Refinements in Assessing Risk Levels
Of Sexually Abusive Youth

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Judicial systems and other professionals working with sexually abusive youth benefit from being informed of the empirical research and accuracy on tools for assessing risk level of sexually abusive youth. Many progressive changes have occurred in the last 20 years regarding these measures (Miccio-Fonseca & Rasmussen, 2018).

There are many challenges in risk assessment of sexually abusive youth. A primary obstacle is that the language, the "lingo" is not standardized, leaving a minefield of opportunities for miscommunications. Professionals themselves are confused by the different types risk assessment tools available; surprisingly, many really do not know the difference!

Funding is limited for risk assessment studies; such research often is not seen as a priority. Only a handful of professionals are specialists and/or researchers in the area of risk assessment measures and sexually abusive youth. Recruiting research sites and locating adequately sized samples to test the tools is a significant challenge. There are few researchers working in the area of risk assessment tools, thus it takes years not only to validate and cross-validate but also have independent studies of risk assessment measures.

One almost must become multi-lingual when thinking about the various interconnectedness of different fields, homing in on a sexual abuse case that entails allegations of a sex offense. Several different professional fields become involved, all with their own idiosyncratic lingo, yet to be synthesized to a level of well understood generalities regarding assessment, including risk assessment tools.

Languages for discussing and dealing with sexual abuse cases begins with law enforcement language used by police, detectives, attorneys, probation /parole officers, and judges. Then there is the language of victim(s) - developmental and gender specific considerations, in a word, the family's lingo implemented when the topic of sex and/or sexuality emerges. This may be different than the language of alleged perpetrators, or the witnesses'

language. Each of the other important professionals involved in sexual abuse cases have their own language, the lingo specific to their field, that is the medical professionals, the psychologists and psychiatrists, and social workers, family therapists, case managers, case supervisors, and administrators.

The "lingo" becomes more precarious when the professionals have to deal with sexuality, sexual behaviors, particularly when describing in a report very specific sexually offensive behavior. Synchronizing the language into a fashionable and applicable risk assessment measure that "hits the mountain tops" of the respective fields and their concerns about risk level is a daunting task. Perhaps because of the various terms used, there seems to be a confusion about risk assessment tools in general and the specific types of tools. Even professionals who would appear to be "in the know", do not really seem to know the differences regarding the different types of risk tools.

The early method of risk assessment was via an *Unstructured Clinical Judgement* approach; this method is unreliable and not anchored in any scientific method or research. The professional is basically "just guessing" the risk level of the youth based on their clinical impressions and work experience (which may be very limited).

Risk assessment tools for youth progressed with the introduction of *Structured Professional Judgement* tools. This type of risk assessment tool was based on going to the research literature and finding empirically supported risk factors. However, a significant drawback: it was not uncommon to find that these tools were based to a great extent on research findings on adult convicted sex offenders. Infusing these results into a risk assessment tool for youth means the tool ends up measuring risk factors related to adults, many of which are not applicable at all to youth. The measure is thus unreliable; it is not measuring what it was originally intended to measure (i.e., the risk factors of youth). Another drawback is this type is still a "guess estimate;" structured professional judgment tools do not have exact cut-off scores for categories of risk. Research has shown that this method is no better than chance (Elkovitch, Viljoen, Scalora, & Ullman, 2008). Systematic reviews of risk assessment research have found the predictive validity of structured professional judgment tools to be inconsistent (Hempel, Buck, Cima, & van Marle, 2013; Fanniff & Letourneau, 2012).

Options for assessment for sexually abusive youth improved notably through the development of risk *recidivism* assessment tools, and/or risk *prediction* (actuarial risk assessment). Actuarial tools primarily focus on static risk factors, giving probabilistic estimates of re-offending over time (e.g., 5 years). To develop this method of risk assessment, a designated, detectable "predictive variable" is examined as it relates to repeating sexually offensive behaviors. This method is better than chance, however, also has limitations since it is more of a measure of a group of individuals versus an individual.

Risk level (calibrated) assessment tools, are not predictive tools per say, that is they do not select a designated, detectable "predictive variable" and examine it as relates to repeating sexually offensive behaviors (although this type of research *can* be done if desired). Rather, calibrated *risk level* assessment tools are apt to be more idiosyncratic, more individualized as the scoring of the tool is anchored according to age groups and gender. Thus, it is likely to be more accurate on assessing *risk level*. *Risk level* (calibrated) assessment tools, are measures that generally have been tested and retested on large samples obtaining data distribution according to age and gender (i.e., normative data), which is more definitive. *Risk levels* are then grounded on given algorithms (i.e., statistically weighted risk and/or protective factors according to age and gender). The *risk level* (calibrated) tool has exact, statistically weighted risk and/or protective factors according to age and gender). The *risk level* (calibrated) tool has exact, statistically derived cut-off scores and is considerably more accurate than structured professional judgment tools. To gather the data distribution, the measure needs to have been tested on a large number of youths in different age groups and gender.

The following example may assist in understanding the difference between risk prediction and risk level (calibrated) tools). Let's say someone goes to the doctor complaining about various symptoms (i.e., excessive hunger, increased thirst, itchy skin, etc.). Hearing the patient's discomfort, the doctor develops several hypotheses as to what the health problem may be. The constellation of symptoms reported by the patient may represent a possible disease (i.e., rule out diabetes, and/or others); therefore, the physician orders various tests to assess the patient.

To assist in assessing *of the patient's immediate presentation*, one of the first tests ordered is a *risk level measure.* This is to determine the blood sugar level (i.e., *risk level* and baseline) and/or level of damage from the effects of possible high blood sugar. The results from this test will directly assess the current status (risk level) of the patient's blood levels as well as point directly to the kind of preventative interventions and/or treatment currently needed. The other test the doctor orders is a "blood *prediction test*" (like a *risk prediction* tool), to determine *what is the probability* that the patient *will develop* diabetes *in the future* with the sugar level the patient currently presents.

The patient receives the laboratory blood results of "*high levels of blood sugar*" and calls the doctor. Exceedingly concerned, the patient exclaims, *"I have diabetes!"* The doctor says, "No", explaining that two (2) separate *types of* blood *tests* were ordered, each giving very different but important pieces of data. The first test was to determine the level of blood sugar (*risk level*). It identifies what the blood sugar level is for an individual (like the patient) who is 40 years of age and male, that is, the calibrated *risk level (according to age and gender)*. The *risk level* informs the doctor what *needs immediate attention* to deal with the current symptoms reported by the patient. Thus, the assessment of high blood sugar is a warning sign, a cautionary, alerting as to what is to be mitigated. The doctor goes on to explain that *assessing risk level simply provides information on the immediacy of the situation*, that is, the *kind* of interventions, *degrees* thereof, *frequency and duration of preventative interventions* that need to be implemented (e.g., change in diet, plan exercise schedule, etc.).

The doctor goes on to explain that the second blood test is "*a prediction test*" (like a risk prediction tool) to determine *what is the likelihood* that the patient *will* progress into having diabetes *in the future* with the current blood sugar level. The results of this test will point to the needed implementation of prevention plans to mitigate *the possibility* that the patient *will develop* diabetes *in the future*. Preventive measures would include things like education on diet, foods, and stress reduction, etc. Thus, *risk level* is *associated with the current*, the here and now status of negative impact of high blood sugar for the individual, with *focus on immediate interventions*, while *risk prediction* focuses on the long-term prevention plan to avert developing diabetes in the future.

So too are risk assessment tools for youth; the *risk level (calibrated)* tool identifies the baseline risk level with exactness (cut-off scores according to age and gender), alerting for immediate concerns and potentially guiding decisions regarding needed interventions to reduce risk. *Risk prediction* on the other hand, attempts to determine the probability that a reoffense will occur. *Risk level (calibrated)* tools are idiosyncratic to the youth, whereas the *risk prediction* tool is not; it can only project the probability that someone in a group of youth will reoffend but cannot identify which youth.

Notable Researcher Gives A Call for a New Direction in Risk Assessment for Juveniles

The well recognized researcher on juveniles, Dr. Michael Caldwell (2016), previously advised researchers, "the predictive utility of sexual recidivism risk assessment methods used with juveniles should include a careful review of the calibration and performance characteristics of the method" (p. 8). More recently, Caldwell (2019) called for ceasing the use of "juvenile sexual recidivism risk assessments", citing as examples the *J-SOAP, ERASOR*, and *J-SORRAT-II*. Caldwell pointed to the research indicating such tools are not reliable and/or have risk factors based on adult literature that are developmentally inappropriate for youth. Caldwell asserted these tools "do more harm than good" (Slide 47). His assertion causes significant pause.

Caldwell's call for ceasing a common practice use of "juvenile sexual recidivism risk assessments", is a plea for a paradigm change that in fact has been gradually happening, as evidenced by the different types of measures that have emerged in assessing juvenile sex offenders (see Miccio-Fonseca & Rasmussen, 2018). These tools are more comprehensive and inclusive in their findings, giving more depth and dimension to the youth's assessment. For example, Drs. Knight & Sims-Knight (2014) developed the *MIDSA* a psychological tool providing a detailed comprehensive report on the various dimensions of the psychological functioning of the individual. *MIDSA* clinical reports are extensive, idiosyncratic and descriptive of the youth assessed than "juvenile sexual recidivism risk assessments" which provide no reports. Another example is the *MEGA♪*, a multidimensional risk level (calibrated) assessment tool that assesses risk levels and protective factors according to age and gender (Miccio-Fonseca, 2013).

The call for a change in methods of risk assessment for sexually abusive youth from such a prominent researcher as Dr. Michael Caldwell may be the final tipping point for the emerging paradigm change to transform the field in assessing sexually abusive youth. Caldwell's recommendation to cease the implementation of "juvenile sexual recidivism risk assessments" marks a step in the evolution and refinement of risk assessment methods for sexually abusive youth. Caldwell's call is an opportunity for a re-examination of state and national guidelines that mandate the use of "juvenile sexual recidivism risk assessments" and move toward the use of appropriate measures.

New and upcoming, risk level assessment measures are apt to be more accurate, more sensitive to age and gender (i.e., have calibrated risk levels and exact cut-off scores). Tools assessing *risk levels* (calibrated according to age and gender), as opposed to attempting to *predict recidivism* outcomes, represent a new generation of risk assessment tools for sexually abusive youth and a step towards greater accuracy in risk assessment.

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