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Chapter 14

Structured Professional Judgment Guidelines for Sexual Violence Risk Assessment

The Sexual Violence Risk-20 (SVR-20) Versions 1 and 2 and Risk for Sexual Violence Protocol (RSVP)

Stephen D. Hart and Douglas P. Boer

In this chapter, we review two related sets of structured professional judgment guidelines for assessing risk for sexual violence. The *Sexual Violence Risk-20* actually exists in two editions, Version 1 (Boer, Hart, Kropp, & Webster, 1997) and Version 2 (Boer, Hart, Kropp, & Webster, 2017), hereinafter abbreviated SVR-20 V1 and V2, respectively. Although V2 is intended to supersede V1, we review V1 here because a number of English-language evaluators have not yet switched to V2 and most evaluators working in other languages cannot use V2 because translations are not yet completed. The *Risk for Sexual Violence Protocol*, abbreviated herein as RSVP, is currently available only in one version (Hart et al., 2003), with Version 2 scheduled for release by December 2020.

This chapter updates our contribution to the first edition of the book (Hart & Boer, 2010). The SVR-20 V1 or RSVP have been reviewed by others, most often as part of narrative or meta-analytic reviews of multiple sexual violence risk assessment tools (e.g., Hanson & Morton-Bourgon, 2009). Our review is unique in three major respects. First, we provide a full description of the administration process of the SVR-20 V1/V2 and RSVP. We discuss the guidelines together because they are similar in format and content and to that extent that we consider them to be parallel forms; yet, there are some noteworthy differences between them, primarily with respect to the complexity of their administration procedures. Second, we provide a narrative summary of all the major disseminations to date we could locate that evaluated the interrater reliability and criterion-related validity of judgments made using the guidelines. Third, we illustrate the use of the guidelines—and the differences between them—using a case example.

Description

Type of Instrument

The SVR-20 V1/V2 and RSVP are structured professional judgment (SPJ) guidelines for conducting comprehensive assessment of risk for sexual violence. They are intended to help evaluators to make two major decisions about risk for sexual violence (Hart, Douglas, & Guy, 2016). The first decision concerns identifying the evaluee's potential for harm with respect to the nature, seriousness, imminence, frequency or duration, and likelihood of any future sexual violence the evaluee may commit. This decision is predictive in the sense that it involves forecasting or anticipating an uncertain future, rather than predictive in the sense of calculating or estimating the absolute, precise, quantitative probability of an event or occurrence in the future. The second decision concerns identifying feasible and effective means of mitigating the risks posed by the evaluee. This decision involves developing action plans that are strategic, tactical, and logistical in nature.

Guidelines, most generally, are "pronouncements, statements, or declarations that suggest or recommend specific professional behavior, endeavor, or conduct" (American Psychological Association, 2002, p. 1052). The development of guidelines is one of the primary methods used to promote best practice in health care professions (Reed, McLaughlin, & Newman, 2002). Consistent with recommendations for health care guidelines (e.g., American Psychological Association, 2002), development of SPJ guidelines such as the SVR-20 V1/V2 and RSVP is based in part on a systematic review of the existing scientific research, standards of practice, ethical codes, and relevant law. Accordingly, the SVR-20 V1/V2 and RSVP may be considered research products (Addis, 2002). They fall within the definition of evidence-based, empirically guided, or empirically supported guidelines to the extent that their use reflect "the conscientious, explicit and judicious use of current best evidence in making decisions about the care of individual patients" (Sackett, Rosenberg, Gray, Haynes, & Richardson, 1996, p. 71; see also Hart, 2009; Hart et al., 2016). They may also be accurately characterized as best practice guidelines, consensus guidelines, or clinical practice parameters, in health care; or, using terms more common in correctional psychology, as management-focused, risk-need-responsivity, or fourth-generation risk assessment instruments (e.g., Bonta & Andrews, 2017; Andrews, Bonta, & Wormith, 2006).

The SVR-20 V1/V2 and RSVP differ from some guidelines in two important ways. First, they reflect the opinions and recommendations of the authors, rather than the official position or policy of any agency, organization, or association. Second, they are not practice standards, as they are not binding on and do not restrict the practice of any professional groups.

Criterion Assessed

As stated previously, the SVR-20 V1/V2 and RSVP are intended to guide assessment of *risk for sexual violence*. Below, we divide this criterion into two parts for the purposes of defining it: *sexual violence* versus *risk*.

Definition of Sexual Violence

The SVR-20 V1/V2 and RSVP define sexual violence as the "actual, attempted, or threatened sexual contact with another person that is nonconsensual" (Hart et al., 2003, p. 2; see also Boer et al., 1997, p. 9, and Boer et al., 2017, p. 2). The sexual contact can be direct or indirect. Direct sexual contact involves one or more of the following: sexual touching of a victim by the perpetrator either physically or with an object; communication of a sexual nature between the perpetrator and victim, either verbal or nonverbal, that does not use an intermediary; or other interaction of a sexual nature between perpetrator and victim while they are in close physical proximity. The sexual contact may be nonconsensual because it occurred despite the victim's explicit refusal to consent, without the explicit consent of the victim, or with the assent of a victim who was legally unable to give consent due to immaturity, infirmity, or (perceived) duress. Put another way, sexual violence is interpersonal behavior of a sexual nature (e.g., with respect to motivation or behavioral topography) that is inherently coercive and thus has the potential to cause people reasonable fear of physical or grave psychological harm.

The definition just presented is broad and includes a wide range of acts that would constitute violations of criminal or civil law in most jurisdictions, although acts need not result in findings of culpability to be considered sexual violence. It excludes some forms of unusual, problematic, or even illegal sexual behavior that do not involve sexual contact with other people or that are consensual (e.g., sex with animals, sadomasochistic sex with a consenting partner). Of course, conduct that does not fall within the definition of sexual violence per se may fall within the definition

of various risk factors for sexual violence and may constitute reasonable grounds for suspecting that the person has a history of sexual violence or is at risk for sexual violence.

With respect to the definition of sexual violence, two types of conduct require special discussion. The first is conduct that involves the production, consumption, or distribution of pornography. When the evaluee was a party to production of pornography that included depiction of sexual violence as defined earlier, the conduct constitutes sexual violence. If the evaluee was a party to consumption or distribution of pornography that included depiction of sexual violence as defined earlier, the conduct constitutes sexual violence. The second type of conduct involves human trafficking and pimping. If the evaluee was party to the commission of sexual violence perpetrated by others by procuring potential victims (i.e., knew or ought reasonably to have known that the people were intended victims of sexual violence) or using duress to force victims to have sexual contact with others, the conduct constitutes sexual violence.

Definition of Risk

The SVR-20 V1/V2 and RSVP, like all SPJ guidelines, conceptualize risk broadly in terms of the nature, severity, imminence, frequency, and likelihood of future sexual violence. According to this definition, risk is about uncertainty—what we do not know about the future, not what we do know. With respect to risk for sexual violence (and, in our view, all forms of violence), that uncertainty is unbounded. We don't know precisely how to conceptualize or define sexual violence (linguistic uncertainty). We don't know exactly what causes sexual violence (epistemic uncertainty). We don't know how to measure causal factors precisely (evaluative uncertainty). We don't know how to apply findings from group-based research to make precise predictions about individuals (ludic uncertainty).

The definition of risk used in SPJ guidelines, with its focus on uncertainty, is consistent with that of major international organizations such as ASIS International and The Risk and Insurance Management Society (2015), the International Standards Organization (2018), and the Society for Risk Analysis (2018), and also consistent with that used in the law in various countries (e.g., in Canada, *Smith v. Jones*, 1999). But it is in stark contrast to the definition used by actuarial tests of risk for sexual violence. They define risk solely in terms of frequentist probabilities, either relative or absolute, based on statistical profiles of recidivism in various reference groups of offenders or forensic mental health patients. We have discussed the problems with such an impoverished definition of risk at length elsewhere (e.g., Hart & Douglas, 2019; Hart et al., 2016), but for the purpose of this chapter it will suffice to say the fundamental problem is that it pretends a degree of certainty—linguistic, epistemic, evaluative, and ludic—that simply does not exist (for a more extensive discussion, see Hart, 2004/2011).

Structure

SPJ guidelines such as the SVR-20 V1/V2 and RSVP are structured in two ways. First, they have administration procedures that comprise specific steps. Second, they identify and define a set of risk factors that should be considered, at a minimum, in all evaluations. Below, we discuss these two types of structure in greater detail. As will be clear from the discussion, the structural differences between the guidelines are relatively minor, and we expect that evaluators could and should reach more or less identical overall decisions about risks posed and management of risks in a given case regardless of which set of guidelines they use. This is the reason why we consider them to be equivalent or parallel forms.

Administration Procedure

As noted previously, the SVR-20 V1/V2 focus primarily on description of risks for sexual violence posed by evaluees and so have a relatively simple administration procedure that comprises four steps. In Step 1, evaluators gather information about the case via document review and interviews with evaluees and collateral sources. The guidelines discuss the sorts of information that evaluators should attempt to gather and the methods they should consider for gathering it. The goal is to establish an information base that is reasonably comprehensive and trustworthy and will permit evaluators to reach findings and opinions with a reasonable degree of professional confidence or certainty.

In Steps 2 and 3, evaluators determine the presence of each of 20 standard risk factors according to two timeframes: Past, or prior to last 12 months; and Recent, or within the last 12 months. (As will be discussed, there are some differences in the standard risk factors included in the SVR-20 V1 versus V2.) Evaluators also have the ability to specify the presence of any case-specific or idiosyncratic risk factors that are not already included in the standard 20. Judgments of presence are based on the existence of evidence in the information base and are made on a 3-point ordinal scale (Yes = *evidence the risk factor is present*, Possibly/Partially = *evidence the risk factor is possibly or partially present*, No = *no evidence the risk factor is present*), except that judgments of Recent presence in the SVR-20 V1 use slightly different anchors and focus on change (*evidence that the risk factor has worsened*, *no evidence that the risk factor has changed*, *evidence that the risk factor has improved*). Presence ratings may be omitted if there is not sufficient information with which to make a judgment. The distinction between Past and Recent is intended to oblige evaluators to consider changes over time in the status or level of risk factors.

In Step 4, evaluators express global opinions about the nature of the risks posed by evaluees, in light of the pattern of risk factors present. Both the SVR-20 V1 and V2 include a summary risk rating that reflects judgments about the degree of effort or intervention that would be required to prevent future sexual violence by evaluees under assumed conditions of release. It is equivalent to a judgment of the likelihood that evaluees would commit future sexual violence if released without any special release conditions or interventions. The SVR-20 V2 also includes additional ratings. Serious Physical Harm reflects judgments about the degree to which evaluees pose a risk for sexual violence that includes lethal, life-threatening, or severe bodily harm. Need for Immediate Action reflects judgments about whether evaluees pose a risk for imminent sexual violence (i.e., pose a clear and present danger). Other Risks Indicated reflects judgments about whether evaluees may pose a risk of harm other than sexual violence that may be worthy of follow-up assessment. Finally, Case Review reflects judgments concerning how soon evaluees should undergo reassessment of risk for sexual violence and what "red flags" (i.e., specific events or occurrences) should trigger an immediate reassessment. Summary risk ratings, as well as ratings of Serious Physical Harm and Need for Immediate Action, are made on a 3-point ordinal scale (*Low*, *Moderate*, *High*); ratings of Other Risks Indicated are also made on a 3-point ordinal scale (*No*, *Possibly*, *Yes*); and ratings of Case Review are made in terms of a recommended timeframe or date for case review in the absence of red flags.

The administration procedure for the RSVP is a bit more complex, comprising six steps, due to its focus on the development of detailed case management plans. Step 1, in which evaluators gather information about the case via document review and interviews with evaluees and collateral sources, is identical to that in the SVR-20 V1/V2.

Step 2, in which evaluators making presence ratings for 22 standard risk factors (see the following) Past and Recent, is a combination of Steps 2 and 3 in the SVR-20 V2. (As will be discussed, there are some differences in the way the domain of risk factors was captured in the RSVP versus the SVR-20 V1/V2.)

In Step 3, evaluators determine the causal or functional relevance of each of the 22 standard risk factors with respect to the perpetration and management of risk for future sexual violence. These judgments are made on the basis of an integrative case formulation (also known as a case conceptualization) of the evaluee's history of sexual violence made using a theoretical framework, either Action Theory (the one most often discussed with respect to SPJ guidelines; see Hart et al., 2003; Hart & Logan, 2011; Hart et al., 2016) or the evaluator's preferred alternative. Relevance is coded on the same 3-point ordinal scale used for presence ratings.

In Step 4, the evaluator identifies the most plausible scenarios of future sexual violence based on the evaluee's history of sexual violence, the evaluator's case formulation of the evaluee, and the evaluator's knowledge and experience. Scenarios are brief narrative descriptions of what kinds of sexual violence the evaluee is most likely to perpetrate, for which kinds of motivations, resulting in what kinds of psychological and physical harm, against which kinds of victims, and at which times or in which situations, as well as a judgment of the perceived likelihood that evaluees will commit sexual violence of that sort given their anticipated living situation (e.g., planed or likely conditions of confinement or community residence). The process of developing scenarios in the RSVP was based on principles and methods of scenario planning, a planning method used widely in other fields (see discussion by Hart et al., 2016).

In Step 5, evaluators develop a detailed case management plan in light of the identified scenarios that details the critical strategies, tactics, and logistics required to effectively manage or mitigate the person's risk for future sexual violence. The strategies and tactics are divided into four categories, according to whether they focus on monitoring (surveillance), supervision (restriction of freedoms), intervention (assessment, treatment, and rehabilitation), or victim safety planning (enhancing the security resources of likely victims).

Step 6, in which evaluators express global opinions about the nature of the risks posed by evaluees, is almost identical to that in the SVR-20 V2, with two exceptions: first, the SVR-20 V2 summary risk rating is referred to as the Case Prioritization Rating in the RSVP; second, the SVR-20 V2 Need for Immediate Action rating is referred to as the Immediate Action Required rating in the RSVP, where it is coded (*No*, *Possibly*, *Yes*).

Of the various global judgments regarding risk included in the SVR-20 V1/V2 and RSVP, the most important is the summary risk rating or Case Prioritization rating. A judgment that the overall risk or prioritization in a case is *Low* indicates the evaluee does not appear to need any special intervention or supervision strategies designed to manage violence risk, and there is no need to monitor the evaluee closely for changes in risk. A judgment of *Moderate* indicates a risk management plan should be developed for the evaluee, which typically would involve (at a minimum) systematic reassessment of risk. A judgment of *High* indicates an urgent need to develop a risk management plan for the evaluee, which typically would involve (at a minimum) advising staff, increasing supervision levels, placing the individual on a high-priority list for available treatment resources, scheduling regular reassessments, or even an emergency response (e.g., hospitalization, suspension of conditional release). But making global judgments of risk is neither necessary nor sufficient to conduct a comprehensive risk assessment. From the SPJ perspective, the most important task is the development of plans to manage or mitigate risk, and this can be done without the need for making global judgments in some contexts.

Content

The standard 20 risk factors in the SVR-20 V1 are presented in Table 14.1. As the table indicates, they are divided into three domains on a purely rational or practical (i.e., not statistical) basis. The *Psychosocial Adjustment* domain comprises 11 risk factors that reflect the evaluee's history of personal problems with respect to such things as employment and education, relationships, antisocial conduct, and various aspects of mental health. The *Sexual Offences* domain comprises

seven risk factors that reflect the evaluee's history of sexual violence, both in terms of past acts of sexual violence and cognitions related to sexual violence. The *Future Plans* domain comprises two risk factors that reflect the evaluee's general ability to develop plans to cope with personal problems and work with professionals to mitigate risk for sexual violence.

The risk factors in the SVR-20 V1 were modified slightly in V2 in light of the updated literature review, as well as the experience of the authors and feedback from other evaluators. (The revision process is discussed in detail below.) The SVR-20 V2 still includes 20 risk factors divided into three domains on a rational basis: *Psychosocial Adjustment*, 10 risk factors; *History of Sexual Offending*, 7 risk factors; and *Future Plans*, 3 risk factors. They are presented in Table 14.2.

The 22 standard risk factors in the RSVP are presented in Table 14.3. They are divided into five domains on a rational basis. The *Sexual Violence History* domain comprises five risk factors that reflect the evaluee's history of sexually violent acts. The *Psychological Adjustment* domain comprises five risk factors that reflect problems with general mental well-being or functioning. The *Mental Disorder* domain comprises five risk factors that directly reflect specific mental health problems. The *Social Adjustment* domain comprises four risk factors that reflect general problems with social integration or functioning. Finally, the *Manageability* domain comprises three risk factors that reflect the evaluee's general ability to develop plans to cope with personal problems and work with professionals to mitigate risk for sexual violence

Intended Applications

Purposes

The primary intended purpose of the SVR-20 V1/V2 and RSVP is to assist evaluators to undertake sexual violence risk assessment. For this purpose, they can be used in several different ways. First, they can function as reference texts, documents that can be read in advance of conducting

Table 14.1 Risk Factors in the SVR-20 V1

Domain	*Risk Factor*
Psychosocial Adjustment	1. Sexual deviation
	2. Victim of child abuse
	3. Psychopathy
	4. Major mental illness
	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 failure
History of Sexual Offenses	12. High density
	13. Multiple types
	14. Physical harm
	15. Weapons/Threats
	16. Escalation in frequency or severity
	17. Extreme minimization/denial
	18. Attitudes that support or condone
Future Plans	19. Lacks realistic plans
	20. Negative attitude toward intervention

Note: SVR-20 V1 = Sexual Violence Risk-20.

Source: Boer et al. (1997).

Table 14.2 Risk Factors in the SVR-20 V2

Domain	*Risk Factor*
Psychosocial Adjustment	1. Sexual deviation
	2. Sexual health problems
	3. Victim of child abuse
	4. Psychopathic personality disorder
	5. Major mental disorder
	6. Substance use problems
	7. Suicidal/homicidal ideation
	8. Relationship problems
	9. Employment problems
	10. Nonsexual offending
Sexual Offending	11. Chronic sexual offending
	12. Diverse sexual offending
	13. Physical harm in sexual offending
	14. Psychological coercion in sexual offending
	15. Escalation in sexual offending
	16. Extreme minimization/denial of sexual offending
	17. Attitudes that support or condone sexual offending
Future Plans	18. Lacks realistic plans
	19. Negative attitude toward intervention
	20. Negative attitude toward supervision

Note: SVR-20 V2 = Version 2 of the Sexual Violence Risk-20.

Source: Boer et al. (2017).

Table 14.3 Risk Factors in the RSVP

Domain	*Risk Factor*
History of Sexual Violence	1. Chronicity of sexual violence
	2. Diversity of sexual violence
	3. Escalation of sexual violence
	4. Physical coercion in sexual violence
	5. Psychological coercion in sexual violence
Psychological Adjustment	6. Extreme minimization or denial of sexual violence
	7. Attitudes that support or condone sexual violence
	8. Problems with self-awareness
	9. Problems with stress or coping
	10. Problems resulting from child abuse
Mental Disorder	11. Sexual deviance
	12. Psychopathic personality disorder
	13. Major mental illness
	14. Problems with substance use
	15. Violent or suicidal ideation
Social Adjustment	16. Problems with intimate relationships
	17. Problems with non-intimate relationships
	18. Problems with employment
	19. Nonsexual criminality
Manageability	20. Problems with planning
	21. Problems with treatment
	22. Problems with supervision

Note: RSVP = Risk for Sexual Violence Protocol.

Source: Hart et al. (2003).

sexual violence risk assessments to enhance the knowledge and skills of evaluations. Second, they can function as *aides mémoire* or memory aids, documents that can be referred to in the course of conducting sexual violence risk assessments to ensure that evaluators practice in a systematic, thorough manner. Finally, to the extent that evaluators follow closely the recommendations outlined in the guidelines, they function as psychological tests—that is, documents that constitute evaluative devices or procedures (e.g., American Educational Research Association, American Psychological Association, & National Council on Measurement in Education, 1999). Like all tests, the SVR-20 V1/V2 and RSVP attempt to structure the process of assessment. Unlike many psychological tests, however, they were not intended to quantify behavior in the form of scores that can be interpreted with respect to norms or other criteria. Similar tests have been developed for use in a wide range of psycholegal assessments and have been referred to as *forensic assessment instruments* or *forensically relevant assessment instruments* (Grisso, 2003; Heilbrun, 2001; Heilbrun, Rogers, & Otto, 2002).

Secondary intended purposes of the SVR-20 V1/V2 and RSVP are to assist research, education, and training with respect to sexual violence and risk assessment as well to judge the quality and adequacy of sexual violence risk assessments conducted by others (e.g., as part of routine quality assurance audits or critical incident reviews).

The SVR-20 V1/V2 and RSVP should not be used to determine whether evaluees have committed an act of sexual violence in the past. Nor should they be used to determine whether evaluees "fit the profile of a sex offender," given the heterogeneity of people who commit sexual violence. Finally, they should not be used to assess risk of nonsexual violence, other forms of violence such as (nonsexual) intimate partner violence and stalking, or nonviolent criminal conduct. If there is any evidence that evaluees may be at risk of antisocial behavior other than sexual violence, evaluators should document their opinions in this regard.

Contexts

The SVR-20 V1/V2 and RSVP are intended for use in a wide range of civil and criminal justice contexts. These contexts include but are not limited to: pretrial and sentencing evaluations; correctional intake and discharge evaluations; post-sentence civil commitment (i.e., sexually violent predator) evaluations; duty to protect, community notification, and sex offender registration evaluations; child protection or custody/access evaluations; bullying, sexual harassment, and sexual violence evaluations in workplaces or institutions of higher education; and investigations such as fatality inquests, critical incident reviews, ethical or professional standard complaints, and civil suits related to professional negligence or wrongful death.

Populations

The SVR-20 V1/V2 and RSVP are most appropriate for use with people who self-identify as cisgender male or female, are adults or emerging adults (age 18 and older), and were raised or reside in countries with developed economies, regardless of their sexual orientation and their history of physical or mental health problems. This is because the scientific and professional literature that served as the basis for constructing the guidelines focused primarily on this group.

The SVR-20 V1/V2 and RSVP are of uncertain appropriateness for the evaluation of some people. One example is people who self-identify as transgender, including those who are transsexual or non-binary, regardless of sexual orientation. Other examples are people who were raised in countries with developing economies, or who self-identify as members of understudied cultures or subcultures. When an evaluation is necessary but involves unusual or even novel group differences, we recommend that evaluators proceed using the SVR-20 V1/V2 and RSVP

as a general framework but explicitly acknowledge its limitations (due to the absence of a well-developed evidence base) and take steps to ensure the evaluation is comprehensive and individualized. This may require evaluators to become familiar with authoritative treatises concerning the group differences, consult with people who are acknowledged as experts in the group differences, and discuss directly with evaluees whether and how the group differences may be relevant to risk for sexual violence.

The SVR-20 V1/V2 and RSVP are inappropriate for evaluations of children and young adolescents (i.e., age 15 and younger). Sexual misbehavior by children and young adolescents differs in important ways from the sexual violence committed by older adolescents and adults. For example, the former is targeted primarily at same-aged victims, is less likely to involve physical coercion, and may also be related to different causal processes, such as delayed social maturation.

Cautions Regarding Use

By their very nature, SPJ guidelines like the SVR-20 V1/V2 and RSVP are neither exhaustive nor fixed. In any given evaluation, there may be case-specific factors that are crucial to professional judgments concerning risk. The existence or use of professional guidelines does not obviate the need to exercise professional judgment (Addis, 2002; American Psychological Association, 2002; Reed et al., 2002).

Also by their nature, SPJ guidelines like the SVR-20 V1/V2 and RSVP cannot be used to estimate the specific likelihood or absolute probability that a given evaluee will commit sexual violence in the future. Indeed, as discussed previously, making estimates of this sort with any reasonable degree of certainty probably lies beyond the ability of science (Hájek & Hall, 2002; Hart, 2004/2011; Hart & Cooke, 2013; Hart, Michie, & Cooke, 2007).

Like all guidelines, the SVR-20 V1/V2 and RSVP have a natural lifespan and must be updated (e.g., American Psychological Association, 2002; Reed et al., 2002). Version 2 of the SVR-20 was released in 2018 (albeit with a 2017 publication date), and a revision of the RSVP is currently in preparation with publication anticipated in late 2020.

The SVR-20 V1/V2 and RSVP focus on the risks posed by the evaluee, rather than on the risks posed to a specific potential victim. Victim-focused risk assessments—sometimes referred to as victim safety planning or victim lethality assessments—differ from perpetrator-focused risk assessments in important ways, including consideration of psychological, social, and environmental factors that may increase the victim's vulnerability to sexual violence (Krug, Dahlberg, Mercy, Zwi, & Lozano, 2002). Evaluators should consider expanding their risk assessments to include consideration of victim vulnerability factors in cases where any future sexual violence is likely to be targeted at a specific person.

User Qualifications

According to the SVR-20 V1/V2 and RSVP, evaluators should meet two general requirements. First, they should have a good understanding of sexual violence, including at least a basic familiarity with the professional and scientific literatures on its nature, causes, and management. Second, evaluators should have training and experience in individual assessment, including interviewing and reviewing third-party information; training and experience in the administration and interpretation of standardized tests can also be helpful.

The guidelines include risk factors related to mental disorder. Evaluators who are not trained or qualified to assess and diagnose mental disorder have four options. First, they can assess risk factors related to mental disorder in consultation with or under the supervision of qualified evaluators. Second, they can assess risk factors related to mental disorder by referring to the results of psychodiagnostic assessments conducted by qualified evaluators. Third, they can assess risk

factors related to mental disorder provisionally, document this, and discuss the importance of having their provisional assessments confirmed by qualified evaluators. Finally, they can decide not to assess risk factors related to mental disorder, document this, and discuss how the incomplete assessment limits their opinions regarding risk.

It is completely acceptable, and even desirable, for the SVR-20 V1/V2 and RSVP to be administered with the involvement of a team. We recommend, however, that one member of the team take formal and primary responsibility for collating information, recording consensus regarding findings and opinions, and authoring reports.

The SVR-20 V1 and V2 manuals do not discuss the training of evaluators. The RSVP manual states that evaluators do not need to complete any specific training program, but rather can accomplish adequate training in a number of different ways, including self-study, supervised practice, and attendance at lectures or workshops. It recommends about 16 to 32 hours of training that includes the following components: a review of the manual, with particular emphasis on basic information and administration issues; a review of any critical advances in knowledge regarding sexual violence or risk assessment subsequent to publication of the RSVP manual; completion of practice cases based on file review; and completion of actual cases under supervision of or in consultation with experienced colleagues.

Method and Rationale for Development

Principles of Development

As noted previously, the SVR-20 V1/V2 and RSVP were based on a systematic review of the scientific and professional literature on sexual violence. The literature reviewed included a wide range of empirical reports, reviews, and previous guidelines that were published in journals and books or as reports available from government agencies. The administration procedures in the SVR-20 V1/V2 and RSVP were based primarily on publications from the professional literature: reviews and previous guidelines published in journal articles, in books, or as agency reports. In contrast, the risk factors in the SVR-20 V1/V2 and RSVP were drawn from the scientific literature, including quantitative and narrative reviews of the empirical literature, individual empirical studies, and theoretical reviews.

The literature reviews were broad in scope. We searched multiple computerized databases covering medicine (primarily psychiatry) and social science (primarily psychology and criminology) to identify disseminations (books, articles, chapters, government reports, conference papers, and graduate dissertations and theses) related to sexual violence, sexual violence risk assessment and management, and cognate terms. We included all disseminations in English, as well as some disseminations in other languages that we were able to comprehend without the need for professional translation, but we excluded publications that focused solely on sexual misbehavior in children or young adolescents (i.e., younger than 15 years old). We then inspected the reference lists of the included disseminations to identify additional studies of potential relevance. Our literature reviews we conducted were greatly assisted by reviewing the meta-analytic and narrative reviews prepared by others, as well as by encyclopedic works (e.g., Boer, 2016).

Our literature review had two major goals. The first was to identify the types and sources of information generally considered important for conducting a comprehensive assessment of risk for sexual violence. The second was to synthesize a list of risk factors. We attempted to identify individual risk factors that were: (a) supported by scientific research; (b) consistent with major theories and previous professional recommendations; and (c) legally acceptable, that is, consistent with human or civil rights. (Some examples of legally problematic or unacceptable factors include ascribed factors such as age, sex, and race; reliance on such factors may be considered problematic or even a violation of constitutional or human rights.) We also attempted to make sure the list

or set of factors was: (a) reasonably comprehensive; (b) not unduly long; and (c) couched in the basic language of practitioners, that is, neither too general nor too specific.

There are differences in the risk factors included in the guidelines. We consider these differences to be minor. The (surprisingly small) differences between the SVR-20 V1 and V2 can be attributed to the fact that the literature on sexual violence reviewed as part of their development evolved between 1997 and 2017. The differences between the SVR-20 V1/V2 and RSVP can be attributed to the fact that the latter places a greater emphasis on the development of case management plans. The RSVP therefore conceptualizes a few risk factors in a more granular and treatment-relevant way than does the SVR-20 V1/V2.

Interrater Reliability

In this section, we summarize the findings of studies that have evaluated the interrater reliability of risk judgments made using the SVR-20 V1/V2 and RSVP. We do not discuss the structural properties of ratings made using the SVR-20 V1/V2 and RSVP. As the SVR-20 V1/V2 and RSVP are formative evaluative devices (i.e., are intended to assist the forecasting of future sexual violence) rather than reflective measures (i.e., indicators of a latent trait or taxon), there is no good reason to expect that the covariance among ratings of individual risk factors in the guidelines will have a specific pattern that is stable across samples. We therefore view research on such things as the internal consistency, homogeneity, or factor structure of risk factor ratings (e.g., Kanters et al., 2017; Walters, Knight, & Thornton, 2009) to be of little relevance in evaluating SPJ guidelines.

With respect to interrater reliability, we review research (publications and conference presentations) for each set of guidelines in chronological order, from oldest to newest. We have attempted to eliminate redundancy by reviewing only a single dissemination (typically, the published or most recent version) when multiple disseminations were based on the same dataset. For the purpose of evaluating interrater reliability, it is conventional for researchers to convert the various ratings of risk made using the guidelines from ordered categories into numerical scores (i.e., 0 = *No*, *Low*, or *Routine*; 1 = *Possibly or Partially*, *Moderate*, or *Elevated*; 2 = *Yes*, *High*, or *Urgent*). Many researchers also create total or domain scores by summing numerical scores for the presence or relevance of risk factors. Also, in research on the RSVP, some researchers combine numerical scores for the presence-past and presence-recent ratings of each risk factor by taking the maximum of the two values to create a single score reflecting presence-ever (i.e., "ever present"). Except where noted otherwise, interrater reliability in the studies reviewed in this section was indexed using single rater intraclass correlation coefficients, abbreviated herein as ICC_1, calculated for absolute agreement using a mixed effects model. ICC_1 is most appropriate for true continuous variables but can also be used with ordinal categorical variables and is mathematically equivalent to another popular index, weighted *kappa* or κ_W. Following Fleiss (1981), we interpreted ICC_1 coefficients as follows: < .39 = *poor*, .40 to .49 = *fair*, .50 to .74 = *good*, and > .75 = *excellent*.

Ideally, the interrater reliability of risk factors should be evaluated individually. In some studies and disseminations, however, this is not feasible due to sample size or page limitations, and so the interrater reliability of risk factors is evaluated as an ensemble by analyzing composite scores. Although this is acceptable for research purposes, we emphasize that this is not the manner in which the SVR-20 V1/V2 and RSVP are intended to be used in practice, and also that such composite scores are not mathematically optimized measures of risk.

SVR-20 V1/V2

Sjöstedt and Långström (2003) evaluated interrater reliability between two independent raters in two subsamples of 15 cases each, randomly selected from a larger sample of 51 adult male rapists

who underwent presentence forensic psychiatric evaluations in Sweden between 1988 and 1990. SVR-20 V1 ratings were made on the basis of file information. Presence ratings for individual risk factors had generally poor to fair interrater reliability in the first subsample of 15 people, $M\kappa = .36$. The authors speculated this may have been due to variation among raters in experience and repeated the analyses in a second set of 15 people after additional training. Interrater reliability for presence ratings increased: κ ranged from .08 to 1.00, with $M = .51$ and $Mdn = .57$. In the second subsample, the interrater reliability of summary ratings of risk for sexual violence was fair, $\kappa = .50$.

De Vogel, de Ruiter, van Beek, and Mead (2004) evaluated agreement between two independent raters in a subsample of 30 cases, randomly selected from a larger sample of adult male sex offenders admitted to a Dutch forensic psychiatric hospital between 1974 and 1996. SVR-20 V1 ratings were made on the basis of file information. Interrater reliability was fair or better for 18 of 20 individual risk factors. Two risk factors had poor interrater reliability: 1 (*Sexual deviance*), $ICC_1 = .38$; and 7 (*Relationship problems*), $ICC_1 = .29$. According to the authors, the low reliability for ratings of 1 (*Sexual deviance*) was due to lack of clinical experience for one of three clinicians who made ratings; interrater reliability was good for the two experienced clinicians, $ICC_1 = .68$. Also according to the authors, the low reliability of ratings for 7 (*Relationship problems*) was due to lack of variance. Presence ratings for individual risk factors were also recoded and summed to create total and domain scores. Interrater reliability for total scores was excellent: $ICC_1 = .75$. For domain scores, it was good to excellent: $ICC_1 = .74$ for *Psychosocial Adjustment*, $ICC_1 = .74$ for *Sexual Offences*, and $ICC_1 = .78$ for *Future Plans*. Finally, interrater reliability of the summary risk rating for sexual violence was fair: $ICC_1 = .48$. In 2 of 30 cases (7%), one rater judged "high risk" whereas another rater judged "low risk."

Hildebrand, de Ruiter, and de Vogel (2004) evaluated the interrater reliability between two independent raters for a single SVR-20 V1 risk factor, 1 (*Sexual deviance*), in a subsample of 24 cases randomly selected from a larger sample of 94 adult male rapists admitted to a Dutch forensic psychiatric hospital. Ratings were made on the basis of file information. Presence ratings were dichotomized, *Absent* versus *Possibly/Partially Present* or *Present*. The interrater reliability of the dichotomized ratings was fair, $\kappa = .59$. Raters agreed on the presence or absence of sexual deviance in 19 of the 24 cases (79%).

Zanatta (2005) evaluated interrater reliability between independent raters in a subsample of 15 cases, randomly selected from a larger sample of 164 adult male sex offenders in Canada, 82 offenders who had received indeterminate sentences as Dangerous Offenders and a control group of 82 repeat sex offenders. SVR-20 V1 ratings were based on file information. Presence ratings were recoded and summed to create *Psychosocial Adjustment* and *Sexual Offences* domain scores. The interrater reliability of both section scores was excellent: $ICC_1 = .87$.

Rettenberger and Eher (2007) evaluated interrater reliability between two independent raters in a subsample of 10 cases, randomly selected from a larger sample of 254 adult male sex offenders admitted to the Austrian federal correctional system in 2002 or 2003. SVR-20 V1 ratings were made on the basis of file information. Presence ratings were recoded and summed to create Total scores, which had excellent interrater reliability: $ICC_1 = .84$.

Pérez Ramírez, Redondo Illescas, Martínez García, García Forero, and Andrés Pueyo (2008) evaluated agreement between two independent raters in 30 adult male offenders, randomly selected from a larger sample of a subsample of 163 sex offenders in Spain. SVR-20 V1 ratings were made on the basis of file information. They reported that interrater reliability for ratings of the presence of individual risk factors, indexed using κ, was good to excellent, ranging from 0.73 to 1.00 with $M = 0.95$.

Barbaree, Langton, Blanchard, and Boer (2008), following on Langton (2003), evaluated agreement between two independent raters in a subsample of 63 cases, randomly selected from

a larger sample of adult sex offenders who completed prison-based treatment in Canada. SVR-20 V1 ratings were made on the basis of file information. Raters coded the presence for all individual risk factors for 99.5% of the subsample. Presence ratings were recoded and summed to create total scores. The interrater reliability of total scores, indexed using Spearman *rho*, was 0.75, which the authors interpreted as "moderate-high" (Barbaree et al., 2008, p. 52).

Hill, Habermann, Klusmann, Berner, and Briken (2008) evaluated interrater reliability between two independent raters in a sample of 166 adult male sexual homicide offenders in Germany. SVR-20 V1 ratings were based on forensic psychiatric reports, except for 19 (*Lacks realistic plans*), which could not be coded. Presence ratings for individual risk factors were recoded and summed to create total scores. The interrater reliability of total scores was excellent: $ICC_1 = .87$.

Rettenberger, Boer, and Eher (2011) studied 430 adult males convicted of sexual offenses and incarcerated in Austrian prisons. Two independent evaluators completed the SVR-20 V1 for a randomly selected subsample of 10 offenders. The interrater reliability of total scores was excellent: $ICC_1 = .84$.

Jackson (2016) evaluated interrater reliability between two independent evaluators in a sample of 100 adult male sex offenders who had completed a community-based sex offender treatment program in Canada. SVR-20 V1 ratings were based on files. Evaluators met after completing each series of 5 to 10 cases to review and discuss their ratings before coding the next series of cases. For individual risk factors, the interrater reliability of presence ratings was generally excellent, ranging from $ICC_1 = .64$ to .96, with *Mdn* = .81. The interrater reliability of total scores was excellent, with $ICC_2 = .96$ (which corresponds to an estimated ICC_1 of .93). The reliability of section scores was also excellent: *Psychosocial Adjustment*, $ICC_2 = .95$ (estimated $ICC_1 = .90$); *Sexual Offences*, $ICC_2 = .94$ (estimated $ICC_1 = 88$); and *Future Plans*, $ICC_2 = .86$ (estimated $ICC_1 = .75$).

Tsao and Chu (in press) studied 134 adult male offenders convicted of sexual offenses in Singapore. SVR-20 V2 ratings were made on the basis of file information. Interrater reliability was examined in a subsample of 10 offenders who were assessed by two evaluators working independently. The interrater reliability of total scores was good: $ICC_1 = .70$.

RSVP

Hart (2003) evaluated interrater reliability in a sample of 50 adult male sex offenders at an outpatient forensic psychiatric clinic in Canada. RSVP ratings were made by two independent evaluators based on file information. Only limited interrater reliability analyses were conducted. The interrater reliability of presence-ever total scores was excellent, $ICC_1 = .91$, and the interrater reliability of Case Prioritization ratings was good, $ICC_1 = .68$.

Watt, Hart, Wilson, Guy, and Douglas (2006) evaluated interrater reliability in a sample of 50 high-risk adult male sex offenders who were under community supervision in Canada. RSVP ratings were made by two independent raters based on file information. For individual risk factors, interrater reliability was calculated for presence ratings, both past and recent, as well as for relevance ratings. Interrater reliability for presence-past ratings was generally excellent, ranging from $ICC_1 = .58$ to .97, with *Mdn* = .91. For presence-recent ratings, one risk factor could not be evaluated due to lack of variance; interrater reliability for the remaining 21 risk factors ranged from .62 to 1.00, with *Mdn* = .87. For relevance ratings, interrater reliability ranged from .65 to .94, with *Mdn* = .88. Item-level ratings were recoded and summed to create total and domain scores. For presence-past ratings, the interrater reliability of composite scores was excellent: $ICC_1 = .99$ for total, .98 for *Sexual Violence History*, .92 for *Psychological Adjustment*, .96 for *Mental Disorder*, .96 for *Social Adjustment*, and .98 for *Manageability*. For presence-recent ratings, the interrater reliability of composite scores was excellent: $ICC_1 = .96$ for total, .93 for *Sexual Violence History*, .88 for *Psychological Adjustment*, .96 for *Mental Disorder*, .90 for *Social Adjustment*, and .93 for *Manageability*. For

relevance ratings, the interrater reliability of summary scores was also excellent: ICC_1 = .98 for total, .93 for *Sexual Violence History*, .91 for *Psychological Adjustment*, .95 for *Mental Disorder*, .90 for *Social Adjustment*, and .93 for *Manageability*. Finally, the interrater reliability of Case Prioritization ratings was excellent, with ICC_1 = .92.

Sutherland et al. (2012) recruited 28 forensic mental health or intellectual disability professionals, to rate six case vignettes using the RSVP. Interrater reliability for presence-past ratings of individual risk factors ranged from ICC_1 = .13 to .77 (*Mdn* = .59); for presence-recent ratings, from .09 to .78 (*Mdn* = .48); and for relevance ratings, from .48 to .92 (*Mdn* = .74). (Sutherland et al. did not calculate total and domain scores for presence or relevance in the usual way, so they are not reported here.) The interrater reliability of summary judgments ratings was: Case Prioritization, ICC_1 = .62; Serious Physical Harm .69; Immediate Action Required, .43; and Other Risks Indicated, .66. An innovative aspect of the Sutherland et al. (2012) study was that it also examined the interrater reliability of scenarios for future violence and scenario-based management plans identified by evaluators. They were asked to make a series of closed-ended ratings for two specific scenarios, "repeat" and "escalation." The interrater reliability of ratings for the repeat scenarios ranged from ICC_1 = .46 to .85 (*Mdn* = .56); for the escalation scenario, it ranged from .25 to .78 (*Mdn* = .48); and for the recommended level of supervision, it was .87. In other analyses, Sutherland et al. (2012) found that the ratings made by professionals also had moderate agreement with "gold standard" ratings by experts; this was particularly true for raters with more extensive training in the use of the RSVP.

Wilson (2013) conducted a study similar to Sutherland et al. (2012). She recruited 17 professionals to take online training in the use of the RSVP and complete six practice cases, selected at random from a pool of 10 cases. For individual risk factors, the interrater reliability of presence-ever ratings ranged from ICC_1 = .11 to .91 (*Mdn* = .42); and for relevance ratings, from .18 to .61 (*Mdn* = .39). The interrater reliability of total scores for presence-ever and relevance was ICC_1 = .56 and .55, respectively; interrater reliability of domain scores for presence-ever ratings ranged from .07 to .78 (*Mdn* = .48) and for relevance ratings it ranged from = .12 to .60 (*Mdn* = .53). The interrater reliability of summary judgments ratings was: Case Prioritization, ICC_1 = .29; Serious Physical Harm, .44; and Immediate Action Required, .21. Wilson (2013) also had researchers rate the overall similarity of integrative case formulations, scenarios of future sexual violence, and management plans between two randomly selected sets of ratings: one set of 69 similarity ratings was made within cases (i.e., for the RSVP evaluations conducted by different evaluators of the same case), and another set of 69 similarity ratings was between cases (i.e., for evaluations conducted by different evaluators of different cases). The researchers were blind to whether the set of evaluations was from the within- or between-case set. Multivariate analyses indicated that the similarity ratings were significantly higher for the within-case set than for the between-case set. In other analyses, Wilson (2013) found that the ratings made by professionals also had fair agreement with "gold standard" ratings by experts.

Darjee et al. (2016) studied 109 people referred to a community-based program for sex offenders in Scotland. They examined the interrater reliability of RSVP ratings in a subsample of 11 who were independently rated by two evaluators. For individual risk factors, the interrater reliability for presence-past ratings ranged from ICC_1 = .09 to 1.00 (*Mdn* = .83); for presence-recent, from .00 to 1.00 (*Mdn* = .83); and for relevance, from .08 to 1.00 (*Mdn* = .72). The interrater reliability of total scores for presence-past, presence-recent, and relevance was ICC_1 = .81, .91, and .83, respectively. The summary judgment ratings also had excellent interrater reliability: Case Prioritization, ICC_1 = 1.00; Serious Physical Harm, .95; and Immediate Action Required, .95.

Vargen, Jackson, and Hart (2020), in a study of 100 adult male sex offenders who had completed a community-based sex offender treatment program in Canada, examined the interrater reliability of RSVP ratings made by two independent raters based on file information. Interrater

reliability for presence-ever (i.e., combined presence-past and presence-recent) ratings of individual risk factors ranged from ICC_1 = .58 to .94 (*Mdn* = .78); and for relevance ratings, ranged from .48 to .92 (*Mdn* = .74). The interrater reliability of total presence and relevance scores was excellent, ICC_1 = .93 and .90, respectively; interrater reliability of domain scores for presence ratings ranged from .75 to .92 (*Mdn* = .87), and for relevance ratings it ranged from = .75 to .89 (*Mdn* = .82). The interrater reliability of summary judgments ratings was: Case Prioritization, ICC_1 = .74; Serious Physical Harm, .85; and Immediate Action Required, .80.

Sea and Hart (in press) conducted a field study specifically to examine the interrater reliability of ratings made using the RSVP. A sample of 47 adult male sexual offenders in Korea was evaluated by 32 experienced correctional psychologists who completed training in the use of the RSVP. The psychologists worked in teams of 4, per standard practice in the corrections service, and so reviewed the same information and conducted a joint interview, but afterward made ratings independently. Interrater reliability for presence-ever ratings of individual risk factors ranged from ICC_1 = .71 to .91 (*Mdn* = .84); and for relevance ratings, from .65 to .96 (*Mdn* = .81). The interrater reliability of total presence and relevance scores was excellent, ICC_1 = .95 and .98, respectively; interrater reliability of domain scores for presence ratings ranged from .87 to .93 (*Mdn* = .89) and for relevance ratings it ranged from .84 to .91 (*Mdn* = .90). The interrater reliability of summary judgments was: Case Prioritization, ICC_1 = .71; Serious Physical Harm, .67; and Immediate Action Required, .51. Following Sutherland et al. (2012), Sea et al. and Hart also examined the interrater reliability of a series of ratings made for two repeat and escalation scenarios of future sexual violence. The interrater reliability of ratings for the repeat scenarios ranged from ICC_1 = .49 to .85 (*Mdn* = .65); and for the escalation scenario, it ranged from .20 to .78 (*Mdn* = .58).

Criterion-Related Validity

In this section we review research on the criterion-related validity of risk judgments made using the SVR-20 V1/V2 and RSVP, which is the facet of validity most relevant to the use of the guidelines in practice. We do not discuss the content-related validity of the guidelines, which in this case is a function of the adequacy of the literature reviews on which they were based. There has been no systematic analysis of or research regarding this issue. Finally, we do not discuss construct-related validity more generally. As the SVR-20 V1/V2 and RSVP are formative rather than reflective in nature, there is no good reason to expect that risk ratings made using the guidelines will have a specific, theoretically meaningful pattern of associations with reflective measures of various constructs or even formative measures of adverse behavioral outcomes other than sexual violence (i.e., a nomological network). Also, although we support the use of the guidelines in more general research endeavors such as to study a specific risk factor for sexual violence (e.g., Hildebrand et al., 2004; Jackson, Read, & Hart, 2008; Nunes et al., 2007), understand clinician's views of the dynamic nature of risk factors (e.g., Sweller, Daffern, & Warren, 2016), evaluate risk communication (e.g., Jung, Pham, & Ennis, 2013; Storey, Watt, & Hart, 2015) and treatment decisions (Smid, Kamphuis, Wever, & Van Beek, 2013), and explore the neurobiological correlates of sexual offending (e.g., Schiltz et al., 2007; Walter et al., 2007), we do not believe such studies to provide strong, clear, or direct evidence of the validity of the guidelines per se.

As in the previous section, we review disseminations (publications and conference presentations) concerning each set of guidelines in chronological order, oldest to newest, and relying on a single dissemination for each dataset whenever possible. Below, we divide our review of research into studies that examined two aspects of criterion-related validity: concurrent validity, that is, the association of risk ratings made using the SVR-20 V1/V2 and RSVP with ratings made using other assessment procedures; and predictive validity, that is, studies that compared those who did

versus did not engage in sexual violence following assessment. Some of these studies were truly predictive in design, whereas others were quasi-predictive or retrospective.

Concurrent Validity

SVR-20 V1/V2 vs. RSVP

As noted earlier, we consider the guidelines to be parallel forms. The association between risk ratings made using the SVR-20 V1 and RSVP was examined in detail originally by Jackson (2016), and more recently in Vargen et al. (2020). The SVR-20 V1 and RSVP both were completed on the basis of file information by two evaluators in a sample of 100 adult male sex offenders who had completed a community-based sex offender treatment program in Canada. Although the evaluators worked blind to each other, their SVR-20 V1 and RSVP ratings were not independent. After making their ratings, the evaluators met to review each case and made a final set of consensus ratings for each set of guidelines. SVR-20 V1 presence total scores were correlated $r = .97$ with RSVP presence-ever total scores and $r = .93$ with RSVP relevance total scores. SVR-20 V1 presence domain scores were correlated between .12 and .92 (*Mdn* = .46) with RSVP presence-ever and between .19 and .85 (*Mdn* = .51) with RSVP relevance domains scores; the correlations were highest between corresponding domains (e.g., *Sexual Offences* on the SVR-20 V1 versus *History of Sexual Violence* on the RSVP).

SVR-20 V1/V2 vs. Other Procedures

Langton (2003) studied 468 adult male sex offenders, the same sample subsequently studied by Barbaree et al. (2008). The SVR-20 V1 was coded from institutional files. Presence total scores on the SVR-20 V1 were correlated with total scores on various actuarial tests of risk for sexual violence: the Rapid Risk Assessment for Sexual Offense Recidivism (RRASOR; Hanson, 1997), $r = .20$; the Static-99 (Hanson & Thornton, 1999), .36; and the Minnesota Sex Offender Screening Tool-Revised (MnSOST-R; Epperson, Kaul, & Hesselton, 1998), .46. The correlations with tests of risk for general (i.e., nonsexual) violence were somewhat higher: Violence Risk Appraisal Guide and Sex Offender Risk Appraisal Guide (VRAG and SORAG; Quinsey et al., 1998), .53 and .58, respectively.

Zanatta (2005) studied 82 adult male sex offenders given indeterminate sentences under Canadian criminal law and compared them to a group of 82 adult male sex offenders who received determinate sentences. The SVR-20 V1 was coded on the basis of institutional records. Presence total scores were correlated $r = .71$ with VRAG total scores and .72 with SORAG total scores.

Dietiker, Dittmann, and Graf (2007) studied 64 sex offenders in Switzerland. They coded the SVR-20 V1 on the basis of institutional records. Presence total scores on the SVR-20 V1 were strongly associated with expert clinical ratings of sexual violence risk, with Area Under the Curve (AUC) = .89, as well as with numerical presence total scores on Version 2 of the Historical-Clinical-Risk Management-20 (HCR-20; Webster, Douglas, Eaves, & Hart, 1997), Spearman *rho* = .85.

Parent, Guay, and Knight (2011) studied 503 adult males who were evaluated at the Massachusetts Treatment Center for Sexually Dangerous Persons (MTC) in Bridgewater, Massachusetts, between 1959 and 1984. They reported the concurrent validity of nine risk-relevant assessment instruments. The correlation (*r*) between total presence scores on the SVR-20 V1 and total scores on the other instruments were as follows: the Hare Psychopathy Checklist-Revised (PCL-R; Hare, 1991, 2003), .75; VRAG, .63; SORAG, .69; RRASOR, .28; Static-99, .55; Static-2002, a revision of the Static-99 (Hanson & Thornton, 2003), .43; Risk Matrix 2000, an actuarial test used in the

UK that yields total scores related to risk for sexual violence and general violence (RM2000S and RM2000V; Thornton et al., 2003), .33 and .37, respectively; and MnSOST-R, .57.

Rettenberger, Matthes, Boer, and Eher (2010) studied 394 adult male sex offenders in Austria. SVR-20 V1 total scores had moderate to large correlations with total scores on German-language translations of several risk-related measures: RRASOR, r = .37; Static-99, .63; SORAG, .79; and PCL-R, .77 (these findings updated those previously reported by Rettenberger & Eher, 2006, 2007).

Kanters et al. (2017) reported analyses of sex offenders in the Netherlands who were assessed using both the SVR-20 V1 and the PCL-R. The correlation between total presence scores on the SVR-20 V1 and total scores on the PCL-R was r = .61 in 24 child molesters and .60 in 32 rapists.

Tsao and Chu (in press), in their study of 134 adult male offenders convicted of sexual offenses in Singapore, examined correlations between SVR-20 V2 ratings and scores on several other risk-relevant measures. SVR-20 V2 total scores were correlated r = .41 with total scores on the Static-99R; .48 with total scores on the STABLE-2007, a measure of dynamic risk factors for sexual violence often used in conjunction with the Static-99 (Fernandez, Harris, Hanson, & Sparks, 2014); .72 with total scores on the PCL-R; and .75 with total scores on the Level of Service/Case Management Inventory, a measure of risk for general recidivism (Andrews, Bonta, & Wormith, 2004). SVR-20 V2 summary risk ratings for sexual violence were made on the basis of file information.

RSVP vs. Other Procedures

Kropp (2001) studied two samples of sex offenders, including a subsample of 53 offenders from the larger sample collected by Dempster (1998) and a subsample of 39 from Klaver, Watt, Kropp, and Hart (2002) and Hart (2003). The RSVP was coded on the basis of institutional files in both samples. Presence-ever total scores on the RSVP had large correlations with total scores on other risk-related measures: MnSOST-R and Static-99, both r = .53; SORAG, r = .63; and PCL-R, r = .75. Case Prioritization ratings of overall risk for sexual violence on the RSVP had moderate to large correlations with total scores on other measures: MnSOST-R, r = .41; Static-99, r = .50; SORAG, r = .33; and PCL-R, r = .40.

Hart (2003), in his study of 50 adult male sex offenders at an outpatient forensic psychiatric clinic, reported that presence-ever total scores on the RSVP had moderate to large correlations with total scores on other risk-related measures: MnSOST-R, r = .51; Static-99, r = .31; and SORAG, r = .45. Case Prioritization ratings of overall risk for sexual violence on the RSVP had moderate to large correlations with total scores on other measures: MnSOST-R, r = .50; Static-99, r = .41; and SORAG, r = .46.

Watt et al. (2006), in their study of 50 high-risk adult male sex offenders under community supervision in Canada, found that total scores on the Static-99 were correlated r = .73 with presence-past total scores on the RSVP, r = .69 with presence-recent ratings, r = .77 with relevance ratings, and r = .77 with Case Prioritization ratings. Total scores on the VRAG were correlated r = .80 with presence-past total scores on the RSVP, r = .76 with presence-recent total scores, r = .82 with relevance total scores, and r = .65 with Case Prioritization ratings.

Darjee et al. (2016), in their study of 109 people referred to a community-based program for sex offenders in Scotland, examined the concurrent validity of the RSVP. RSVP presence-past total scores were correlated r = .77 with PCL-R total scores, r = .41 with RM2000S total scores, and r = .47 with RM2000V total scores. RSVP presence-recent total scores were correlated r = .45 with PCL-R total scores, r = .31 with RM2000S total scores, and r = .24 with RM2000V total scores. Finally, RSVP relevance total scores were correlated r = .75 with PCL-R total scores, r = .43 with RM2000S total scores, and r = .48 with RM2000V total scores.

Vargen et al. (2020), in their study of 100 adult male sex offenders who completed a community-based sex offender treatment program in Canada, reported concurrent validity with respect to two actuarial tests. RSVP presence-ever and relevance total scores were correlated $r = .68$ and .66, respectively, with total scores on the SORAG; and .51 and .43, respectively, with total scores on the Static-99R. With respect to summary judgments of risk, Case Prioritization ratings were correlated $r = .65$ with total scores on the SORAG and .63 with total scores on the Static-99R; Serious Physical Harm ratings, .44 with total scores on the SORAG and .24 with total scores on the Static-99R; and Immediate Action Required ratings, .44 with total scores on the SORAG and .51 with total scores on the Static-99R.

Sea and Hart (in press), in their study of 47 sex offenders in Korea, reported concurrent validity of the RSVP with respect to two actuarial tests. RSVP presence-ever and relevance total scores were correlated $r = .67$ and .52, respectively, with total scores on the Hallym Assessment Guide for Sex Offender Risk (HAGSOR; Joe, 2010); and .67 and .49, respectively, with total scores on the Static-99R. With respect to summary judgments of risk, Case Prioritization ratings were correlated $r = .10$ with total scores on the HAGSOR and .11 with total scores on the Static-99R; Serious Physical Harm ratings, .57 with total scores on the HAGSOR and .35 with total scores on the Static-99R; and Immediate Action Required ratings, −.18 with total scores on the HAGSOR and −.16 with total scores on the Static-99R.

Predictive Validity

SVR-20 V1/V2

Using a retrospective case-control design, Dempster (1998) studied a sample of 95 adult males in Canada who were released to the community following incarceration for serious sexual offenses. Based on review of official records (police reports and criminal records) at the end of a follow-up period lasting several years, the offenders were divided into three groups: 42 non-recidivists, 29 nonsexual violent recidivists, and 24 sexually violent recidivists. The SVR-20 was coded from files. Dempster examined summary risk ratings and then numerically recoded items and summed them to yield total scores. According to ROC analyses, both SVR-20 summary risk ratings and total scores significantly discriminated between sexually violent recidivists and non-recidivists, AUC = .77 and .74, respectively, $p < .001$. Summary risk ratings significantly discriminated between sexually violent and nonsexually violent recidivists, AUC = .68, $p < .05$, but total scores did not, AUC = .55, *n.s.* The predictive validity of the SVR-20 was equal or superior to that of other risk assessment instruments, including the RRASOR, SORAG, and VRAG. Finally, incremental validity analyses indicated that summary risk ratings had unique predictive power with respect to recidivism, even after controlling for numerical risk scores on the SVR-20.

Dempster and Hart (2002), following on Dempster (1998), studied a sample of 95 adult males who were released into the community upon completion of sentences for serious sexual offenses. The SVR-20 V1 was coded on the basis of pre-release correctional files, blind to case outcome. Based on review of police reports and criminal records at the end of a follow-up period lasting several years, the offenders were divided into three groups: 42 non-recidivists, 29 nonsexual violent recidivists, and 24 sexually violent recidivists. Dempster and Hart (2002) calculated the correlation between lifetime presence ratings for the 20 individual risk factors and recidivism, coded dichotomously (0 = *No*, 1 = *Yes*). The correlations between SVR-20 V1 item presence ratings and sexual violence ranged from −.06 to .50, with *Mdn* = .23; 18 of 20 correlations were positive in sign, and 9 of 20 were both positive and statistically significant ($p < .05$). The item with the lowest validity was 6 (Major mental illness), which was correlated −.05 with nonsexual violence

and −.06 with sexual violence; this is due primarily to the fact that very few of the offenders suffered from serious psychopathology aside from substance use or personality disorders.

Lennings (2003) studied 27 males, aged 16 to 68, charged with sexual offenses. He completed the SVR-20 V1 on the basis of complete clinical evaluations. He divided the sample into two groups: 18 who were found or pleaded guilty, and 9 who were not found guilty (including one whose charges were dismissed due to health reasons). Despite the small sample size, the offenders who were found or pleaded guilty had presence total scores that were significantly higher than those of the offenders not found guilty on 9 of 20 items; none of the items had presence ratings that were significantly lower on offenders not found guilty.

McPherson (2003) studied a sample of 40 sexual offenders assessed or treated at a forensic psychiatric outpatient clinic. The SVR-20 V1 was coded on the basis of clinical records. All were convicted of non-contact sexual offenses, completed assessment and treatment, and then reoffended. Based on the nature of their new sexual offenses, they were divided into two groups: 20 committed a second sexual offense that also was non-contact, whereas the other 20 escalated to commit contact sexual offenses. McPherson reported that offenders who subsequently escalated had significantly higher presence ratings on 10 of 20 individual risk factors; none of the items had presence ratings that were significantly lower in offenders who escalated.

Sjöstedt and Långström (2003) studied 51 adult male rapists who underwent presentence forensic psychiatric evaluations in Sweden between 1988 and 1990. The SVR-20 V1 was coded on the basis of file information. Recidivism (new convictions for sexually violent offenses) was coded from official records during a follow-up period that averaged about 9.5 years after release. According to ROC analyses, neither presence total scores nor summary risk ratings on the SVR-20 V1 significantly predicted recidivism, all $.47 \leq \text{AUC} \leq .56$. VRAG scores also were not significantly predictive of recidivism, AUC = .58, but RRASOR total scores were AUC = .71. According to correlational analyses, none of the risk assessment measures was significantly predictive of recidivism.

de Vogel et al. (2004) studied 122 adult male sex offenders admitted to a forensic psychiatric hospital in the Netherlands. Dutch translations of the SVR-20 V1 and Static-99 were completed on the basis of file information. Using a retrospective design, they coded recidivism (new convictions for sexually violent offenses) from official records during an average follow-up period of about 11.5 years. ROC analyses indicated that the SVR had good predictive validity: for presence total scores, AUC = .80; summary risk ratings, AUC = .83. The predictive validity of total scores on the Static-99 was lower, although not significantly so, at .71. Finally, incremental validity analyses indicated that summary risk ratings had some unique predictive power with respect to recidivism, even after controlling for numerical risk scores on the SVR-20 V1.

Craig, Browne, Beech, and Stringer (2006) evaluated the predictive validity of several risk assessment measures, including the SVR-20 V1, Static-99, and RM2000S, in a sample of 85 sexual offenders in the UK. The risk assessment measures were coded from files. Using a retrospective design, they determined recidivism (reconviction for new sexual offenses) over a follow-up period that averaged about 8.5 years. The base rate of recidivism was estimated to be 7% at 2 years, 12% at 5 years, and 18% at 10 years after release. According to ROC analyses, none of the risk assessment measures, including SVR-20 V1 total scores, significantly predicted sexually violent recidivism at 2, 5, or 10 years after release in the group of sexual offenders, with AUCs ranging from .46 to .68.

Stadtland et al. (2005, 2006) studied 134 treated sex offenders in Germany, all adult males. The SVR-20 V1 was coded on the basis of institutional files. Using a retrospective follow-up design, they examined the association between the risk assessment instruments and recidivism. Recidivism was defined as new convictions for sexually or nonsexually violent offenses during a post-release follow-up period lasting an average of 9 years. SVR-20 V1 ratings were available for

119 men who successfully completed treatment. The rate of recidivism among 67 offenders with SVR-20 V1 presence total scores of 20 or lower was 16% ($n = 11$); the rate among 52 offenders with scores of 21 or higher was 38% ($n = 20$). According to Kaplan-Meier survival analyses, the difference between these two groups in recidivism as a function of time was statistically significant, with Log rank and Breslow tests both $p < .001$. According to ROC analyses, the AUC for SVR-20 V1 presence total scores was .68, which was lower than that of Static-99 total scores (.72) but slightly higher than that of HCR-20 numeric total scores and PCL-R total scores (.65 and .64, respectively), although none of the differences was statistically significant.

Barbaree et al. (2008), following on Langton (2003), evaluated the predictive validity of the SVR-20 in 468 adult sex offenders who completed a prison-based sex offender treatment program in Canada. SVR-20 V1 ratings were made on the basis of file information. Using a retrospective design, they coded recidivism, defined as any new conviction for a sexual or violent offense during a follow-up that averaged 5.1 years after release. According to ROC analyses, SVR-20 V1 presence total scores significantly predicted recidivism, with AUC = .63.

Hill et al. (2008) examined the association between SVR-20 V1 ratings and recidivism in 166 adult male sexual homicide offenders in Germany. SVR-20 V1 ratings were based on forensic psychiatric reports; one risk factor, 19 (Lacks realistic plans), could not be coded. Recidivism was defined as new convictions for sexually violent offenses, according to official records, during a lengthy follow-up period. Presence total scores were dichotomized, low (≤ 24) and high (≥ 25). SVR-20 V1 scores were not significantly associated with recidivism: the rate of sexually violent recidivism in both the low and high groups was 24%. Total scores on the Static-99 were also not significantly associated with recidivism. In other studies based on the same dataset, it was reported the sexual homicide perpetrators detained in forensic hospital received significantly higher summary risk ratings on the SVR-20 V1 than did sexual homicide perpetrators detained in prison (Ujeyl, Habermann, Briken, Berner, & Hill, 2008), but there were no significant differences between sexual homicide perpetrators whose victims were children versus those whose victims were adults with respect to SVR-20 V1 presence total scores (Spehr, Hill, Habermann, Briken, & Berner, 2010).

Pérez Ramírez et al. (2008) studied 163 adult male offenders in Spain. The SVR-20 V1 was coded on the basis of file information. Using a retrospective design, they coded recidivism from official records; the base rate of new sexual offenses was 15% over a follow-up that averaged about five years. ROC analyses indicated that SVR-20 presence total scores had a statistically significant association with recidivism; AUC = .83.

Parent et al. (2011) studied 503 adult males who were evaluated at the Massachusetts Treatment Center for Sexually Dangerous Persons (MTC) in Bridgewater, Massachusetts, between 1959 and 1984. Using a retrospective design, they examined recidivism (defined as new charges or convictions for sexual offenses) over a 15-year follow-up period. They compared the predictive validity of nine risk-relevant assessment instruments, including the SVR-20 V1, PCL-R, VRAG and SORAG, RRASOR, Static-99 and Static-2002, RM2000S and RMS000V, and MnSOST-R. All of the instruments had moderate and statistically significant predictive validity with respect to new charges or convictions for hands-on sexual offenses, $.65 \leq AUC \leq .71$, with the exception of the RM2000V which had small and non-significant predictive validity, AUC = .52. The predictive validity of the SVR-20 V1 presence total scores was AUC = .66. All of the instruments had small and non-significant predictive validity with respect to sexual offenses that were not hands-on (i.e., "nuisance" offenses), all AUC $\leq .61$. Predictive validity tended to be slightly higher in extrafamilial child molesters than in rapists; for the SVR-20 V1, AUC = .67 and .68, respectively.

Rettenberger et al. (2010) studied 394 adult male sex offenders in the Austrian Prison System. They examined the predictive validity of five risk-relevant assessment instruments—including the

PCL-R, RRASOR, Static-99, SORAG, and SVR-20 V1—with respect to recidivism (defined as reconvictions) over a follow-up period that averaged about 36 months. All of the instruments had moderate and statistically significant predictive validity with respect to any new convictions for sexual offenses, .69 ≤ AUC ≤ .74, with the exception of the PCL-R which had small and non-significant predictive validity, AUC = .59. The predictive validity of the SVR-20 V1 presence total scores was AUC = .71. Predictive validity was higher in extrafamilial child molesters; for the SVR-20 V1, AUC = .75, which was higher than that of the other instruments, although not significantly so. The findings of Rettenberger et al. (2010) were extended in two studies published subsequently. In the first, Rettenberger et al. (2011) examined the predictive validity of the SVR-20 V1 in an expanded sample totaling 493 adult male sex offenders studied over a follow-up that averaged more than 4 years. The predictive validity of presence total scores was AUC = .72 for convictions for any new sexual offense and .71 for any new hands-on sexual offense; among extrafamilial child molesters, predictive validity was .77 for any new sexual offense and .72 for any new hands-on sexual offense; whereas among rapists predictive validity was .71 for any new sexual offense and .74 for any new hands-on sexual offense. For the prediction of any new sexual offense, 16 of 20 individual risk factor presence ratings had AUC > .50 (7 of them significantly so) and 4 had AUC < .50 (none of them significantly so), and the average (*Mdn*) AUC was .59. For the prediction of any new hands-on sexual offense, 18 of 20 individual risk factor presence ratings had AUC > .50 (4 of them significantly so) and 2 had AUC < .50 (none of them significantly so), and the average (*Mdn*) AUC was .60. In the second, Yoon et al. (2018) examined whether protective factors had incremental predictive validity with respect to risk ratings made using the SVR-20 V1; they did not.

Blacker, Beech, Wilcox, and Boer (2011) studied 88 sex offenders, 44 of whom had intellectual impairment and 44 of whom did not. They examined the predictive validity of four risk assessment instruments, including the RRASOR, RM2000V, SVR-20 V1, and the Stable and Acute scales of the Assessment of Risk and Manageability of Individuals with Developmental and Intellectual Limitations Who Offend—Sexually (ARMIDILO-S; Boer et al., 2012). Recidivism was coded from records over a follow-up period that averaged more than 9 years. In offenders with special needs, only ARMIDILO-S Stable and Acute scores had significant predictive validity; but in the other offenders, the SVR-20 V1 total presence scores had the highest predictive validity. When recidivism was defined broadly as any sexually motivated misbehavior, including non-criminal acts, the predictive validity of SVR-20 V1 presence total scores was AUC = .40 in offenders with special needs and .70 in the other offenders; when recidivism was defined more narrowly as any new convictions for sexual offenses, predictive validity was .45 in offenders with special needs and .73 in the other offenders.

Smid, Kamphuis, Wever, and Van Beek (2014) studied 397 sex offenders in the Netherlands. They examined recidivism, defined as any new charges or convictions, over a follow-up period that averaged about 12 years. They compared the predictive validity of nine risk-relevant instruments, including the RRASOR, Structured Anchored Clinical Judgment Minimum (SACJ-Min; Grubin, 1998), Static-99R, Static-2002R, RM2000S, SORAG, and SVR-20 V1. The predictive validity of SVR-20 V1 total presence scores was lower than that of total scores on the other instruments: AUC = .58 at 5 years, .61 at 10 years, and .61 overall.

Jackson (2016) studied 100 adult males who completed a community-based sex offender treatment program. She examined recidivism, defined as any new police contact (including investigation, charge, and conviction) for sexual offenses, over a follow-up period of 10 years post-treatment. She reported the predictive validity of presence scores for individual risk factors on the SVR-20 V1 and also compared the predictive validity of SVR-20 V1 presence total scores to total scores on the Static99R, Static-2002R, and SORAG. (Comparisons of the

predictive validity of the SVR-20 V1 and RSVP are summarized in the next section.) With respect to presence scores for individual risk factors, 19 of 20 individual risk factor presence ratings had AUC > .50 (2 of them significantly so) and 1 had AUC < .50 (not significantly so); the average (*Mdn*) AUC was .56. The predictive validity of presence total scores was AUC = .68, which was the same as that of the Static-99R and slightly (but not significantly) smaller than that of Static-2002R and SORAG total scores, both AUC = .71.

Kanters et al. (2017) studied 70 sex offenders in the Netherlands who were released following treatment in a forensic mental health facility. They examined the predictive validity of SVR-20 V1 ratings made before and after treatment. Recidivism was defined as any new conviction over a follow-up period that averaged about five years. SVR-20 V1 ratings presence total scores had small and nonsignificant predictive validity with respect to any new convictions for sexual offenses: for ratings made before treatment, AUC = .62; and for ratings after treatment, .60. The predictive validity of summary risk ratings made before treatment was also small and nonsignificant, .58; but for ratings made after treatment was moderate and significant, .76.

Tsao and Chu (in press), in their study of 134 adult male sex offenders in Singapore, examined the predictive validity of SVR-20 V2 ratings. Recidivism was defined as any new offenses and any new sexual offenses during a follow-up that averaged 3.7 years after conviction. (All offenders received community sentences.) SVR-20 V2 total scores and summary risk ratings for sexual violence had large and statistically significant predictive validity with respect to any new sexual offenses, AUC = .76 and .78, respectively. The predictive validity of the SVR-20 total scores and summary risk ratings was slightly (but not significantly) higher than that of total scores on the Static-99R, STABLE-2007, PCL-R, and LS/CMI.

RSVP

Kropp (2001) studied a subsample of 53 offenders from the larger sample collected by Dempster (1998) that included 15 sexually violent recidivists and 38 non-recidivists or nonsexually violent recidivists. The RSVP was coded from files; "past" and "recent" presence ratings on the RSVP were recoded into numeric scores, combined, and summed to yield total scores. RSVP case prioritization ratings were significantly correlated with sexually violent recidivism, $r = .40$, $p < .05$; the correlation between total scores and sexually violent recidivism was not significant, $r = .23$. In comparison, total scores on the MnSOST-R, Static-99, and SORAG were correlated $r = .18$, .30, and .33 with sexually violent recidivism; the latter two correlations were statistically significant, $p < .05$. Turning to case prioritization ratings, 8 of 15 offenders (53%) rated as high priority were sexually violent recidivists, compared to 5 of 20 offenders (20%) rated as moderate priority and 2 of 19 offenders (11%) rated as low priority.

Darjee et al. (2016) conducted a field study of 109 people who were assessed using the RSVP by various professionals working for a community-based program. They examined recidivism (new investigations, charges, or convictions) with respect to both any new sexual offenses and serious sexual offenses over a follow-up period of a little over 3 years. According to ROC analyses, total presence-past, presence-recent, and relevance scores on the RSVP had small but nonsignificant predictive validity vis-à-vis any sexual offenses, AUC = .58, .61, and .60, respectively; but higher predictive validity vis-à-vis serious sexual offenses, AUC = .68, .71, and .66, respectively. In comparison, the predictive validity of Case Prioritization, Serious Physical Harm, and Immediate Action Required ratings vis-à-vis any sexual offenses was .59, .53, and .55, respectively; and vis-à-vis serious sexual offenses was .63, .60, and .68, respectively. According to survival analyses, Case Prioritization ratings were associated with time to new sexual offenses. Interestingly, there was a good match between scenarios of future sexual violence identified by evaluators and the

actual sexual offenses that were (allegedly) committed; according to Darjee et al., the match was 96% for victim gender, 77% for victim age, 69% for relationship to victim, and 62% for seriousness of harm.

Vargen et al. (2020) and Jackson (2016) reported the predictive validity of RSVP ratings from Jackson's study of 100 adult males who completed a community-based sex offender treatment program. Recidivism was defined as any new police contact (including investigation, charge, and conviction) for sexual offenses over a follow-up period of 10 years post-treatment. Looking first at the predictive validity of individual risk factors in the RSVP, according to the Cox regression survival analyses, for both presence-ever and relevance ratings, 20 of 22 had Hazard Ratios (HRs) greater than 1 (3 significantly so for presence-ever ratings and 6 for relevance ratings) and only 2 had HRs less than 1 (none significantly so for either presence-ever or relevance ratings); the *Mdn* HR was 1.33 for presence-ever ratings and 1.30 for relevance ratings. Looking next at Case Prioritization ratings, there was a strong association with recidivism. The proportion of recidivists among those rated *Low*, *Moderate*, and *High* was .17, .32, and .62, respectively; using those with *Low* ratings as a reference group, the odds of recidivism was 2.20 times greater among those with *Moderate* ratings and 8.60 times higher among those with *High* ratings. Finally, a series of analyses compared the predictive validity of RSVP Case Prioritization ratings and presence-ever total scores (divided into quintiles, i.e., five equal-sized groups) to that of total scores on the Static-99R and SORAG (both of the latter also divided into quintiles, to permit direct comparison with RSVP presence-ever scores). The predictive validity of RSVP presence-ever, Static-99R, and SORAG total scores was HR = 1.61, 1.56, and 1.66, respectively, all somewhat lower than that of RSVP Case Prioritization ratings but still statistically significant. Incremental validity analyses indicated that neither Static-99R nor SORAG total scores significantly improved the predictive validity of RSVP presence-ever total scores or Case Prioritization ratings.

Limitations of Supporting Research

What We Know: Conclusions Based on Research to Date

Based on the research reviewed, we offer three general conclusions regarding judgments of risk for sexual violence made using the SVR-20 V1 and RSVP. First, research supports the view that judgments of risk for sexual violence made using the SVR-20 V1 and RSVP typically have interrater reliability that may be characterized as *good* to *excellent* in absolute terms. Second, judgments of risk for sexual violence made using SPJ guidelines have concurrent validity with respect to actuarial tests of risk for sexual violence and other risk-related measures that is moderate to high in absolute terms. Third, judgments of risk for sexual violence made using the SVR-20 V1 and RSVP typically have predictive validity with respect to sexual violence that is moderate in absolute terms and, in relative terms, equal to that of actuarial tests of risk for sexual violence. This last conclusion is similar to that reached by others in meta-analyses. For example, in the meta-analyses by Hanson and Morton-Bourgon (2009) and Singh, Grann, and Fazel (2011), the SVR-20 V1 had the highest predictive validity among the various sexual violence risk assessment tools evaluated.

What We Don't Know: Problems With Past Research and Recommendations for Future Research

In our chapter in the first edition of this book, we identified four major problems with research on SPJ guidelines for sexual violence. As they are still relevant, we provide an updated discussion

of them. We recognize that all studies (including, of course, our own) have flaws or limitations, many of which reflect strategic decisions or operational limitations. The point here is not to blame researchers for being imperfect, but rather to enhance their awareness of problems they may be able to avoid.

Inadequate File Information

Most researchers made ratings on the basis of file information. It is difficult or even impossible to code some risk factors when institutional records are limited in quality and quantity, especially when the original assessments summarized in the records were themselves restricted in breadth or depth. The risk factors that seem to be adversely impacted most often by reliance on files are those related to mental health problems and future plans. Best practice when evaluating the SVR-20 V1/V2 and RSVP is to conduct risk comprehensive assessments *de novo* following the administration procedures set out in the guidelines. In disseminations, researchers should describe the file information that was available to evaluators in their studies and identify any systematic or substantial limitations of the file information.

Inadequate Training and Experience of Evaluators

Some researchers acknowledged use of evaluators who lack adequate training and experience in the use of the SVR-20 V1/V2 and RSVP, and others failed to provide information about the training and experience of evaluators. Although the guidelines are written in plain language, it is not a simple matter for evaluators to make judgments about such things as sexual deviance, psychopathy, or the chronicity of an offender's history of sexual violence; to develop formulations of risk for sexual violence; or develop scenario-based management plans. Best practice when evaluating the SVR-20 V1/V2 and RSVP is to recruit evaluators who meet the criteria outlined in the guidelines, provide them with standardized training, and then provide them with regular supervision or booster training. In disseminations, researchers should provide a clear summary of how evaluators were recruited, trained, and supervised to use the guidelines.

Inadequate Evaluation of Risk Ratings

This is perhaps the most serious problem. Researchers have tended to limit their evaluations of the reliability and validity of judgments made using the SVR-20 V1/V2 and RSVP to presence ratings of individual risk factors, composited into numerical total scores reflecting lifetime presence. This does not reflect the manner in which the guidelines are intended to be used in practice. First, the administration procedures of the guidelines do not require evaluators to convert ratings into numbers or composites; indeed, evaluators are specifically advised not to engage in such practices. Second, such ratings are of limited importance. Rating the presence of individual risk factors is only the second step of the administration procedures of the SVR-20 V1/V2 and RSVP; in subsequent steps, evaluators consider the dynamic nature of the risk factors (i.e., fluctuations in their presence or severity over time), as well as their relevance to the person's overall risk for sexual violence and management of those risks. Best practice when evaluating the SVR-20 V1/V2 and RSVP is to follow the administration procedures outlined in the guidelines as closely as possible and, whenever possible, to focus on presence ratings for individual risk factors or, alternatively, global judgments of risk (e.g., Summary Risk or Case Prioritizations ratings) rather than on numerical presence total scores. In disseminations, researchers should note any deviations from the administration procedures outlined in the guidelines.

Inadequate Assessments in Follow-up Studies

Most evaluations of the predictive validity of judgments made using the SVR-20 V1/V2 and RSVP focus on recidivism status at the endpoint of a long-term follow-up. In research of this sort, risk assessments conducted at the start of the follow-up are used to forecast recidivism over a period of years, in the absence of any reassessments of risk or any control over case management tactics implemented. Best practice when evaluating the SVR-20 V1/V2 and RSVP is to conduct reassessments on a regular basis (e.g., from every 1 or 2 months up to once or twice per year) and also to record and control such things as monitoring and supervision conditions, treatment received, and so forth. In disseminations, researchers should identify any limitations in their ability to assess recidivism (e.g., failure to take into account emigration, institutionalization, mortality, and so forth) and implementation of case management tactics.

Directions for Future Research

In light of discussions in this chapter and elsewhere (e.g., Hart et al., 2016), we have a number of recommendations concerning avenues for future research on the SVR-20 V1/V2 and RSVP.

Consumer Satisfaction Research

Previously, we (Hart & Boer, 2010) called for research in the form of surveys, focus groups, and so forth on the extent to which various stakeholders—evaluators and other interested parties—view the guidelines as acceptable, useful, in need of improvement, and so forth. We are pleased to report that, in addition to one review and two studies known to us when we prepared the original chapter (Archer, Buffington-Vollum, Stredny, & Handel, 2006; Lally, 2003; Witt, 2000), two others became known to us immediately thereafter (Bengtson & Pedersen, 2008; Khiroya, Weaver, & Maden, 2009), and others have been published in the intervening years (e.g., Judge, Quayle, O'Rourke, Russell, & Darjee, 2014; Kelley, Ambroziak, Thornton, & Barahal, 2020; Viljoen, McLachlan, & Vincent, 2010). These studies have found that at least a substantial minority of practitioners across various countries and within various agencies use the SVR-20 V1/V2 and RSVP regularly and also view them as useful. But key issues remain unexplored by the existing research. These include:

- *Training of evaluators*. What background knowledge, skills, or experience best prepare evaluators to use the SVR-20 V1/V2 and RSVP? What do evaluators with different levels of experience perceive to be critical needs that would prepare them to use the SVR-20 V1/V2 and RSVP? Which training curricula, delivered by which methods, do evaluators find most helpful in helping them to acquire the knowledge and skills required to make good use of the SVR-20 V1/V2 and RSVP?
- *Usefulness of guidelines according to evaluators*. How often are the SVR-20 V1/V2 and RSVP considered by experienced evaluators to be clearly appropriate, clearly inappropriate, or questionably appropriate for use in practice in various settings? For what decision-making purposes or with which types of evaluees are they considered to be especially helpful or unhelpful? What kinds of revisions or modifications would make the guidelines easier to use or more useful?
- *Acceptability of guidelines according to other stakeholders*. How are the guidelines perceived by evaluees, correctional or forensic mental health administrators, legal professionals, and laypeople with respect to such issues as face validity, fairness, and relevance to decision-making? What could be done to improve the perceived acceptability of the guidelines? Surveys of this sort

could also include reviews of case law in various decisions focusing specifically on the SVR-20 V1/V2 and RSVP, similar to previous reviews focusing on other SPJ guidelines such as the HCR-20. For example, a brief search conducted at the time this chapter was being prepared returned more than 120 reported decisions by Canadian courts in which the SVR-20 V1/V2 was cited and more than 100 in which the RSVP was cited.

Judgments Related to Relevance of Risk Factors, Formulation, and Scenarios

Most research on SPJ guidelines, including the SVR-20 V1/V2 and RSVP, has focused on presence ratings and global judgments of risk in the form of Summary Risk or Case Prioritization ratings made on a 3-point ordinal scale. This is understandable, as the presence rating and overall judgments of risk are simple to code and analyze; but it is also unfortunate, as they reflect only one part of the process of risk assessment. Research is needed to explore how evaluators and stakeholders make sense of risk factors—how they develop mental models of what caused the past sexual violence of evaluees and what might cause them to be sexually violent in the future, as well as how they determine what steps could be taken to prevent sexual violence. The RSVP is particularly well suited to this sort of research, as it includes steps in which evaluators make explicit formulation-based ratings of the relevance of each risk factor with respect to past sexual violence, as well as describe what they consider to be the plausible scenarios of possible future sexual violence. (Indeed, the RSVP was the first set of SPJ guidelines to include these steps.) We have followed with great interest the research of several groups on formulation generally, including several studies focusing specifically on formulation using the RSVP (e.g., Sea & Hart, in press; Sutherland et al., 2012; Wilson, 2013), and eagerly await further research on topics such as:

- *Process of making judgments*. How do evaluators construct mental models of the sexual violence risk of evaluees? For example, how do they decide which risk factors are most relevant and how they act synergistically to cause sexual violence? What implicit theories guide the judgments of untrained or novice versus trained or experienced evaluators? Can evaluators be trained to use different theories to make formulations and, if so, which theories appear to be most useful for constructing good formulations? What makes a formulation "good"? How do training and experience influence the scenarios identified by evaluators? What features of scenarios are most helpful for the development of management plans? What are the best models for conceptualizing, developing, and communicating about management plans? To answer questions of this sort, it would be helpful to use qualitative research methods, for example, to observe evaluators conducting risk assessments in real-world settings; ask them to "talk aloud" while or immediately after making judgments; and conduct in-depth interviews with them (individually or in focus groups) to explore how they understand their own judgment processes or evaluate the adequacy of their own judgments. Research could also use quantitative methods to examine the impact of training, experience, or varying decision-making processes on the quality of judgments.
- *Interrater reliability of judgments*. To what extent do evaluators agree on judgments about formulation-based relevance and scenario-based management plans? This is a tricky question. There are two basic approaches to answering it. The first is to deconstruct the judgments into a series of highly structured ratings and then use conventional methods to analyze them. For example, Sutherland et al. (2012) and Sea and Hart (in press) asked evaluators to identify specific scenarios of future sexual violence (e.g., repeat, escalation) and make a series of ratings about them (e.g., characteristics of victims). The second is to find novel ways to analyze the judgments more holistically. For example, Wilson (2013) asked evaluators to write short narrative formulations for a series of cases, and then asked blind raters to judge the

overall similarity of two pairs of narrative formulations: either by different evaluators for the same case or by different evaluators for different cases. Each approach has its own strengths and limitations, of course, and so both approaches should be used.

- *Impact of judgments on evaluators' management plans*. Do complex judgments enhance the ability of evaluators to develop case management plans? Do they increase the quality of those plans with respect to detail, feasibility, sequencing of interventions, and so forth? One way to answer these questions is to ask evaluators to conduct risk assessments with versus without making judgments related to the relevance of risk factors, formulations, and scenarios to determine the impact of such judgments on the management plans they recommend as well as their overall ratings of risk for sexual violence. Research could also examine different ways to increase the usefulness of complex judgments.

Field Studies of Sexual Violence Risk Assessments

Research on risk assessment tends to be conducted under conditions that do not closely resemble actual practice. For example, it is common that the evaluators are researchers with specific training in the use of one or more tools and limited experience in assessment, rather than by actual practitioners; the evaluations are based solely on file information collected by others, rather than on complete clinical data (including interviews) collected by evaluators; or the evaluations are focused on assessment of risk at a very specific point in time, rather than on the process of risk assessment and management over time. This also holds true for the SVR-20 V1/V2 and RSVP. There are notable exceptions, of course, such as the studies by Darjee et al. (2016) and Sea and Hart (in press). But more evidence is needed concerning the extent to which findings observed in research settings or under controlled conditions generalize to the "field"—that is, practice settings or more open conditions. Put differently, there is a need to determine the effectiveness of sexual violence risk assessments, rather than their efficacy (e.g., Hart & Logan, 2011). Key topics here include:

- *Interrater reliability in field settings*. What level of agreement or consistency is observed across evaluators with respect to the various ratings and judgments they make using the guidelines? To what degree is the level of agreement or consistency affected by factors such as the training or experience of evaluators, the adequacy or completeness of the information base for assessments, and so forth?
- *Impact on case management decisions*. Do risk judgments made using the guidelines, including complex judgments, influence (i.e., were incorporated into) the management plans recommended or implemented in cases?
- *Predictive validity of risk judgments made in the field settings*. Are risk judgments made using the guidelines associated with actual case outcomes—that is, the nature, seriousness, imminence, and frequency of future sexual violence? More importantly, is there evidence that implementation of the management plans recommended for cases lead to a reduction in risk for future sexual violence?
- *Other facets of the utility of guidelines*. What policies, initial and continuing education, and quality assurance procedures support successful agency-wide adoption of the guidelines in field settings? In what proportion of cases do evaluators actually complete risk assessments using the guidelines? How long does it take evaluators to complete their risk assessments? What is the fidelity of those assessments with respect to the administration procedures outlined in the guidelines? What case characteristics are associated with failure to complete risk assessments, undue length of time to completion, or low-fidelity risk assessments? Does use of the

guidelines influence—and, more specifically, improve—risk communication (written reports, expert evidence), reassessment of risk, and the development, implementation, and revision of case management plans? To what extent does the utility of the SVR-20 V1/V2 and RSVP vary across settings and, if so, what factors appear to be related to this variability? To answer these questions, it may be helpful to conceptualize the adoption of the SVR-20 V1/V2 and RSVP in field settings as a novel intervention (in contrast to alternative methods of risk assessment, including "risk assessment as usual"), and to study it using methods from implementation science and treatment outcome research (e.g., Hart, 2003).

Diversity and Risk Assessment

There is increased awareness of the potential susceptibility of risk assessments to bias on the basis of diversity, including group differences related to gender (e.g., biological sex, gender identity, gender role, gender expression, or sexual interest), age (e.g., development or maturity), ethnicity (e.g., race, culture, nationality, language, religion, or other aspects of heritage), and physical or mental disability (e.g., health problems, limitations, or differences). Although there has been some development work on specific guidelines for assessing sexual violence risk in, for example, male adolescents, it is simply not feasible to develop and validate a new assessment tool for each potential subgroup of interest (e.g., for evaluating a transgender adolescent of European heritage with intellectual disability). Is it possible to develop frameworks that can be used with risk assessment guidelines that will help evaluators identify and respond to the full range or potentially important diversity? Does the use of such frameworks lead to increases in the interrater reliability, predictive validity, and utility of risk judgments? And does it lead to increases in consumer satisfaction with risk assessments (i.e., a perception that they are unbiased or less biased)?

Case Example

Here, we present a more detailed version of a case presented elsewhere (Hart & Kropp, 2008). Key details have been omitted or changed to protect the privacy of people involved.

Overview

Mr. V was 84 years old at the time he was assessed. His heritage was German, but his family immigrated to the United States three generations ago and he was born and raised in the rural area of a midwestern state. He was referred for a comprehensive sexual violence risk assessment to help determine whether, four years after being declared a sexually violent predator, he continued to meet statutory criteria for civil commitment or should be granted a conditional or unconditional discharge.

Psychosocial History

Sexual Offenses

Mr. V had a history of 6 sexual offenses that involved noncoercive sexual touching and oral sex with and by prepubescent boys, aged 10 to 12. In each instance, Mr. V approached the boys, who were previously unknown to him, in public places and offered them money to engage in sex. The offenses occurred over an extended period of time: The first offense occurred when Mr. V was about 46 years old, and the most recent offense occurred when he was about 72 years old.

Past Functioning

Mr. V's development and social adjustment were positive until he reached the age of 46. His child-drearing experiences were unremarkable, with the exception of unwanted sexual touching by his brother for a brief period of time when he was about 7 years old. He had no problems at school or work. He graduated from high school and completed 2 years of college. He served in the military during World War II and received an honorable discharge. He operated a successful business for many years. His social attitudes and orientation were prosocial, and he had no problems with the law. He had a stable marriage for many years and together with his wife raised four children, despite the fact that his wife had serious physical and emotional health concerns until her death when he was 46 years old. He was actively involved in a local church. Finally, during this period of his life, Mr. V no serious problems related to physical or mental health.

Mr. V's psychosocial adjustment decreased markedly following his wife's death. There was no indication from any source that Mr. V had engaged in sexually deviant behavior or had experienced sexually deviant thoughts, images, urges, or fantasies prior to his wife's death. But afterward, he became sexually interested in and sought out sexual contact with boys. As noted earlier, this resulted in convictions for sexual offenses on three occasions, each time as a result of sexual contact with boys aged about 10 or 11 years old. Although Mr. V consistently minimized his personal responsibility for sexual contact with boys in a highly defensive manner, it was clear from available evidence that after the death of his wife he also began to experience thoughts and urges involving sex with boys, and in fact masturbated to such thoughts on many occasions. Based on his history, Mr. V was diagnosed by health care providers with a paraphilic disorder, specifically, pedophilia. Concurrent with the onset of his paraphilic disorder and subsequent convictions, Mr. V. had serious employment and financial problems, as well as problems with his personal relationships, including the dissolutions of a second marriage and strained relationships with his children.

Recent Functioning

Mr. V's adjustment following his civil commitment as a sexually violent predator, when he was about 70 years old, was generally positive. There is no indication that he exhibited serious behavior problems, including problems related to sexual behavior. He participated actively in treatment, including related activities such as polygraphic evaluations, and made progress (albeit limited) in some areas.

Mr. V's physical health was generally good, given his advanced age. He suffered from mild heart disease. His mobility was mildly restricted. He had an enlarged prostate gland. He reported a significant decline in sexual appetite, functioning, and behavior over the previous 5 years, and in particular during the previous 3 years (e.g., said he did not masturbate, did not experience sexual urges, was no longer able to achieve an erection). He was not upset or distressed by the decline in his functioning, which he accepted as a foreseeable consequence of normal aging and his physical health problems.

Mr. V's mental health also was generally good. He exhibited mild symptoms of dysthymia (e.g., periods of feeling distressed and irritable). He also exhibited some signs of mild cognitive impairment, which likely reflected normal aging but also may have reflected the early stages of dementia. He did not exhibit signs or report symptoms of paraphilic disorder over the previous 5 years, and in particular during the previous 3 years (e.g., reported he no longer had sexual fantasies, urges, or behavior involving sexual contact with boys).

Mr. V's self-reported decline in sexual functioning and appetite were consistent with reports by institutional staff: Mr. V was not observed masturbating in his room, engaging in sexual talk

or sexual activity with other patients, or attempting to acquire or make pornographic materials. Mr. V's reports also were consistent with the results of medical testing, which indicated that he was suffering from heart disease and prostate problems that would likely cause erectile difficulties, and with the results of polygraphic interviews, which indicated that he was not lying about his decreased sexual functioning and behavior.

Plans for the Future

Mr. V developed plans for his release from civil commitment that were reasonably detailed, feasible, and confirmed by collateral informants. He intended to seek accommodation at an approved facility, where the management had experience housing registered sex offenders. He arranged for volunteer and other activities, on a limited scale, that would allow him to make appropriate use of public transit (e.g., not on routes or at times where he was likely to encounter unaccompanied minors). He also made arrangements for financial support and plans for developing positive social relationships (i.e., with peers at suitable locations).

Analysis Using SVR-20 V1

There was evidence that seven risk factors were definitely present in Mr. V's case by history: 1 (*Sexual deviation*), 2 (*Victim of child abuse*), 7 (*Relationship problems*), 8 (*Employment problems*), 12 (*High density sex offences*), 17 (*Extreme minimization/denial of sex offences*), and 18 (*Attitudes that support or condone sex offences*). There was also possible or partial evidence of 20 (*Negative attitude toward intervention*). But in each of these areas, Mr. V had demonstrated some capacity for good adjustment over extended periods of time, that is, up until the age of about 46.

In terms of recent change, there was evidence that four of the risk factors present by history had improved to some extent over the previous 12 years, including: 1 (*Sexual deviation*), 17 (*Extreme minimization/denial of sex offences*), 18 (*Attitudes that support or condone sex offences*), and 20 (*Negative attitude toward intervention*). There was no good evidence that the remaining factors had improved or worsened significantly over time, which for 2 (*Victim of child abuse*) was due to its fixed nature and for 12 (*High density sex offences*) was due to lack of opportunity to commit sexual violence.

No case-specific risk factors were coded as present in the case. The evaluator considered Mr. V's physical health problems to be risk reducing rather than risk enhancing, as they would likely reduce both his motivation and his capacity to perpetrate sexual violence.

With respect to the summary risk rating, given the overall pattern of risk factors, both in terms of lifetime presence and recent change, the evaluator considered Mr. V to pose a *Low* risk for future sexual violence. It seemed as though little effort or intervention would be required to prevent further offending in Mr. V's case, at least relative to other cases.

Analysis Using SVR-20 V2

It is a simple matter to recast the findings and opinions obtained with the SVR-20 V1 into those using the SVR-20 V2. There was evidence that seven SVR-20 V2 risk factors were definitely present in Mr. V's case in the past, that is, prior to the past year: 1 (*Sexual deviation*), 3 (*Victim of child abuse*), 8 (*Relationship problems*), 9 (*Employment problems*), 11 (*Chronic sexual offending*), 16 (*Extreme minimization/denial of sexual offending*), and 17 (*Attitudes that support or condone sexual offending*). There was also possible or partial evidence of 19 (*Negative attitude toward intervention*). Recently—that is, in the past year—only two of these risk factors appeared to be definitely present: 3 (*Victim of child abuse*) and 8 (*Relationship problems*). The remaining risk factors possibly or partially present, with the exception of 11 (*Chronic sexual offending*) which was rated as absent due to lack of opportunity to

commit sexual violence. As Mr. V's physical health problems were considered risk-reducing rather than risk-enhancing, 2 (*Sexual health problems*) was not coded present either recently or in the past.

With respect to the overall judgments of risk, the evaluator considered Mr. V to pose a *Low* risk for future sexual violence on the summary risk rating. Serious Physical Harm and Need for Immediate Action were also rated *Low*. Other Risks Indicated was rated *No*. Case Review was recommended for a month after release into the community, as more rapid case review or reassessment did not appear necessary.

Analysis Using the RSVP

In Mr. V's case, there was evidence that eight RSVP risk factors were definitely present in the past: 1 (*Chronicity of sexual violence*), 5 (*Psychological coercion in sexual violence*), 6 (*Extreme minimization or denial of sexual violence*), 7 (*Attitudes that support or condone sexual violence)*, 8 (*Problems with self-awareness*), 11 (*Sexual deviance*), 16 (*Problems with intimate relationships*), and 18 (*Problems with employment*). There was possible or partial evidence of a further two risk factors: 10 (*Problems resulting from child abus*e) and 21 (*Problems with treatment*). The remaining risk factors appeared to be absent. Recently, in the past year, there was definite evidence of 16 (*Problems with intimate relationships*) and possible or partial evidence of 6 (*Extreme minimization or denial of sexual violence*), 7 (*Attitudes that support or condone sexual violence*), 8 (*Problems with self-awareness*), 18 (*Problems with employment*), and 21 (*Problems with treatment*).

The evaluator's formulation of Mr. V's past sexual offending was that the death of his wife led to loneliness and a blockage of his normal or appropriate sexual outlets. The blockage apparently allowed an underlying sexual deviance to emerge, which until that point had been managed by a combination of internal and external controls (e.g., adequate self-regulation, active engagement in conventional social relationships and activities). He apparently did not actively search for potential victims, but on the few occasions in which he was alone with children who resembled his preferred sexual stimulus, he experienced a strong desire to have sex with boys, projected this sexual desire onto them (i.e., convinced himself that the boys wanted to have sex with him, rather than vice versa), and opportunistically engaged them in sexual activity. According to this formulation, the risk factors with highest relevance in the past were 16 (*Problems with intimate relationships*), 11 (*Sexual deviance*), 8 (*Problems with self-awareness*), and 21 (*Problems with treatment*). But in light of the changes in Mr. V's life circumstances, his needs for intimacy and sexuality appeared to have declined, and so the evaluator considered 8 (*Problems with self-awareness*) and 21 (*Problems with treatment*) to be the most relevant risk factors with respect to his risk for future sexual violence. Mr. V's intact interpersonal skills and his general prosocial attitudes and orientation appeared to the evaluator to be areas of personal strength (i.e., resource or resilience factors).

The evaluator developed two primary scenarios of future sexual violence. In the first, a "repeat" scenario, Mr. V is released into the community and has good initial adjustment, but becomes increasingly lonely, misses intimate and sexual contact with others, begins to visit locations frequented by young boys (such as parks or schoolyards), and eventually tries to convince a young boy to have sex with him. In this scenario, the primary motivation is to reduce feelings of loneliness. The most likely victims are young boys, aged 10 to 12, strangers targeted in an opportunistic manner. The nature of the sexual activity is likely to be non-coercive sexual touching. There is some chance of an escalation to threats of psychological or physical harm, but the likelihood of serious physical harm seems remote, given the absence of any relevant history of such violence and Mr. V's declining physical health. The risk of the scenario seems chronic or long-term, rather than acute or imminent, and possible warning signs of escalating risk include increasing complaints of dysthymia or loneliness and increasing time spent outside in outdoor activities (i.e., not in his residence).

In the second scenario, a "twist" scenario, Mr. V's mild cognitive impairment worsens progressively over the months following his release, his behavior becomes increasingly disinhibited, and he tries to sexually touch another person—probably a young boy aged 10 to 12, but possibly a male of female of any age, once again strangers targeted opportunistically. In this scenario, the primary motivation is sexual gratification; it is not so much that Mr. V's urge to engage in sex is strong, but rather that he is so disinhibited he acts out on even mild urges. If his behavior is disorganized by dementia, the chances of physical harm to victims may be even lower than in the first scenario. The risk appears to be distant or remote rather than acute or imminent, and warning signs of increasing include noticeable worsening of cognitive functions (e.g., declining memory, impaired abstract thinking) and seriously disinhibited behavior (e.g., walking around naked, making grossly inappropriate sexual comments). The evaluator did not perceive any other plausible scenarios of future violence, such as alternative "twist" scenarios (e.g., obscene phone calls to young boys) or "escalation" scenarios (e.g., rape of an adult female, sexual homicide of a young boy). In contrast, the evaluator found it easy to develop an "improvement" or "desistence" scenario in which Mr. V is released, his decline in sexual appetite and function continues, and he develops a routine of activities that help him fulfill his personal needs in an appropriate manner. In this scenario, Mr. V does not experience any significant desire for contact—sexual or otherwise—with young boys and develops coping strategies that are sufficient to control any urges he experiences.

Based on the scenarios, the evaluator made detailed recommendations for case management plans. Briefly, these included developing strategies for: (1) caregivers and supervisors to monitor Mr. V's mood and social contacts, his cognitive functioning, and any evidence of disinhibited sexual behavior; (2) restricting Mr. V's residence and travel to limit his contact with children, whether intentional or accidental; and (3) increasing Mr. V's involvement in appropriate activities that included daily social contact with age-appropriate peers.

Finally, the evaluator reached a number of conclusory opinions to assist communication of the findings of the risk assessment. The rating of Case Prioritization was *Low*, as the evaluator believed it was feasible to develop and implement the case management plan with little effort and good chance of success. The rating of risk for Serious Physical Harm also was *Low*, as the evaluator did not perceive any grounds to believe Mr. V would escalate to any sort of physical violence, let alone life-threatening violence. The rating of Immediate Action Required was *No*, as the evaluator did not see any special management activities that would require implementation prior to or immediately upon release. The rating of Other Risks Indicated was *No*, as the evaluator did not perceive Mr. V to pose a risk for other interpersonal or self-directed violence. Finally, in terms of date for Case Review, the evaluator recommended that if Mr. V was released, his risk should be reassessed within a month, and immediate reassessment should be triggered by any sign that Mr. V's sexual appetite or functioning are, in fact, still active.

Case Discussion

This brief case example illustrates some of the key features of the SVR-20 V1/V2 and RSVP. The most important lesson to be learned is that both sets of guidelines help evaluators reach findings and form opinions regarding the risks for sexual violence posed by an evaluee and the management of those risks. The SVR-20 V1/V2 and RSVP do this in somewhat different ways—the SVR-20 V1/V2 are simpler but provide less structure for developing management plans than does the RSVP—yet none relies on quantification, reference to norms, or specific probability estimates that the evaluee will commit sexual violence. The decisions made using the guidelines can be framed, justified, and challenged in narrative terms. They are grounded in the scientific literature, but not cloaked in a mantle of science that makes them invisible or inaccessible to people

who are not statisticians. As forecasts or predictions of the future they are, admittedly, educated guesses—much preferable to wild, ill-informed, or ignorant guesses, but guesses nonetheless. Yet they have great potential utility for guiding action in a manner that is both reasoned and reasonable. We believe this is the best science can offer to decision-makers at this time, given the inchoate state of our knowledge about sexual violence.

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Author Notes

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