. Relationship Problems | No subject reported good relationships or an absence of problems in relationship. Just over 50% in both groups reported significant problems with their relationships. | Chi-square not significant. |
| 8. Employment Problems | Marginally significant differences were found in employment status with only 1 of the not guilty group and 3 of the guilty group reporting no problems with employment, but many more of the guilty group (66%) reporting significant employment problems than the not guilty group (22%). | X ² =6.7, p=.15 X ² =3.63,p=.056 |
| 9. Past Non-Sexual Violent Offences | 61% of the guilty group and 56% of the not guilty group reported no history of past non sexual violent offence. | Chi-square not significant. |
| 10. Past Non-Violent Offences | 50% of the guilty group and 56% of the not guilty group reported no history of past non-violent offences. For both past non-sexual and non-violent offences almost 1/3 of the guilty group reported significant histories. | Chi-square not significant. |
| 11. Past Supervision Failure | 33% of the guilty group but 66% of the not guilty group reported past supervision problems. However, since many of the not-guilty group had no prior history, this variable is in fact hard to meaningfully interpret. | No analysis undertaken |

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|---|--|--|
| 12. High Density Sexual Offences | 33% of the guilty group but 56% of the not-guilty group reported no previous sexual offences. | $X^2=3.93$, $p=.42$ $X^2=9.44$, $p<.05$ |
| 13. Multiple Sexual Offences | 39% of the guilty group but 56% of the not guilty group had no history of prior sexual offences. | $X^2=2.07$, $p=.72$ $X^2=5.13$, $p<.05$ |
| 14. Use or Threat of Weapons | 72% of the guilty group and 89% of the not guilty group did not, or were not alleged to have used weapons. | Chi-square not significant |
| 15. Physical Harm (or threats) | 50% of the guilty group and 56% of the not guilty group were not alleged to have caused harm to their victims. | Chi-square not significant |
| 16. Escalation in Frequency of Sex Offences | 39% of the guilty group and 67% of the not guilty group did not report an escalation in the frequency of sexual offences. | $X^2=2.92$, $p=.57$ $X^2=14.63$, $p<.01$ |
| 17. Denial or Minimisation | 61% of the guilty group evidence extreme denial, only 33% of the guilty group do. (I am assuming that the case not proceeded with and one case found not guilty by a jury are in fact guilty). | Chi-square not significant |
| 18. Attitudes Condoning of Sex-Offending | 28% of the found guilty but 56% of those found not guilty did not profess attitudes supportive of, or condoning sexual offending. | $X^2=3.55$, $p=.46$ $X^2=14.96$, $p<.001$ |
| 19. Future Plans | 28% of the guilty group and 22% of the not-guilty group had realistic plans. The rest did not, but only moderately so, in the main. | Chi-square not significant |
| 20. Negative Attitude Towards Therapy | For both groups 11% reported positive attitudes towards therapy. For both groups most reported mildly negative attitudes towards intervention. | Chi-square not significant |

DISCUSSION

The analysis of the individual items reveal that some important differences can be discerned between those found guilty of a sex-offence and those not found guilty. Given the small sample size involved here, results are only indicative. However, if we accept a division between high risk and the aggregate of low and moderate risk, we are able to identify nine items that seemed important in the current sample. Most of these also form important items as noted in the literature, and are not surprising that even in a small sample these items retain apparently strong discriminative power. They are: sexual deviation, a history of sexual abuse, psychopathy, suicidal or homicidal actions or intense ideation, employment problems, increases in sex offending, multiple sex offences and escalation in the pattern of sex offending, and finally attitudes condoning sex offending. Some

items which seemed important, such as denial did not achieve significance although the analysis undertaken here shows the importance of considering each item on its merits. It should be noted that to complete the RSV-20 a full range of data are required, and the use of the RSV-20 is as much as a summary table of important factors as it is a checklist forcing a most comprehensive clinical assessment.

The current study did not set out to demonstrate the superiority of the guided clinical approach. Although data were collected that would allow for the computation of an actuarial index score such as the RRASOR, that is not the intention of the current study. The current analysis reports on the individual variables that appear to indicate the presence of risk. The preponderance of static variables as predictive indicators fits with recent research that indicates static variables retain importance as

predictors of risk and generally supports the adoption of actuarial devices (Andrews and Bonta, 1994). However, I argue that the structured clinical approach is more sensitive to the individual case (see also Blackburn, 1993). From the defence psychologists perspective, the evaluation of the offender often proceeds from an assumption that treatment planning is a significant outcome of the forensic report (Benn & Brady, 1994). That is the role of the forensic examination is more than just risk assessment, but to help decide what we do with the person with an assigned risk rating. To that extent, a risk assessment has to consider potential causal factors related to offending (such as sexual deviancy), static factors predictive recidivism (such as prior criminal behaviour), and factors related to criminogenic needs and rehabilitation such as substance abuse. The RSV-20 requires the comprehensive assessment of the offender and addresses the broad range of activities involved in risk assessment.

The prevalence of static variables in the current analysis raises an interesting question. Treatment planning works on the basis that dynamic risk factors can be modified, and thus moderating such risk factors should lead to a reduction in risk. On the other hand, the dominance of static risk factors as predictors of risk, even in structured clinical instruments such as the RSV-20, suggest that judgements about risk are likely to occur without much consideration of the impact treatment might have on the individual. The argument for the use of structured clinical instruments is that, despite the strong showing of static risk factors, such an instrument allows for a sensitive exploration of the individual and the impact treatment (if it were available) might make on the offender. As the current study shows, such a sensitive analysis does not occur at the expense of minimising potential risks, but if anything, it draws attention to them in a much more deliberate way than reliance on an actuarial device will do. But what it also does is place them in the context of the offender, which is what, in the end, a good psychological evaluation must do.

ACKNOWLEDGEMENTS

I would like to acknowledge the assistance of Paul Nelson in completing this paper.

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ⁱ The status of this client was that he was facing charges deriving from crimes alleged to have occurred more than 25 years ago. He was very ill and there was no chance that his case would be heard before he died. His accusers were elderly, and also with poor memory function. It seemed expedient for the current study to treat this as a case falling into the not-guilty group.