

## Ethical issues regarding risk assessment and treatment of sex offenders in Brazil

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**ABSTRACT:** In this article we discuss ethical issues associated with the use of actuarial (statistical) tests developed in other countries or on unique populations, with offenders in Brazil who are very different from the test-development sample. This practice is problematic in that it could result in prolonging incarceration or the premature release of a dangerous individual. Other measures, such as the structured professional clinical guidelines may provide a short-term solution to the widespread use of unguided professional judgement and the lack of population-based actuarial tests. While current assessment measures may provide some idea of treatment needs, Brazil is also lagging behind in terms of applying "state of the art" sex offender treatment, both pharmacologically and psychologically. We discuss how these issues are related and suggest some means for their resolution.

**KEYWORDS:** Risk assessment. Sexual harassment. Ethical. Sex offenses.

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### INTRODUCTION

**R**isk assessment of sexual offenders is an important topic in forensic psychiatry and psychology. Test users argue the strengths and weaknesses of "clinical judgement" versus "actuarial tests" versus "structured professional judgement" risk guideline assessment strategies. Assessors try to minimize errors of overestimating or underestimating risk, as the first type of error results in the needless prolonging of incarceration for low risk offenders and the other type of error in needless risk for additional victimization

of the public by high risk offenders. It is our opinion that there is more argument in the literature as to what is the best type of risk assessment instrument than there is evidence of concern for public safety or about the ethical issues involved in the practice of risk assessment.

The oldest type risk assessment approach is "clinical judgement" which is unguided by risk assessment tests. Psychologists or psychiatrists who do not use risk assessment tests follow clinical hypotheses and also follow diagnostic indicators

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on which to base their risk judgements. As a result, clinical judgement is generally significantly better than chance, but such judgement (regardless of the experience of the clinician) is much poorer in terms of overall accuracy than the actuarial tests and structured clinical guideline approaches.

“Actuarial tests” are statistical tests that use items that have been shown statistically to be related to risk. The items are evaluated for their individual predictive validity on a group of offenders who have been released for a known period of time and predictive items are then combined and weighted according to an algorithm that is chosen to maximize the overall predictive validity of the items when used together. Essentially, the result is an equation which provides reoffence likelihoods based on the recidivism data of the subject sample used in the study. This equation is composed of the best items which differentiate recidivists from non-recidivists which are then weighted according to the individual predictive power. The usefulness of the resulting “test” depends on the similarities between the test developer’s sample and the offender being assessed. Differences in legal context, uniqueness of the offender being assessed, race and culture, amongst other variables all affect the usefulness of the actuarial test in question with one’s current client.

“Structured professional judgement” (SPJ) risk assessment guideline measures are also referred to as “guided clinical judgement” or “structured clinical guidelines”. Regardless of title, it is assumed (a) that the assessment is being done by a trained professional, and (b), the structured guidelines result in a risk assessment judgement, but in the final analysis (c) the professional doing the risk assessment is being asked to follow a set of guidelines (with some freedom to exercise clinical override) to structure his/her risk judgement. SPJs have been widely adopted by experienced clinicians around the world who are tasked with assessing reoffence risk of a variety of offenders because of the flexibility of the method and the fact that these instruments allow for a very wide analysis of risk including likelihood, imminence, lethality, victim specificity, and issues related to sexual disorders that may be reflected in criminal behavior (e.g., sadism, fetishism, partialism). To be sure there are many sorts of risk and the types of risk are compounded by the nature of the referral questions given to clinicians. For example, “how likely is it that this

offender will re-offend in a violent manner before the end of his sentence if he is granted parole”?

#### CURRENT STATUS OF RISK ASSESSMENT RESEARCH

It is probably accurate to say that the only things that risk assessment researchers agree upon are the above definitions regarding types of risk assessment methodologies. Adherents of any one sort of approach are often very steadfast in their admiration of their own sort of assessment practice or instruments. There are claims of superiority of one approach over the others, and both actuarial and SCG against unstructured clinical approaches. There are actuarial tests that naively suggest the use of very few variables (sometimes only three or four) to describe the overall risk posed by an offender. No actuarial tests account for improvements with treatment, although we know that treated offenders reoffend at half the rate of untreated offenders. Similarly, few SCG tests include variables that account for improvements with treatment. In addition, many of the SCG tests often include variables arguably unrelated or distally related to risk, or place equal emphasis on variables that have differing empirical relationships to risk, or have a great deal of overlap with existing tests. And, neither sort of risk assessment strategy account for decrements in reoffence risk due to aging. In sum, there are problems with the risk assessment literature. Issues such as how to handle missing data or how to use dynamic (i.e., changeable) variables when accounting for changes as a result of treatment are rarely addressed by risk assessment test authors.

In addition to above warnings, it is our contention that we must be very careful to not conclude that any test or set of clinical guidelines can replace our clinical acumen – both are needed in a good risk assessment. When a clinician uses a well-known personality test in a mental health assessment, he or she also uses their clinical observation skills and diagnostic acumen to come up with a complete clinical picture of the patient. If the clinician’s observations do not match the results of the personality profile, the clinician has been trained to form their clinical opinion primarily based on their observations and make reference to the differing test data. Risk assessors should do the same. There is no point in blind allegiance to one’s clinical intuition

or hypothesis-driven diagnosis of risk if the research literature suggests that actuarial or SCG results provide more accurate depictions of risk. However, it would seem equally foolhardy to abandon one's clinical hypotheses when dealing with clients who are each unique and may be quite different from the standardization sample of the most useful actuarial test or have idiosyncratic risk factors that are not captured in the most relevant SCG.

#### **ETHICAL CONCERNS REGARDING RISK ASSESSMENT IN BRAZIL**

The area of risk assessment of any violent offender group involves many ethical issues, which are broadly, the rights of the victims and the public for safety, and the rights of the offender for accuracy and fairness. These two broad concerns are linked since a fair and accurate risk assessment ought to serve to protect the public, reduce victimization and provide an accurate picture of the offender's risk to the public so that the agencies charged with his rehabilitation or incarceration can do these tasks in the most fair and expedient fashion.

The ethical concerns for the offender and the public involve the problems of "false negative" (FN) and "false positive" (FP) errors. These concerns are, respectively, inaccurate risk depictions of the offender as not dangerous when he is (FN) and risk depictions of the offender as dangerous when he is not (FP). A FN error puts the public at risk for victimization as it may allow the offender to be released too early or not be supervised adequately upon release as the risk assessment under-represents his risk to the public. A FP error keeps the offender in jail too long or puts too many resources into his supervision unnecessarily as the risk assessment has over-estimated his risk to the public. Neither type of risk is good for the offender or the public, but the latter type of error is preferable as our key concern is public safety and if an error is to be made it ought to be made in favor of protecting victims not offenders. However, over-incarceration is a drain on public funds and it is obviously preferable to be as accurate as possible, and release offenders when optimal so that these men (or women) can return home and become contributors to society as opposed to a burden on the taxpayer.

In the Brazilian context it would be safe to assume that an actuarial test developed elsewhere needs to

be validated in Brazil before use as anything other than an indicator of potential relative risk. Actuarial tests are only completely useful when validated in the setting in which they are to be used. It makes absolutely no sense to do otherwise as such tests are derived and have any claim to predictive accuracy only when used with members of a population wherein which such tests have been evaluated. Doing otherwise is a nonsensical application, much like using influenza vaccine developed in Canada to treat influenza in Brazil – the strains of influenza are different and as a result the vaccine from Canada may have no effect and may even be worse than no vaccine at all. Similarly, an actuarial test may yield meaningless results, or worse, underestimate risk and result in a dangerous offender gaining the opportunity to create new victims.

The items that comprise Structured Clinical Guideline instruments are derived from the international research literature and the overall test is then applied to the individual. Some of the SCGs have been shown to have validity in a variety of countries, but this does not necessarily mean that a commonly used SCG would work in the Brazilian context. However, the items are less sample-dependent than are those in an actuarial test. Hence, we would cautiously recommend the adoption of the Sexual Violence Risk – 20<sup>2</sup>, already proven to work in number of countries, as a basic SCG for examination. However, we would also propose that the best of the actuarial measures, the STATIC-99 by Hanson and Thornton<sup>4</sup> be examined for adoption. As the first author has written elsewhere, it may well be that a convergent appraisal of risk – coming at the risk picture of a client from a number of directions – may well provide the best and most well-rounded appraisal of risk. In our view, the better the risk picture, the more likely we are to come up with effective risk management strategies for that individual offender.

#### **ETHICAL CONCERNS REGARDING SEX OFFENDER TREATMENT IN BRAZIL**

There are many questions that risk assessments attempt to answer and some are beyond the scope of this paper. However, two of these questions include:

1. What steps could be taken to manage the individual's risk for sexual violence? (this question

is best answered once the dynamic or changeable risk factors have been specified – presumably the best management strategies would be those that address the dynamic factors related to the offender's offending pattern – this can also be addressed via the depiction of risk-decreasing scenarios – the situations, feelings, thoughts and behaviors associated with decreasing risk potential);

2. What circumstances might exacerbate the individual's risk for sexual violence? (this question is probably best answered following completion of the SVR-20 and the depiction of risk-increasing scenarios – the situations, feelings, thoughts and behaviors associated with increasing risk potential).

Neither of these questions can be answered using statistical tests, but must be answered through the use of structured clinical guidelines like the SVR-20. Finding out the details to answer these questions requires sex offender treatment focused on risk reduction. Effective sex offender treatment requires a multi-modal approach – including cognitive-behavioural treatment (CBT), pharmacological treatment, and community-based relapse prevention and maintenance (RPM) treatment as part of the supervision strategy upon release.

While a complete review of treatment modalities for sexual offenders is beyond the scope of this paper there are some observations that can be made. First, CBT delivered in a group format has the most support as an effective intervention for sexual offenders. Pharmacological treatment has also been proven to reduce reoffending in particularly sexually deviant offenders<sup>3</sup>. Also, RP and maintenance therapy has been shown to reduce recidivism in sex offenders. There are ethical dilemmas involved in all of these treatment modalities.

First, CBT has the most theoretical support, but there are problems in evaluating treatment of this sort. It is not possible to do a perfect study and randomly assign offenders to treatment – no treatment conditions. Hence, treatment professionals always end up with the motivated offenders who want to change in the treatment group and those who refuse treatment or are stuck on a waiting list as the control group. Clearly, a randomized design would be better to determine if CBT groups work, but it would be difficult to explain that a child was victimized by a member of a control group!

Second, pharmacological treatment has some

opponents who see it as an unethical treatment despite international data supporting its use. We do not understand why some medical professionals are opposed to the use of anti-androgen treatments. However, such treatments offer reversible sex-drive reduction for offenders who are motivated to decrease their deviant sexual drives and need to be examined as possible short-term solutions to a long-standing problem. In conjunction with CBT, anti-androgen treatment can be very effective in increasing CBT compliance and reducing re-offending. Clearly this sort of approach needs complete informed consent as there are negative side-effects to the medication.

Finally, RPM therapy is an important aspect of sex offender treatment. A good risk assessment will specify risk factors and situations that increase the risk for an offender and RPM will help to ensure those factors stay under control.

## CONCLUSIONS

There is much that we now know about risk assessment and treatment of sexual offenders. In terms of the former, we would like our risk assessment research to advance to the point where those men who are safe to release are released and reduce the cost of jailing offenders unnecessarily. Our Courts and Penitentiary system in Brazil do not yet demand risk assessments on which to base their decisions. However, as we develop our own norms and research, we will have the responsibility to advise policy and law makers regarding risk and intervention to reduce risk. Thus, we provide the risk basis for decisions that affect the offender's life, but also decisions that could affect the life of potential victims. As a result, we need to do the best and most ethical job possible to allow the offender to regain a normal life as soon as possible while protecting the public.

Once we have some developed and trained people in risk assessment, we need then to train our professionals in treatment that reduces the risk of sex offenders to reoffend. Whether all professionals view sex offenders as a medical or legal problem, the treatment options are similar – and it our responsibility to overcome the obstacles that may interfere with effective treatment through education and pilot programmes that show the effectiveness of those treatment modalities currently in use elsewhere in the world.

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Boer DP, Baltier DA, Andrade AG de. Questões éticas referentes à avaliação de risco e ao tratamento de autores de ofensas sexuais no Brasil. *Saúde, Ética & Justiça*. 2008;13(1):28-32

**RESUMO:** Neste artigo discutimos questões éticas associadas ao uso de testes estatísticos desenvolvidos em outros países ou em populações únicas para avaliar autores de abuso sexual no Brasil, que são diferentes das amostras utilizadas no desenvolvimento dos testes. Esta prática é problemática por poder resultar no prolongamento da detenção ou na prematura liberação de um indivíduo perigoso. Outras medidas, tais como diretrizes clínicas estruturadas, podem prover uma solução a curto prazo para o julgamento profissional realizado sem diretrizes, amplamente aplicado, e para a falta de testes baseados e validados na população. Na medida em que medições correntes podem indicar alguma idéia a respeito da necessidade de tratamento, o Brasil está ficando atrasado no que se refere à aplicação do "estado da arte" ao tratamento de autores de abuso sexual, tanto farmacologicamente e psicologicamente. Nós discutimos como estas questões se relacionam e sugerimos alguns meios para solucioná-las.

**DESCRITORES:** Medição de riscos. Delitos sexuais. Assédio sexual. Ética.

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