
Queensland boards a sinking ship

New dangerous offenders legislation

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Preventive detention for dangerous offenders. But can we tell which ones are dangerous?

The Queensland State Government recently legislated for indeterminate sentencing of 'dangerous' offenders in the *Penalties and Sentences Act* 1992. In practical terms, the thrust of such legislation is to provide for longer terms of incarceration for such people than are provided for under pre-existing legislation. It is timely to consider the implications and viability of such a law.

From a human rights perspective, the Act can be criticised on the ground that it punishes individuals for crimes not yet committed. Proponents of the legislation might argue in reply that the paramount issue is prevention rather than punishment: we know that particular individuals will commit further acts of violence if released; it is therefore irresponsible to sit back and allow these new crimes to occur before imposing further incarceration. The fact that the individuals detained might find the experience punitive is of little consequence, when weighed against the fact that new crimes are being prevented.

Implicit in the latter argument is an assumption about technology, although this is not often recognised in the debate. An instructive analogy may be drawn with drink-driving legislation. Current laws prohibit driving with a blood alcohol content in excess of 0.05%. These laws assume the existence of a technology which can accurately measure blood alcohol content. Without such a technology the law would be unworkable and absurd.

In like manner, dangerous offender legislation assumes the existence of a technology that can accurately and consistently differentiate dangerous and non-dangerous offenders; or in more operational terms, one which can distinguish between offenders who will behave violently after release, and those who will not. This article focuses on whether we currently possess a technology which can make valid discriminations of this nature. If not, then it would seem premature to have introduced legislation which calls for the labelling of certain offenders as 'dangerous' or 'posing an unacceptable risk', and which applies special conditions to their sentencing.

Approaches to prediction

Efforts to predict any type of future behaviour involve two essential tasks: data collection and data interpretation. The first has to do with gathering facts about the individuals in question. They must be appraised or assessed in some way, that is, information must be collected on their history and current characteristics.

Once the various data have been amassed, the second task is to draw from them an inference about future behaviour. Some of the facts we discover are likely to have positive implications for future violence, and others, negative implications. It is necessary somehow to weigh these various positive and negative facts against each other, and combine them to arrive at an overall conclusion about the future.

Responsibility for predicting violent behaviour is typically entrusted to the mental health and behavioural science professions. Within the relevant professional communities, there are two opposing schools of thought as to how the tasks of data collection and data interpretation should be approached. These are generally referred to in the professional literature as the 'clinical' and the 'actuarial', or 'statistical', approaches.

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In relation to data collection, the two schools differ markedly on the question of which characteristics or variables are to be taken into account as a basis for the prediction. The actuarial approach considers only those characteristics which have been scientifically validated as correlates of violent behaviour. Monahan reviewed the research literature and put forward the following list of offender characteristics which had been demonstrated to be associated with higher rates of violent crime: number of prior arrests for violent crimes; youth; being male; being black (within US population); lower socio-economic status or unstable employment record; opiate or alcohol abuse; unstable or unsupportive family environment; social networks including other criminals; and access to weapons.¹ It is noteworthy that each of these factors is either demographic or criminological in nature.

While the actuarial approach limits its field of vision to variables such as these, the clinical approach employs a considerably broader canvas. The clinically oriented examiner tends to place considerable weight on variables which are assessed via face-to-face interview and psychological testing, for example, mental health status; expression of remorse; degree of insight; dreams and fantasies; indications of repressed anger, etc.²

At face value, such factors may seem to be of great psychological significance and to offer important insights into the person under examination. The counter-argument from the actuarial school is that such characteristics have not been shown to be consistently associated with violent behaviour: they are therefore red herrings which do not contribute usefully to the task of prediction.

There are also profound differences between the clinical and actuarial schools in the interpretation of the collected data. The clinical approach employs little in the way of systematic procedures or rules for making the transition from facts to forecasts. The process of weighing the various data in relation to each other is essentially done subjectively. A premium is placed on clinical intuition. Clinicians may draw on theoretical models, their own experience with previous cases, and perhaps the research literature, but there is no structured sequence of decision points which are applied consistently from one case to the next.

In the actuarial approach, on the other hand, subjectivity is almost entirely banished from the interpretive process. There is instead an explicit formula prescribing how the different variables are to be combined with each other and processed to yield a prediction. Moreover, this formula is itself derived in a way which scientifically ensures that it yields the maximum possible number of correct predictions.

We briefly review the results achieved by these two contrasting approaches.

Outcomes of clinical prediction

Given the lack of structure inherent in the clinical approach, it is natural to wonder to what extent clinicians agree with each other in their conclusions about given cases. Quinsey and Maguire found little consistency between clinicians in their ratings of dangerousness, even after they had had the opportunity to discuss the cases with one another.³

If clinicians tend to disagree among themselves it cannot be expected that their predictions will often be correct. There is a small body of research, of variable quality, which addresses this issue of the aggregate success rate of clinical predictions.

Melton and others have prepared a convenient tabulation of the findings of 12 of these studies.⁴ What is immediately striking about these results is the consistency with which clinicians tend to over-predict violence.

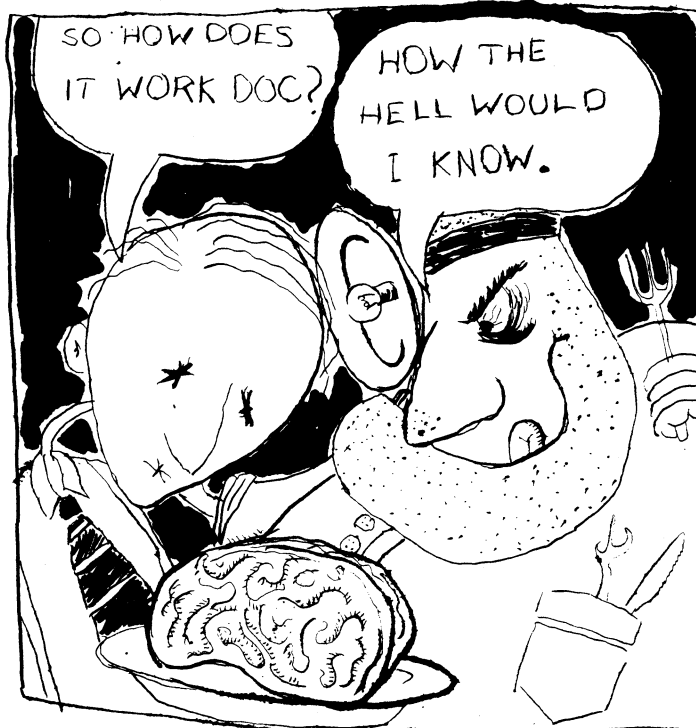
The term 'false positive' is used to denote an instance where an incarcerated person is predicted to be violent but then released and found not to have committed further violent acts afterwards. Of all the studies reviewed, the lowest false positive rate achieved was 19%. This is to say, for every five persons predicted to be violent, one was in fact not violent. This may be considered an impressive result, but it has never been emulated in any other study. The three next best studies in Melton and others' review achieved false positive rates around 45%, an outcome only slightly better than would be achieved by tossing a coin. In the remaining eight studies, the false positive rate was above 60%, and in several instances, around 80%, meaning that the great majority of

offenders who were designated 'dangerous' in fact committed no further violent acts.

Clearly there is no reason for society to place any confidence in clinical predictions of dangerousness.

Outcomes of actuarial prediction

Actuarial approaches to prediction are less well understood and have been applied far less extensively in the criminal justice system. It would appear though that these methods have been gaining in popularity, as disillusionment with clinical methods has increased.⁵ In examining the literature on the outcomes of actuarial methods, there are two types of study which must be clearly distinguished. First, there are studies on recidivism in *unselected* samples of offenders: that is, a wide range of offence types is represented in the criminal histories



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of the subjects studied. Furthermore, any type of criminal conviction after release from prison is counted as an instance of recidivism, irrespective of how serious or how similar to the original offence. Second, there are studies which specifically sample subjects with histories of violent offences, and restrict attention to re-convictions for violent offences after release. It is the former set of studies which has produced the most promising results, even though it is the latter which is more pertinent to the current discussion.

The work of Nuffield in the Canadian parole system provides a useful illustration of the process of actuarial prediction in general, and of the two types of study differentiated above.⁶ In her first study, Nuffield collected data on a large array of demographic and criminological predictor variables from a sample of about 1200 unselected parole applicants. She then monitored reoffending within this group over a certain period following their release to parole. Statistical procedures were then applied to determine a standard way of combining the various predictors into a single score for each subject, such that this score would give the best possible indication of his/her likelihood of reoffending. In this manner, she succeeded in deriving a predictor scale which had a strong relationship with parole outcome.

To test its robustness, she then took a fresh sample of parole applicants, and worked out their scores on her predictor scale. She defined five broad bands of scores on the scale and divided the sample into five groups accordingly. She then compared rates of reoffending across these five groups after their release. The results were as displayed in Table 1.

TABLE 1

	Band of scores on predictor scale	Proportion in each band who actually reoffended
A	(Predicted to be least likely to reoffend)	15%
B		32%
C		49%
D		58%
E	(Predicted to be most likely to reoffend)	68%

Adapted from Nuffield, 1982, as cited in Webster and others, 1985.

These figures confirm that Nuffield's scale was able to accurately rank offenders according to their likelihood of reoffending.

In her second study, Nuffield narrowed her focus of attention to violent offenders, and sought to predict further violent offences after release to parole. She considered only those offenders convicted of homicide, assault, rape, or indecent assault; and looked at the rates at which these men engaged in these same categories of offence after release to parole. She found that violent reoffending was far less amenable to prediction than reoffending in general. In this instance, she abandoned the attempt to construct a composite predictor scale, and instead utilised the best available single predictor, namely the number of previous convictions for violent offences.

She found that inmates with a history of one to three such convictions had a violent recidivism rate of only 17.6%. Those with a history of five or more such convictions had the marginally

higher recidivism rate of 27.6%. While a violent history maybe a better predictor of future violence than any other piece of information, it remains in absolute terms, a very poor predictor.

Other researchers have reported similarly disappointing results. Again the bulk of the published research has been summarised by Melton and others.⁷ The best false positive rate achieved was 46%, where the behaviour being predicted was violence within the setting of a forensic mental health facility. In studies looking at violence after release to the community, false positive rates ranged from 69% (for forensic patients), to 99.7% (for parolees). Again then, when the scales led to a prediction of dangerousness, they were incorrect in the great majority of cases.

A small subset of these studies directly compared clinical and actuarial methods of prediction within the one sample of offenders. The actuarial methods were consistently superior, but the margin of improvement in each instance was rather meagre.

Despite its objectivity and scientific rigour then, the actuarial approach has not proven an effective way of circumventing the shortcomings of the clinical approach.

Let us briefly consider the practical implications of the above findings. Say, for example, that the Queensland criminal justice system develops its own predictor scale, and a cutting-score is set which leads to 70% false positives. Consider a group of 100 violent offenders whose scores place them in the 'dangerous' bracket. If we give them all indeterminate long sentences, we would be protecting the community from about 30 individuals who would truly have done serious harm to others. We would achieve this at the price of detaining 70 individuals who would not have committed any further violent acts.

Society may or may not consider this price justifiable. The point which needs to be borne in mind though, is that current technology affords us no way of achieving the same benefit for a lower price. We have no effective means by which to review each of these 100 offenders, and work out whether he/she belongs among the 30 who will reoffend or the 70 who will not. We could hope to do this only by looking at characteristics outside the scope of the predictor scale. To do so, however, is to abandon the actuarial method and revert to the clinical. As demonstrated earlier in this discussion, there is no reason to expect that clinical judgment will reduce the false positive rate below 70%.

Predictions not viable

In summary then, the mental health and behavioural science professions have as yet been unable to demonstrate an effective technology for distinguishing violent offenders who will recidivate from those who will not.

The above point has been gaining wider recognition over the past 20 years. As long ago as the mid-1970s, the American Psychiatric Association issued two clear disclaimers of predictive expertise on the part of its members: the first, in the report of the Task Force especially appointed to examine this issue;⁸ and the second, in the *amicus curiae* brief submitted in the *Tarasoff case*.⁹ It would appear that there has been no subsequent statement reversing or qualifying this position.

The issue has received less attention within the relevant professional communities in Australia. Recently though, interest has been sparked in Victoria by proposals to introduce spe-

cial legislation for preventive detention of 'dangerous' offenders. A parliamentary inquiry in that State sought and published the views of a range of interested bodies.¹⁰ The Victorian Branch of the RANZCP, in its contribution to the latter volume, issued a disclaimer similar to those of the American Psychiatric Association (p.306). This position was echoed by several individual psychiatrists who also contributed (e.g. Ellard, p.165; Walton, p.291).

The literature reviewed above should not be misconstrued as exposing failings which are peculiar to the mental health and behavioural science professions. The reason we have focused on these disciplines is that all of the data published to date pertain to their efforts. There are negligible data available on the predictive prowess of other groups in society, for example police officers, lawyers, judges, clairvoyants, astrologers, laypersons, etc. There is no reason to assume then that these other groups would perform any better (or any worse for that matter). Given the persistent efforts and the range of methodologies trialled by the mental health and behavioural science professions, it would seem reasonable to conclude that nobody can make dependable predictions about future violence or non-violence. At this point in time we simply do not know enough about human behaviour.

We submit then, that dangerous offender legislation, which pivots on predictions of future violence is simply not viable. It requires that courts and expert witnesses pretend to abilities which they plainly do not possess.

Alternative approaches

Alternative approaches to the disposition of violent offenders therefore demand serious consideration. One worthy alternative is the 'just deserts' model, as articulated by Potas.¹¹ Under this system, sentences are determinate, and based solely on information relating to past events: the heinousness of the instant offence; any mitigating factors operative at the time; and the perpetrator's prior criminal record. It requires the court to make difficult value judgments, but does not demand that anyone give answers to unanswerable empirical questions. It would, therefore, provide for more rational, honest and consistent dispositions of violent offenders, without necessarily being more lenient.

We submit then, that 'just deserts' should be the basic principle informing the disposition of violent offenders. Predictive considerations should be limited to a very minor role, if any, in determining when serious offenders are released. One scenario in which prediction might be relevant, is where the prisoner voices the prediction that he/she will commit further violent acts. On purely commonsense grounds it would seem advisable to take his/her word for it, and extend the period of detention. A second relevant scenario is where a previously violent offender develops some mental or physical disability while in custody, which substantially reduces his/her capacity for further violent offences. This might conceivably constitute grounds for an earlier release than was originally ordered.

Despite the fact that Queensland's new Act is premised on the predictability of violence, it is imperative that the judiciary and mental health experts do their work in a manner which honestly and responsibly reflects the serious limitations of our current predictive technology.

We concur with Melton and others' recommendation that mental health professionals' testimony should never include statements to the effect that the subject is (or is not) 'danger-

ous' or 'likely to do serious harm to others'.¹² As demonstrated above, such statements must be regarded as pure speculation. They do not stem from any fund of expert knowledge or skill or interpersonal sensitivity; they merely reflect the 'expert's' ignorance of the relevant scientific literature.

The above comments apply, even in respect of offenders who may seem so far beyond the pale that the examiner feels no sense of doubt as to the prospect of future violence. In such cases, some mental health professionals have been tempted to make pronouncements along the following lines:

I am well aware of the difficulties of predicting future violent behaviours, but in this man's case I believe that there are particular characteristics present which enable me to make an accurate prediction.

The reasoning behind such statements is unsound: we have not yet discovered any characteristics which mark someone out as being an exception to the general rule of unpredictability. When mental health professionals make such statements then, they are essentially speaking as lay people rather than experts. The most that a mental health professional can currently do, given the present boundaries of our expertise, is to assess the subject with respect to characteristics known to be associated with violent behaviour, and make statements such as:

Factors A, B and C increase the risk of Mr . . . behaving violently, whereas factors X, Y and Z decrease the risk.

Mental health professionals should not attempt, nor should the criminal justice system encourage them, to violate these boundaries.

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