CHAPTER 1

VIOLENCE RISK ASSESSMENT

An Introduction

For a variety of purposes, and in a range of settings, clinicians may be involved in providing formal assessments for the courts or other quasi-judicial boards. In fact some estimates have shown that approximately half of all psychologists in general practice will at some point provide an assessment for the court (Tolman & Mullendore, 2003). Although readers of this clinician's guide are likely to be interested in the practice of violence risk assessment, the assessment and management of violence risk is not limited to forensic psychologists and psychiatrists. Approximately 25% of offenders will seek community-based mental health services (Morgan, Rozycki, & Wilson, 2004); thus, the

> assessment and management of violence risk are critical issues, not just for psychologists and psychiatrists in forensic settings but for all practicing clinicians. Despite a long-standing controversy about the ability of mental health professionals to predict violence, the courts continue to rely on them for advice on these issues and in many cases have imposed on them a legal duty to take action when they know or should know that a patient poses a risk of serious danger to others. (Borum, 1996, p. 954)

To ensure consistency of terminology between us as writers and you as readers, we define our use of the term *risk assessment*. Many times in the literature the term "risk assessment" refers to the determination of the level of risk (risk estimation), whether actuarial (percent likelihood) or descriptive (low, moderate, or high). When we refer to risk assessment we are referring to the whole process of (1) determining an individual's level of risk (risk

estimation), (2) identifying the salient risk factors that contribute to that risk, (3) identifying risk management strategies and considerations to manage or minimize that risk, and (4) communicating the risk information to the decision maker.

This book will lead you through the practical steps of conducting one type of clinical assessment, a violence risk assessment. Violence risk assessments are almost always completed within the context of the competing interests of society (public safety) and the person being assessed (freedom and fairness). Clinicians typically form a therapeutic alliance with their clients, working jointly to improve their lives. However, within the violence risk assessment process, we emphasize a reliance on the *data* (the specific facts as they relate to the potential for violence) to avoid therapeutic bias. The forensic assessor is partial to neither "side" in a legal proceeding, but to whatever conclusions and recommendations to which the facts and case specifics point. It therefore follows that forensic assessments of violence risk will differ from other clinical assessments in approach, content, and tenor. For example, a clinical assessment is typically conducted to aid in the rehabilitation of the client, whereas a forensic (violence) assessment typically aids in answering a legal question, with the focus of protecting society at large. These differences also lead to what appear to be competing ethical obligations not typically experienced within clinical practice.

In this opening chapter we introduce you to some of the issues surrounding violence risk assessment. The information we provide assumes a certain level of training and experience and so we have adopted the term *clinician* as we understand that similar training and experience may be found in different disciplines (psychology, psychiatry, nursing, social work, etc.). In outlining some of the essential skills the clinician needs to bring to the process, we will identify *who* should be conducting a violence risk assessment. Clinicians are often asked to provide an opinion regarding the potential for violence of a client. There are competing arguments for and against conducting these types of assessments. We review some of these arguments to answer the question of *why* a clinician should undertake a violence risk assessment.

As a clinician you are very familiar with therapeutic reports and assessments, but we introduce you to some of the similarities and differences between therapeutic assessments and violence risk assessments. Differences between these two types of assessments include differences in the scope, purpose, procedures, and reports. We also review the advances that have been made in violence risk assessment over the past few decades to set our approach within the development of the field and to demonstrate that it represents the current direction of violence risk assessment. From a historical perspective, violence risk assessment has moved from purely clinical judgment of dangerousness to an actuarial approach with reliance

on probabilities based on statistical information. We show that over time actuarial measures have been combined with dynamic risk factors within a risk management and intervention paradigm, resulting in what we term an *integrated–actuarial* approach. We also report on an emerging approach that integrates changes in dynamic risk factors that modify static–actuarial estimates and is now in the forefront of violence risk assessment. We refer to this approach as a *dynamic–actuarial* approach. With our review of the differences between therapeutic and violence risk assessment and the overview of assessment advances we hope to introduce *what* a violence risk assessment should include. Finally, we look at the special ethical obligations that are associated with conducting violence risk assessments. The purpose of ethical standards is to ensure that *how* we conduct violence risk assessments meets the highest standards of science and professional practice.

THE CLINICIAN'S KNOWLEDGE AND TRAINING

The purpose of this book is to provide knowledge on the specifics of violence risk assessment for professionals who already provide other types of clinical intervention and assessment services. *Clinician* is the term we have chosen to describe those professionals who have advanced knowledge and training in a number of areas important for the conducting of violence risk assessment. This knowledge and training is not specific to any particular professional group but can be found in psychology, psychiatry, psychiatric nursing, counseling, and social work. It is the clinician's ethical responsi-

Actuarial Risk Assessment

The term *actuarial* means "relating to statistical calculation" (Merriam-Webster's Collegiate Dictionary, 1999). Confusion exists within the literature because some researchers have equated instruments that are primarily composed of static and historical risk factors with the term actuarial. In fact, instruments with potentially changeable factors can and do incorporate actuarial risk estimates. Also, actuarial has sometimes been used to describe instruments that are not "structured clinical/professional judgment." So to be clear, *actuarial* is a term we reserve for any instrument that has a structured scoring method and associates a statistical or probabilistic statement with the resulting score. To run the risk of complicating things further, instruments that employ the structured professional judgment (more on this later in the chapter) approaches could quite easily become "actuarial" simply by applying statistical probabilities to the resulting scores. While this would be, in our opinion, an improvement, it is not in keeping with the structured professional judgment approach to risk assessment.

bility to judge if he or she is competent to complete a violence risk assessment. Most professional governing bodies will have specific guidance on what would constitute competence. Similarly we assume that clinicians will belong to a licensing body that regulates their profession through standards of practice and ethical guidelines. In keeping with this we are assuming that the clinician will operate within these guidelines.

Violence risk assessment requires graduate-level training or equivalent knowledge and experience in understanding personality and psychopathology. Similar levels of knowledge and training are necessary in the areas of theories of behavior and interviewing skills. Experience and competence in the area of case formulation and clinical report writing are very important. A comprehensive knowledge of mental and personality disorders and their relationship to behavior in general and violence in particular are essential. While it is not necessary to be able to diagnose a mental disorder, in many cases it is essential to have access to a professional who can diagnose a mental disorder and/or personality disorder, as these disorders are features of some risk appraisal instruments. Finally, knowledge of statistics and an ability to apply and communicate their meaning in an assessment context is also important. Terms such as *receiver operating characteristic* and *base rates*, although cumbersome to some, are essential for analyzing and communicating the results of risk assessments.

A Word about Statistics

Clinicians often dislike statistics. However, we are making the assumption that you may have to testify in court and may be called upon to express an opinion based upon the scientific literature. The relationship of risk appraisal instruments with violence will be featured prominently throughout this book, and to that end we have included enough statistical information for you to speak to the issue of risk assessment.

Researchers employ many different types of statistics in order to communicate the accuracy of a given risk appraisal instrument. Among these statistics is the more commonly known and understood Pearson's *r* (between two continuous variables), point–biserial correlation (between continuous and dichotomous variables), or phi coefficient (which is a measure of the degree of association between two binary variables). Other statistics used include percent correct classifications, relative improvement over chance (RIOC), positive predictive power (which is the proportion of those predicted to fail who actually did fail), Cohen's *d*, and area under the curve (AUC) from a receiver operating characteristic (ROC), among many others.

For ease of understanding we will report correlation statistics and AUC statistics. The latter statistic is a relatively recent development but is appealing because

of its robustness as a statistical measure of accuracy and ease of understanding for lay consumers of information. ROC analysis has its origins in signal-detection theory in engineering and psychophysics (Green & Swets, 1966; Swets, 1988). Research by Marnie Rice and Grant Harris (1995, 2005) has helped to promote the more frequent use of ROC and make it better understood within forensic contexts. AUCs can be interpreted as the probability that a randomly selected recidivist will have a higher score than a randomly selected nonrecidivist. For example, most AUCs fall within the range of .50 (chance) to 1.0 (perfect prediction). If an instrument used to predict recidivism had an associated AUC of .75, this means that there is a 75% likelihood that the score of a randomly selected recidivist would be higher than the score of a randomly selected nonrecidivist. Conceptually this is easier to explain than other types of statistics. From an accuracy perspective the AUC is not as susceptible to changes in the *base rate* (the sample mean likelihood for an outcome) as are measures of correlation. As an example, point–biserial correlations of .100, .243, and .371 are considered small, medium, and large, respectively, when the base rate (overall likelihood of recidivism) is 50% (see Harris & Rice, 2005). These correspond to AUCs of .556, .639, and .714 for small, medium, and large effect sizes. If the base rate for recidivism changes to 25%, then point–biserial correlations of .086, .212, and .327 would correspondingly be considered low, medium, and high. A more complete listing of equivalent values between AUC, Cohen's *d*, and point–biserial correlations is reported by Rice and Harris (2005).

Another illustration of the correlation versus ROC difference was the result of a statistical exercise by one of us (JM). Using previously published data, a known predictor of recidivism was correlated with the dichotomous outcome of recidivism (point–biserial correlation) which resulted in a moderate and significant correlation. The data were then manipulated so that recidivism failure was indicated only for the top scorers so that the AUC would equal 1.0, perfect prediction. A point–biserial correlation was then undertaken on the manipulated data and resulted in a correlation approximating $r = .82$. This illustrates that when point–biserial correlations are reported in recidivism studies they do not have the same theoretical range of –1.0 to +1.0 as would potentially be the case when two truly continuous variables are correlated.

WHY CONDUCT VIOLENCE RISK ASSESSMENTS?

The arguments for and against conducting violence risk assessments are at times addressed under cross-examination. Thus, a basic understanding of these arguments may assist a clinician in giving testimony. In addition, these arguments help to outline how a local criminal justice agency can benefit from a rational, empirically based, routine violence risk assessment. In this section, we review common reasons for conducting violence risk assessments, along with some criticisms of risk assessment.

Public Safety

The tension between the autonomy of the client and an obligation to protect foreseeable victims from a client's violent actions was central to the *Tarasoff v. Regents of the University of California* (1976) decision. This decision continues to have a significant role in current ethical standards, legal decisions, and lawmaking that governs mental health services. Embedded in this decision is the requirement to assess clients for potential violence. Even if a clinician never plans to do forensic work, at some point he or she may be required to conduct an assessment and act on the conclusion. Therefore, every clinician needs to be competent to assess risk for potential violence (most jurisdictions in the United States and Canada have endorsed the *Tarasoff* duty-to-protect decision, and de facto a requirement to assess). But just what kind of assessment is required of a clinician, particularly one who is not working formally as a forensic psychologist?

The *Tarasoff* decision gives a broad legal requirement for clinicians to assess for specific or targeted violence. There is a duty to protect that stems from the *Tarasoff* findings when the clinician has reasonable grounds to believe a specific individual is at imminent risk of serious harm or death. Clinicians should be aware that the criteria for the duty to protect may vary somewhat by jurisdiction due to legal interpretations and professional standards of practice. Additionally, they should be aware of the impact that these specific guidelines will have on their practices.

The focus of this book is on the longer term assessment of violence risk, not on *Tarasoff* situations. In general there are five significant differences between conducting a longer term violence risk assessment and determining the duty to protect in a *Tarasoff* situation. First, "duty-to-protect" arises when you are treating a client. Violence risk assessments, on the other hand, typically happen outside the context of treatment. Second, the clinician has a choice whether to conduct a formal violence risk assessment. The clinician in these situations selects assessment methods, management strategies, and instruments, and considers base rates and placing risk within a context. Conversely, in treatment, when a clinician determines that a client may pose a clear risk to another person, the clinician has no choice but to conduct a *Tarasoff* evaluation. Third, *Tarasoff* situations generally occur when a specific person (or group of persons) can be identified as being at risk for violence by the client, whereas longer term violence risk assessments more often focus on the risk to society in general. Fourth, *Tarasoff* situations typically focus on imminent risk as opposed to long-term risk. (Imminence, though, may arise when conducting a long-term violence risk assessment, at which time one is then required to conduct a *Tarasoff* evaluation, notify appropriate authorities and the potential victim, and include the evaluation in the broader violence risk assessment report.)

Fifth, the strategies for conducting a *Tarasoff* assessment are different from the strategies for conducting a violence risk assessment. Borum and Reddy (2001) argue that the *Tarasoff* assessment is more deductive and relies more upon clinical judgment as compared to violence risk assessments, which focus on a broad array of risk factors and base rates. They use the acronym ACTION to outline the areas for consideration in a *Tarasoff* evaluation: *A*ttitudes supportive of violence, *C*apacity to carry out the threat, *T*hresholds crossed in a progression of behavior, *I*ntent to act versus threats alone, *O*ther's knowledge of the client, and *N*on-compliance with strategies to reduce risk. We reiterate that it is very important for the clinician to have a clear understanding of the local jurisdiction's requirements surrounding the duty to protect.

While *Tarasoff* introduces the legal obligation for therapists to consider pubic safety, we believe clinicians have a broader duty to public safety through violence risk assessment. Applying a validated assessment protocol systematically in cases requiring violence risk assessments will more consistently identify high-risk offenders over unstructured decision making (Nugent, 2000). That improved consistency has the potential to reduce violence because it will lead to the detention, treatment, and management of high-risk cases, with the result of improved public safety. Informed decisions based on valid risk assessment instruments will provide better decisions than those based on no assessment, and in most cases better than clinical judgment alone (Hilton & Simmons, 2001). In addition, a risk assessment will be able to suggest evidence-based strategies that may reduce the likelihood of future violence. Decision makers can then use these suggestions in forming their dispositions.

Increased Fairness for the Client

Balancing public safety and the assessed person's rights is one outcome of conducting ethical, competent violence risk assessments. In order to contribute to this balance, the clinician must have a strong commitment to present findings in keeping with the facts of the case (the data), rather than advocating for either the assessed person or those representing public safety. The best approach to balancing this tension is to "conduct objective risk evaluations according to the best standards available" (Tolman & Rotzien, 2007, p. 73).

In addition to presenting findings in keeping with the facts, there are specific ways to facilitate a better balance between public safety and the client's rights. For example, the inclusion of a standardized violence risk assessment may increase the potential for a fair decision for the assessed person by reducing the relative influence of other factors not related to risk. Some of these factors include public pressure, fears and emotions of the decision

maker, the influence of the last case (recency effect), and prejudices stemming from ignorance such as overestimating the risk posed by the mentally ill. The clinician who can present an assessed person's risk within a context (e.g., compare the client's probabilities with other relevant probabilities, or explain the psychosocial contributors or mental health contributors to the behavior) will give the decision maker a better basis on which to make a decision. Courts and boards of review are the arbiters of the public interest and weigh the rights of the assessed person with the protection of society. A properly conducted violence risk assessment can provide such decision makers with a broader picture, such as describing how the assessed person could have his or her level of risk reduced or managed. With that broader context in hand, the decision maker could then determine that release is possible, despite the potential for future violence. For example, release destinations (halfway houses, inpatient units, etc.) often differ in levels of services available, whether they are for supervision or intervention and treatment. If your report identifies supports and supervision that can be put in place to help an assessed person avoid violent behavior, it may give a decision maker confidence in releasing the assessed person, rather than detaining him or her further.

Value-Added Information for Decision Makers

The research into violence risk factors has increased our knowledge on the risk factors among diverse samples. With the current risk assessment literature, clinicians can better account for individual differences among assessed persons. Standardizing individual differences is an important advancement in the risk assessment enterprise. For example, psychopathy has been shown to have predictive value with sexual offenders (Olver & Wong, 2006): the higher a person scores on a psychopathy scale, the more likely he or she is to commit a future sex offense. Other research has shown that including deviant arousal with psychopathy improved the prediction of sexual recidivism (Harris et al., 2003). This result has also been found with juvenile sexual offenders (Gretton, McBride, Hare, O'Shaughnessy, & Kumka, 2001). Factoring in these kinds of individual differences allows clinicians to provide more reliable and precise risk assessments, thereby providing more information on risk factors and the potential intervention and management associated with those risk factors to the decision makers.

Arguments against Risk Assessment

Despite the general acceptance of violence risk assessment, there are some who have argued against conducting them. Campbell (2000) likened the use of clinical judgment and guided clinical risk assessment (what we call struc-

tured professional judgment)[1] to phrenology (personality assessment based upon the shape of the individual's head) in terms of meeting the requirements for admissibility in court. He further suggested that there was no known error rate for these methods, and therefore they did not meet the *Daubert* criteria for admissibility of scientific evidence in court (*Daubert v. Merrell Dow Pharmaceuticals*, 1993). Although the *Daubert* ruling did not provide a checklist for admissibility of scientific information, it did outline several guidelines: (1) the theories and techniques used in the assessment process need to be falsifiable, (2) the techniques must have a known error rate, (3) the method used has to have been subjected to peer review and publication, and (4) the method used has to have found widespread acceptance in the relevant scientific community. In a subsequent paper, Campbell (2003) took issue with the classification errors of actuarial risk assessments and concluded that psychologists undertaking such assessment had to accept that they offered "very limited accuracy" (p. 277).[2] Despite these objections, Tolman and Rogzien (2007) note that not all states follow the *Daubert* criteria, that the Supreme Court has stated the necessity of expert testimony in assessing violence potential (*Addison v. Texas*, 1979), and that research has found that actuarial data are admissible in court over 90% of the time (Tolman & Rhodes, 2005). The courts' general acceptance of actuarial data seems the undoing of these arguments of admissibility.

Another criticism of conducting risk assessments relates to the generalization of risk assessment to specific groups of offenders (Whiteacre, 2006). For example, despite a number of studies that have shown a significant relationship between the actuarial risk instrument, the Level of Service Inventory—Revised, and women offenders' recidivism (see Chapter 3), the use of this instrument with women offenders has drawn some criticism (Holtfreter & Cupp, 2007). Some of the criticisms appear to be rooted in ideology (feminist "pathways to crime" vs. a gender-neutral social learning theory), while other concerns have more merit and are empirically based. It is true that many of the instruments developed with men offenders have not been as extensively researched with women offenders, yet evidence for their validity remains. In recent years a growing emphasis on the unique issues and needs of women offenders suggests that this discrepancy in risk assessment instrument evaluation will be resolved with time and more research (Blanchette & Brown, 2006). It is also quite likely that some risk factors that effectively predict violence with men may not predict as well with women, or the manner in which risk factors are measured may need to be

[1]Later in this chapter we cover in some detail the different approaches to risk assessment.

[2]Without getting ahead of ourselves, actuarial estimates assume a degree of error. More will be said on this later.

adjusted to accommodate gender differences. These differences do not mean risk assessment should be abandoned, but rather that we need to adjust risk assessment protocols to accommodate these differences. In fact, examples of risk appraisal instruments that have been modified to account for differences between adult and juvenile offenders include the Level of Service Inventory—Revised and the Psychopathy Checklist—Revised (Youth Level of Service/Case Management Inventory 2.0 and Psychopathy Checklist—Youth Version, respectively).[3]

Some researchers are looking empirically at both gender-neutral and gender-responsive risk factors with the aim of improving assessment accuracy. Wright, Salisbury, and Van Voorhis (2007) examined both of these types of risk factors as they relate to incarcerated women offenders and their subsequent institutional misconduct and found that both types of variables were related to misconduct. The strength of the relationship with misconduct was very similar for both types of risk factors, leading these researchers to conclude that there is room for both risk factors when assessing women offenders.

In any case, having a competent violence risk assessment, even if it does not account for group-specific differences, will be better than having none at all. We also note that limitations of the assessment based upon these differences do need to be clearly stated. Hilton and Simmons (2001) provide an excellent example of what contributes to risk decisions when actuarial data are ignored. In their study, a tribunal board made decisions to detain or to transfer forensic psychiatric patients to lower security. The variables examined included patient characteristics, patient history, clinical presentation, and the actuarial risk estimates of the Violence Risk Appraisal Guide (VRAG). Compared to other variables, the senior clinician's testimony was the strongest predictor of the tribunal's decisions. What, then, predicted the senior clinician's decisions? They were (1) institutional management problems, (2) psychotropic medication use and success, (3) the patient's physical attractiveness, and (4) the patient's preindex criminal history. The actuarial risk estimates as measured by the VRAG were not related to the tribunal decision ($r(169) = .06$), team recommendation ($r(160) = .01$), or the senior clinician testimony ($r(152) = -.02$). Essentially, the attractiveness of the patient was more of a factor in the decisions than the actuarial risk estimates. This is disappointing and somewhat surprising, given that the VRAG was developed at the institution where the study was conducted.

In our opinion the benefits of public safety and improved decision making for both society and the assessed person outweigh the limitations that

[3]Similar adjustments have also been undertaken in psychology more broadly when considering the measure of intelligence or psychopathology.

are evident in the violence risk assessment process. Clinicians need to be aware of the differences between risk assessment and clinical assessment, the current practice in risk assessment, and the ethical considerations when undertaking risk assessment in order for the benefits to be realized. These issues are the topics covered in the next sections.

THERAPEUTIC VERSUS VIOLENCE RISK ASSESSMENTS

As we have noted, we assume that the clinician brings to the violence risk assessment knowledge and experience in conducting a clinical assessment and writing a therapeutic report. However, therapeutic clinical assessments differ from violence risk assessments (see also Heilbrun, Marczyk, Dematteo, & Mack-Allen, 2007) and clinicians should not assume that clinical skills alone are sufficient. As noted by Skeem and Golding (1998), "Occasionally experts rely primarily on their traditional clinical skills and attempt to generalize these to psycholegal assessment" (p. 365). Even with solid clinical training, clinicians need to understand the basic and unique characteristics of conducting violence risk assessments before they agree to undertake the task. Understanding these conceptual differences will (1) assist in providing a focus and purposeful framework for conducting risk assessments, (2) highlight aspects of clinical training that contrast with conducting a risk assessment, and (3) reduce the likelihood of applying procedures for therapeutic assessments to violence risk assessments inappropriately. Traditional clinical therapeutic assessment and the violence risk assessment share some common features, but are also different in key ways. These differences have to do with the scope of the work, the importance of the assessed person's perspective, voluntariness, autonomy, threats to validity, and the nature of the assessor–client relationship.

Similarities between Therapeutic Assessments and Violence Risk Assessments

Both therapeutic assessments and violence risk assessments require a reasonable degree of scientific certainty. For example, according to the ethical code of the American Psychological Association, "Psychologists' work is based upon established scientific and professional knowledge of the discipline" (2.04). Other mental health disciplines share similar expectations. Thus, in both the therapeutic and violence risk assessment, clinicians must be able to justify their techniques, conclusions, opinions, and recommendations. With both kinds of assessment there will be a merging of scientific theories and procedures with training and experience.

No assessment includes all information. It simply is not possible in a

therapeutic or violence risk assessment to obtain all information. Rather, the goal is to obtain as much relevant information as is reasonable to secure and necessary to answer the referral question ethically and scientifically. Both therapeutic and violence risk assessment results must be presented in an accurate, organized, and easily understood format. The therapeutic assessment and violence risk assessment will both present similar types of information. In fact, certain components of the assessment reports overlap. As one example, a psychosocial history will be common to both types of assessment. Finally, competent assessment techniques are, naturally, a necessity for both the therapeutic assessor and the violence risk assessor.

Differences between Therapeutic and Violence Risk Assessments

Despite the similarities between therapeutic and violence risk assessments, there are important differences between them.[4] Generally, the scope and focus of the therapeutic assessment is broad and tends to be geared toward identifying and understanding psychopathology for the purpose of guiding interventions. However, the therapeutic assessment is more likely to involve multiple contacts with the patient. The violence risk assessment, on the other hand, is very specific with the predetermined goal of predicting future behavior, and is typically limited to one or two contacts.

The purpose of the therapeutic assessment is to aid in the rehabilitation of a patient. Although the guidelines for this type of assessment are predominantly standards of practice, this is not to say that a therapeutic assessment is void of legal standards. In fact, standards of practice for therapeutic assessment are influenced by legal decisions. The violence risk assessment, however, presents a unique shift for the clinical generalist, one that includes the recognition that the client is not necessarily the individual being assessed. Because the client in a violence risk assessment may not be the person being assessed we try to use the term *assessed person*. Furthermore, a violence risk assessment is requested to help answer a legal question that is before a legally constituted decision-making body (e.g., court, forensic mental health board, parole board). The legal question in these instances is often to what degree the assessed person poses a threat of violence to others. Thus, the guidelines for conducting a violence risk assessment are likely to involve both a legal standard (i.e., meeting standards for admissibility to

[4]Interested readers are referred to Heilbrun, Marczyk, DeMatteo, and Mack-Allen (2007); Melton et al. (2007); Packer (2008); and Skeem and Golding (1998) for a more thorough review of the differences between therapeutic assessments and violence risk assessments.

court proceedings) as well as standards of practice by a governing body (i.e., licensing board).

Astute and ethical clinicians recognize these differences between the therapeutic assessment and the violence risk assessment and develop their procedures accordingly, beginning with the initial contact. The initial contact outlines the assessment process, with explicit reference to a third party. In fact, licensing boards may require both a written and a verbal notification of both parties' involvement in the assessment. The therapeutic assessment focuses on the collection of treatment-relevant information concerning a patient's daily functioning, mental status, and identification of psychopathology. The client is generally assumed to be credible, since in a treatment context there are fewer motives to withhold or distort information. Although clients in therapeutic assessments are prone to subconscious distortions, there is generally less intent to deceive or manipulate the assessor. Reliability and validity of psychological tests (e.g., MMPI2, WAIS-IV) are not the primary foci, as accuracy is secondary to understanding the client's perspective. For example, exaggerated responses on a psychometric test have a different set of implications within a therapeutic setting (where there may well be a cry for help) than within a violence risk assessment (where it's more likely an interviewee is malingering for gain). The person being assessed in a violence risk assessment may consciously and intentionally distort information (e.g., present in an overly favorable manner). Thus, the reliability and validity of assessment information are of great importance, and clinicians need to take special care to assess for dissimulation. Furthermore, the procedures used to address the referral question are generally not scrutinized in many therapeutic settings, whereas the procedures used to assess the risk for violence are often carefully scrutinized, sometimes under cross-examination in a court room.

The time frame of the therapeutic assessment is generally determined by client need (e.g., severity of condition), and may be more leisurely paced. The schedule for a violence risk assessment, on the other hand, is often predetermined by the governing body and is therefore outside of the clinician's control. The client requesting a violence risk assessment may require a quick response time, or may be in no particular hurry, so there may be significant differences in time frames to complete the evaluation.

The report for a therapeutic assessment is written in technical language, is read by other health professionals, and contains diagnostic formulations (i.e., DSM language). Psychological and psychiatric terms are often included, and the tone of the report may be caring, empathic, and nurturing, with an emphasis on trust and confidentiality. The structure of the report is often left to the discretion of the psychologist, with the content of the report generally limited to issues and information of therapeutic relevance.

In contrast, the report for a violence risk assessment is read by lawyers,

judges, and releasing bodies, and contains information relevant to all legal issues pertinent to the case. Issues surrounding the limits to confidentiality become more complex. In fact, we recommend that the report explicitly state such limits and how consent, with regard to these limits, was obtained. The structure of the report is often determined by the legal issue at hand as there are frequently multiple stages of the legal question that need to be systematically covered in a report. Psychological jargon has no place in a violence risk assessment. Instead, plain and professional language should be employed, with care taken to explain technical terms. The primary reason for this approach is that the consumers of the violence risk assessments are typically not clinicians and are generally not familiar with the acronyms and technical terms utilized by those who work within the mental health arena.

With a therapeutic assessment, the client is likely to be a voluntary participant, and the clinician will have autonomy in addressing the clinical issues, usually with the cooperation of and input from the client. Violence risk assessments, on the other hand, are generally requested by a third party (e.g., court or decision-making body) such that the individual being assessed typically has little choice as to whether the assessment is completed. In fact, even if the individual refuses to participate in the assessment process, in some jurisdictions a report with the clinician's opinions will be provided to the governing body requesting the violence risk assessment. In such circumstances the clinician's opinion, based on other available information, is still considered in the decision-making process. In these situations, the assessed person's choice is limited to whether he or she will choose to participate in the assessment process.

With therapeutic assessments the assessor in most clinical situations has clear ethical duties to respect the dignity of and provide responsible care for the client. The clinician is operating with substantial therapeutic responsibilities, and therefore developing a working alliance is critical for success. The clinician is generally working on behalf of the patient. However, within a violence risk assessment, the assessed person may have no helping alliance with the assessor. The main responsibility is to the decision-making body, with a focus on documentation. Moreover, the assessed person may or may not find the content within the report helpful to his or her current situation (Packer, 2008).[5]

These differences between clinical and violence risk assessments outline

[5]Although there may be no formal alliance with the assessed person, rapport remains a valued goal as the more effort the assessor puts into establishing a relationship with the individual being assessed, the greater the likelihood for a more fully informed assessment. More specifically, efforts should be taken to foster an accepting and empathic attitude with the individual; the mere purpose of a violence risk assessment does not warrant a callous and distant interpersonal interaction.

part of the challenge of conducting an assessment within the forensic arena. We turn next to a brief history of the advances in violence risk assessment over the past decades. Understanding these advances will help you understand how the field has reached the current practice and where the field is likely to go in the coming years. It will also set our recommended approach within the historical context of risk assessment.

ADVANCEMENTS IN RISK ASSESSMENT

Assessing "dangerousness" has for many years represented the intersection between the legal system and the mental health system (Monahan, 1984). In fact, *dangerousness* is more of a legal term than a meaningful mental health construct. It has been suggested that for advancements to occur in risk assessments, research must first distinguish among the component parts of dangerousness: risk factors (the variables that predict violence), harm (the degree of violence), and risk (the likelihood of violence) (Steadman et al., 1994). Through the years research has focused on risk factors and on risk likelihood, but less so on the assessment-of-harm component.

Advancements in risk assessment have been described as "generational" by different authors (Andrews, Bonta, & Wormith, 2006; Doyle & Dolan, 2002). These descriptions seem to be tied to the advent of specific risk assessment tools as opposed to paradigm shifts. Doyle and Dolan accounted for advancements as moving from clinical judgment (first-generation risk assessments), to actuarial judgments (second-generation risk assessments), and then to currently structured clinical/professional judgment (third-generation risk assessments). Later Andrews, Bonta, and Wormith identified clinical judgment as first generation in which they included structured clinical judgment. They then identified empirically based but atheoretical instruments as second generation and then empirically based instruments that included static and dynamic factors as third generation. They proposed a fourth generation that "guides and follows service and supervision from intake through case closure" (p. 8). Our recapitulation of the advancements in risk assessment (see Figure 1.1) is focused more on the approach to the overall assessment process and less on specific instruments, though clearly one is associated with the other.

Clinical Judgment of Risk

The authority of the clinical judgment estimate of risk relies solely upon the clinician's subjective evaluation of the case factors. There are no formal rules or guidelines to identify risk factors and no specifications on how to integrate identified risk factors. There are no decision-making guidelines in

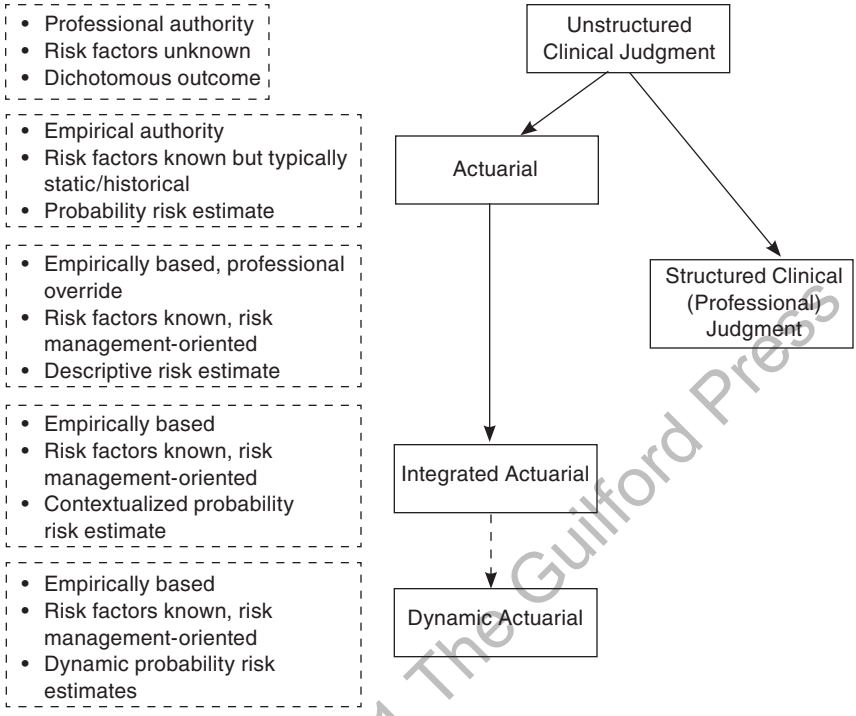

FIGURE 1.1. Advancements in risk assessment.

terms of what constitutes elevated risk, and there is no integration of the base rate (average rate) of violence. Clinical judgment is inaccurate mainly because it fails to systematically consider empirically based risk factors. Even if those risk factors are known and assessed by the clinician, the integration of the information is inconsistent. Research into decision making in other areas has shown that both laypersons and professionals fail to incorporate multiple pieces of information into their decisions (Northcraft & Neale, 1987; in a poststudy analysis only the amateurs knew they were influenced by a single piece of information whereas the professionals had more confidence that they had considered many sources of information). In addition to being unable to integrate multiple pieces of information systematically, individuals tend to make decisions without considering the base rate of the outcome (Kahneman & Tversky, 1973).

Moreover, clinicians are not immune to influences of the graphic nature or severity of violence, and may be unduly influenced by the context in which the assessment takes place, the clinician's personal characteristics, and the personal characteristics of the offender (Hilton & Simmons, 2001;

Static and Dynamic Risk Factors

Static risk factors are those risk factors that are related to the outcome (crime, violence, sexual violence, etc.) but do not change over time. These would include age of first offense or prior history of alcohol abuse. Some static risk factors can change over the long term but are called static because they generally do not change between the time of the assessment and the point of a new conviction. Example of these types of risk factors can include number of prior incarcerations and number of prior violent offenses.

Dynamic risk factors are those risk factors that are related to the outcome that have the potential to change over time. These risk factors have sometimes been referred to as "criminogenic need areas" (see Andrews & Bonta, 2010)—areas of functioning (attitudes, associates, substance abuse, etc.) that are related to outcome but can be potentially changed by appropriate intervention. In most instances within the literature when researchers report on dynamic risk factors they are really reporting on *potentially* dynamic risk factors. A truly dynamic risk factor is one that is empirically shown to change over time and that change over time must be related to a change in the likelihood of the outcome (risk). In fact this strict application of dynamic has been rarely demonstrated within the literature on risk assessment.

Hilton, Harris, Rawson, & Beach, 2005). Further, clinical judgment often involves backward inference (deriving causal links from historical information that is known in the present). The clinician has much latitude in identifying past facts to explain the behavior but this does not always mean those prior facts were indeed causal. For example, knowing that psychosis is related to violence (relatively small contribution) and that the person assessed who was violent also suffered from schizophrenia would lead some clinicians to conclude (infer) that the person was violent because of his or her mental illness and therefore will be violent in the future because of his or her mental illness. However, other clinicians who understood that research has found that mental illness is infrequently related to crime in the mentally ill (Junginger, Claypoole, Laygo, & Cristanti, 2006) may not infer the same causal relationship and arrive at a very different conclusion.

Because of the influences of backward inference, variable knowledge of risk factors, and personal characteristics of the offender on subjective judgment, agreement among forensic clinicians tends to be low. Stated another way, the accuracy of a measure (in this case the clinical judgment) cannot exceed the reliability of the measurements (in this case the ability for agreement in assessment). For example, think of a ruler with fuzzy lines and numbers. Two different people use the ruler to measure the same distance. The accuracy of the distance measurement (validity) cannot exceed the ability of each of those two people to agree on the distance (reliability). A ruler with

sharply focused lines is more likely to produce the same measurement when used by more than one person. Clinical judgments lack accuracy because they inconsistently measure risk factors. As evidence accumulated that clinical judgment was not an accurate way to predict violence, alternate methods began to appear (Monahan, 1983, 1996).

Actuarial Assessment

Advocacy for an actuarial risk estimate for use in parole decision making is not new. Hornell Hart recommended that the Parole Board of Massachusetts utilize "prognostic scores" (p. 410) associated with probabilities of parole failure as far back as 1923. In addition to individual research efforts that have shown actuarial assessment to be more accurate than clinical assessment when predicting general violence (Harris, Rice, & Cormier, 2002) and sexual violence (Bengtson & Langstrom, 2007), meta-analyses consistently favor actuarial over clinical (subjective) decision making. Grove and Meehl (1996) considered a broad array of decisions across many disciplines (e.g., bankruptcy, parole violation, adjustment to the military), and found actuarial methods to be more accurate overall than subjective methods.[6] Additionally, meta-analytic results demonstrate the superiority of statistical (actuarial) assessment over clinical assessment among sex offenders (Hanson & Bussiere, 1998).

In a recent meta-analysis by Hanson and Morton-Bourgon (2009), the data showed actuarial assessments of sex offender risk to be more accurate than structured professional (clinical) judgment. In a separate meta-analysis, in which clinician decision making was specifically identified, the data showed that actuarial assessments continued to perform better than clinician judgments (Aegisdottir et al., 2006). Actuarial approaches to risk classification can be as simple as scoring a person's criminal history (e.g., scoring the Static-99, a sexual violence actuarial instrument), or as complex as making sophisticated iterative classification tree analyses requiring computer support (Banks et al., 2004). Actuarial risk instruments have been shown to increase in predictive accuracy when scored with high reliability, when items are not missing, and when individuals within the samples have the same opportunity (time) to reoffend (Harris & Rice, 2003).

Actuarial instruments tend to be robust across groups of offenders. Dennis Doren (2004) compared the original risk estimates of two actuarial measures, the Static-99 (Hanson & Thornton, 2000) and the Rapid Risk

[6]These authors found 136 suitable studies in which actuarial systems performed better in 64 studies, there were mixed results in another 64 studies, and clinical judgment performed better in eight studies.

Meta-Analysis

Meta-analysis is a relatively new statistical method, which has grown in use over the past 15 years, of combining the findings from multiple research studies to determine what the overall effect size (strength of relationship) might be between a predictor variable and an outcome variable. The formulas for combing the findings can become quite complicated as correlations, chi-squares, and *t*-tests must all be mathematically changed to a common metric, usually *r* or Cohen's *d*. The strength of meta-analysis is the ability to compare different variables from across studies as they relate to the outcome of interest. A weakness is that many of the studies must be collapsed into common variables, and this sometimes leads to combining variables that are not measuring the same construct. Overall, a methodologically sound meta-analysis can provide much information into the relative importance of variables across a wide variety of settings.

Assessment for Sex Offence Recidivism (Hanson, 1997), with risk estimates from a combined group of studies that differed from the original samples on which the instruments were developed. This was undertaken to determine if the original risk estimates generalized to other samples of sexual offenders. Generally the results were positive, indicating fairly consistent risk estimates; however, there were some discrepancies particularly with the Static-99. When the comparison studies were examined individually there was a general finding that risk estimates were more aligned with the original estimates for samples that shared a similar base rate and follow-up time. A similar base rate simply means that the offenders were similar in terms of their overall risk level. Another unreported and related contributor to differences would also include the distribution of the offenders' risk scores. For example, a sample with a low base rate (lower average risk) is likely to have fewer individuals with higher scores. If the sample has fewer individuals with high scores, then the resulting risk estimates for those high scorers will be *unstable* because the group of high scorers is too small a sample. Those who are opposed to actuarial risk assessment may use these types of findings to bring disrepute on the process when in fact the explanation is not so much process but weak statistical comparisons.

Actuarial risk assessment accepts error in the ability to predict violence in at least three ways. First, it acknowledges that the world is inherently uncertain.[7] Second, it permits determinism at the level of the physical world, but believes that our knowledge of that world will always be fragmentary

[7]Actuarial estimates reflect the premise that the world is inherently uncertain and, regardless of how much information is available, certainty is not possible.

and imperfect. Third, it accepts that the use of an equation or algorithm can never capture the richness and full complexity of the phenomenon it is meant to predict. Actuarial assessment also demands empirical evidence rather than professional authority as the source of predictive validity.

There are some limitations to a purely actuarial approach to risk assessment. First, actuarial instruments tend to focus on historical or static risk factors, and there has been a tendency for the scores only to change to indicate more risk. For example, the number of prior violent offenses is a static risk factor (it will not change between the time of the assessment and the next possible offense), but over the long term the individual may commit more violent offenses and this risk factor may worsen. Second, these static factors tend to provide little information about the specific areas that should be targeted for intervention. For example, knowing the age of first violent offense is an excellent predictor but offers little information on the treatment targets for intervention. Third, actuarial instruments provide estimates of risk, and there is a need to cross-validate the instruments on different populations of individuals to ensure predictive accuracy. This may not be as much of a limitation as some detractors would suggest, given that intelligence and personality measures are often adjusted for different populations when measuring specific constructs. Fourth, static risk factors often do not suggest an etiology for the behavior they predict, which is often a question of inquiry when assessments are conducted. Fifth, actuarial methods become less accurate when predicting increasingly rarer events; as the base rate of a behavior decreases, so does the accuracy of actuarial estimates (though one would argue the same for clinical judgment, structured or otherwise).

Dawes, Faust, and Meehl (1989) suggested that professionals continue to ignore the advantage of actuarial over clinical judgment decisions due to habit or misconception based on training, theoretical understanding, or personal values. They debunk a common argument that group statistics do not apply to single individuals or events by suggesting that this position overlooks the fact that it is the common features shared among persons that permits *any* prediction of behavior. Much of clinical hypothesizing of future behavior is predicated on the observation of factors that would indicate the likelihood of the behavior. Extrapolation of individuals' responses to psychometric testing to current or subsequent behavior/experiences is predicated on relating individual responses to group norms. The clinical integration of this information, however, is not transparent, as it happened within the confines of the clinician's head—and we would argue is unique in each instance a judgment is made. The clinical process (the exact factors and method of combining those factors) cannot be measured and therefore tested empirically. Actuarial methods, by contrast, are transparent; they can be tested and they can be critiqued. Dawes et al. (1989) concluded that "failure to accept a large and consistent body of scientific evidence over

unvalidated personal observation may be described as a normal human failing or, in the case of professionals who identify themselves as scientific, plainly irrational" (p. 1673).

Structured Professional (Clinical) Judgment

Structured Professional Judgment (SPJ) is a process that identifies and rates a number of risk factors as clearly not present, may be present, or definitely present. Examples of SPJ instruments include the HCR-20 (Webster, Douglas, Eaves, & Hart, 1997), which is used to predict general violence in correctional and forensic settings; the Spousal Assault Risk Assessment (SARA; Kropp, Hart, Webster, & Eaves, 1994), for spouse assault; and the SVR-20 (Boer, Hart, Kropp, & Webster, 1997), for sexual violence.

Proponents of SPJ advocate in favor of a risk management or violence prevention model over a purely actuarial approach (Douglas & Kropp, 2002). This SPJ approach identifies the salient risk factors through the use of structured scoring. These risk factors include both static and dynamic variables. Based upon the number of risk factors present and the subjective importance of specific risk factors to the assessor, the assessor makes a judgment as to the risk an individual represents (low, moderate, or high). This method imposes a structure on the evaluation and sets as a minimum the number of risk factors to be considered through the use of the SPJ instrument. Following the identification of the risk factors, the clinician makes suggestions on how best to intervene to reduce risk or how best to manage the risk the individual poses.

SPJ differs from purely clinical judgment in that risk factors are reliably identified and integrated for an overall classification of risk. SPJ differs primarily from purely actuarial assessment in that it does not offer a probability statement. Some have referred to SPJ as "ostensibly a moderate position but in fact clinical judgment in new clothing" (Hilton, Harris, & Rice, 2006). The strength of this approach is the structure imposed on measuring the risk factors and the focus on risk management.

The SPJ approach has the clinician assess the structured risk factors from the specific instrument (usually 20), incorporate other risk factors or weight some risk factors with greater weight than others, and then make a determination of risk (typically characterizing risk as low, moderate, or high). The central limitations to the SPJ method are the absence of numerical probabilities and the allowance for clinical override in the estimate of risk: that is, the adjustment of the estimate by the assessor based upon other risk factors. Hanson and Morton-Bourgon (2009) reviewed three studies that reported an actuarial risk score and an adjusted actuarial risk rating. Raters (correctional staff) within these studies were permitted to adjust the final risk rating of an actuarial instrument based upon other factors. In each

case the adjusted risk ratings were not as accurate as the actuarial risk score. With evidence that base rates are not routinely incorporated in clinical risk appraisal, and that descriptive categories tend to be perceived by both clinician and laypersons as being of greater risk than actuarially supported for acts of violence, we see it as an important step to anchor risk assessment with an actuarially determined probabilistic statement wherever possible. In a nutshell, what advocates of SPJ view as a strength (the ability to incorporate or weight additional information at the clinician's discretion), we view as a weakness. We see this process of override as a return to clinical judgment.

Integrated–Actuarial Risk Assessment

Among the criticisms of purely actuarial risk assessment was that the approach omitted from consideration pertinent risk factors not captured by the actuarially based instruments. Other criticisms painted actuarial assessment as void of dynamic risk factors, intervention recommendations, and risk management strategies. Further, criticisms pointed to the absence of "critical" risk factors, those deemed particularly germane to the case. In many respects this argument was a straw man used by some advocates of SPJ who prefer to use descriptive categories and clinical override over an actuarially anchored assessment. In response to these criticisms of purely actuarial risk assessments, experts have advocated for the inclusion of both actuarial information and risk management strategies within risk assessment (Dvoskin & Heilbrun, 2001; Heilbrun, Dvoskin, Hart, & McNiel, 1999). Since the early 1990s we have been conducting actuarially based violence risk assessments, and we have never written an assessment without including comments on intervention recommendations and risk management strategies. In order to distinguish between a purely actuarial assessment as has been represented in some of the literature from what we have been practicing for many years, we have employed the term *integrated–actuarial risk assessment* to refer to the integration of (1) actuarial risk estimates, with (2) potentially dynamic risk factors, (3) intervention/treatment recommendations, and (4) risk management strategies within the overall risk assessment process.

Dynamic–Actuarial Risk Assessment

We have coined the term *dynamic–actuarial risk assessment* to refer to risk assessment procedures that measure both static and dynamic factors and that in the remeasurement of those dynamic factors can potentially alter the actuarial estimate of an individual's risk (Mills, 2005). This is unique as it potentially changes actuarial risk estimates through reassessment of risk

factors. Note that research in the field on this approach is still very much at the beginnings of development—with some room for optimism but no replicated applied findings at this point.

Harris and Rice (2003) correctly note that the measurement of any construct at a single point in time is a static measure. Researchers often refer to dynamic variables (e.g., antisocial attitudes, criminal associates, alcohol use) or items in a scale as "dynamic" when what is meant is that those items are potentially changeable. Whether or not the risk factors are dynamic is an empirical question, as is whether or not the change is meaningfully related to risk. It is also important to note that researchers will sometimes add potentially dynamic variables (attitudes, mood, etc.) to static/historical variables in an attempt to demonstrate that dynamic variables can add to the prediction of recidivism over static information alone. The question that so often goes unanswered is whether it is the content of the construct versus a change in the construct that is contributing to the improved prediction. More often than not it is the former that is being demonstrated and not the latter.

Having said this, the focus of researchers who are on the cutting edge of the risk assessment field is to identify a reliable and theoretically relevant measure that can account for actual change in risk to reoffend. These measures include both static/historical and potentially changeable or dynamic items. The *dynamic–actuarial risk assessment* measures dynamic items repeatedly whereas the static/historical items are measured only once.

The Violence Risk Scale (VRS; Wong & Gordon, 2006) is a more recently peer-reviewed instrument that was specifically developed to assess change in risk that may occur during the treatment of violent offenders and also measures how much change the treatment has produced. The VRS contains 20 dynamic variables and only 6 static variables. Correlations with violent recidivism varied by length of follow-up but were significant for both the static (r = .21 to .31) and dynamic (r = .28 to .40) variables. Presently, no peer-reviewed research has been identified that demonstrates changes in the VRS scores to be related to recidivism; however, one retrospective study using a sex offender version showed some success in this regard (Olver, Wong, Nicholaichuk, & Gordon, 2007). This provides reason for optimism that as research continues more dynamic measures of risk will be available to the clinician.

Perhaps the closest risk appraisal instrument to a truly dynamic–actuarial risk assessment is the combination of the Static-99, Stable-2007, and Acute-2007—a combination that forms the Dynamic Supervision Project (Hanson, Harris, Scott, & Helmus, 2007). With this assessment process, the initial static assessment of risk can be adjusted by changes to the dynamic risk factors, which are measured repeatedly over time during the offender's postrelease in the community. (We'll say more about this project in the next chapter.)

At this point in the development of the field, we advocate for the integration of dynamic and actuarial information that will, first, establish an underlying level of actuarial risk; second, inform that risk from an etiological perspective; third, suggest risk management strategies that reflect the integration of both actuarial and dynamic risk factors; and fourth, communicate the risk information to decision makers effectively.[8] Underlying all of these procedures is the clinician's commitment to ethical practice. We view ethics not so much as a list of rules, but rather as guidelines that will ensure scientifically sound, fair, and thorough risk assessments that can benefit both society and the assessed person. We next look at these ethical guidelines, which though specific to psychology should be accepted practice by any clinician undertaking the risk assessment process.

ETHICS ESSENTIALS

Ethical Practice and Violence Risk Assessment

Clinicians must comply with standards of ethical practice. For example, psychologists are obligated to comply with the *Ethical Principles of Psychologists and Code of Conduct* (American Psychological Association, 2002). However, in no other arena are the principles of ethical practice more prominent than in forensic assessment, including violence risk assessment. In a study of ethical dilemmas, Pope and Vetter (1992) discovered that forensic psychology ranked fifth out of 23 categories of practice for reported ethical concerns. Personal liberties are typically at risk when clients are evaluated for risk of future violent behavior, and we submit that clinicians engaged in the assessment of risk should be held to an especially high ethical standard. In fact, the uniqueness of forensic work, including violence risk assessment, necessitates specialty guidelines and principles of ethical practice. The *Specialty Guidelines for Forensic Psychologists* (1991) was developed by the Committee on Ethical Guidelines for Forensic Psychologists of the American Psychological Association. Whether you are an experienced clinician with thousands of evaluations under your belt, or a neophyte clinician, we encourage you to reread your specific profession's code of conduct as well as your licensing board rules and regulations. In Table 1.1 we highlight the

[8]We are by no means the first to recommend the integration of risk estimation and risk management. Some have done so in an attempt at resolving the conflict in the literature between advocates of actuarial risk estimation and clinical risk determination (Dvoskin & Heilbrun, 2001), others because the science of violence prediction was pointing them in that direction (Hanson & Harris, 2000; Hanson, Harris, Scott, & Helmus, 2007; Thornton, 2005), and still others because of the need to measure risk-related treatment change (Olver, Wong, Nicholaichuk, & Gordon, 2007; Wong & Gordon, 2006).

standards and guidelines from our respective codes (i.e., *Ethical Principles of Psychologists and Code of Conduct* [American Psychological Association], 2002]; *Specialty Guidelines for Forensic Psychologists* [Committee on Ethical Guidelines for Forensic Psychologists, 1991]) most applicable in the assessment of risk for violence.

When reviewing Table 1.1 we suggest you read the guidelines and answer the question, "Do I meet this standard of practice?" For example, Guideline III notes the following "provides services only in areas in which they have specialized knowledge, skill, experience, and education." In the far right column we have provided space where you can note for self-evaluation purposes whether you meet the criteria. This exercise will give you an opportunity to identify areas of practice that requires further training, knowledge, or supervision in order for you to provide high-quality violence risk assessment.

Ethical Pitfalls in Violence Risk Assessment

A common pitfall in clinical practice is the use of techniques without proper training (Caudill, 2002). This is particularly applicable when discussing actuarial risk assessment and SPJ models of risk assessment. We contend that clinicians who perform risk assessments but do not keep abreast of developments in the field of violence risk assessment are practicing unethically. To be current, one simply must keep up with debates about the use of actuarial risk assessments with or without professional overrides, proposed advantages of SPJ, statistical concepts that are directly relevant to risk assessment, such as base rates, and other developments in the field. Books such as this one as well as attendance at workshops and symposia will assist in keeping you current. As noted in both the *Ethical Principles of Psychologists and Code of Conduct* (American Psychological Association, 2002) and the *Specialty Guidelines for Forensic Psychologists* (Committee on Ethical Guidelines for Forensic Psychologists, 1991), it is the psychologist's responsibility to ensure that he or she is *competent* to provide the services offered, and this includes competence in the techniques utilized within his or her work. Other mental health professions (e.g., psychiatry, social work) have comparable ethical codes of conduct.

Other pitfalls in psychological assessment that appear relevant for violence risk assessment include confirmation bias, unstandardizing tests, and ignoring the effects of low base rates (Pope, 2003). According to Pope, confirmation bias occurs when we give undue weight to data that support our initial opinions and hypotheses, resulting in a "premature cognitive commitment" to our initial impressions (see Chapter 6, "The Risk Assessment Process," for discussion of avoiding the confirmation bias in violence risk assessment). Unstandardizing tests includes changing administration

(*text continues on page 30*)

TABLE 1.1. Summary of Ethical Guidelines Relevant for the Provision of Violence Risk Assessments

Ethical standard	*Ethical Principles of Psychologists and Code of Conduct* (American Psychological Association, 2002)	*Specialty Guidelines for Forensic Psychologists* (Committee on Ethical Guidelines for Forensic Psychologists, 1991)	Criteria met/ not met
Responsibility	• Psychologists are aware of their professional and scientific responsibilities to society and to the specific communities in which they provide risk assessment services. (Principle B: Fidelity and Responsibility)	Guideline II. Responsibility. Forensic psychologists: • Provide risk assessments in a manner that is consistent with the highest standards of the profession. • Make a reasonable effort to ensure that the results/opinions of the risk assessment are used in a forthright and responsible manner.	
Competence	• Psychologists must be qualified by education, training, or experience to provide risk assessments and use risk assessment techniques, e.g., actuarial measures. (Standard 2.01)	Guideline III. Competence. Forensic psychologists: • Provide services only in areas in which they have specialized knowledge, skill, experience, and education. • Present to the client (e.g., Court) the boundaries of their competence, the factual bases for their qualifications, and relevance of those qualifications to the risk of violence. • Are responsible for knowledge and understanding of the legal and professional standards which govern their forensic practice. • Are obligated to understand and uphold the civil rights of the offenders they assess. Recognize their personal values, moral beliefs, or personal/professional relationships that may interfere with competent performance of their risk assessment.	
Relationships	• Avoid multiple relationships (e.g., treating an offender and then asked to complete a violence risk assessment). (Standard 3.05) • Obtain the *informed consent* of individuals using language that is reasonably understandable to that person or persons. (Standard 3.10)	Guideline IV. Relationships. Forensic psychologists: • Inform the client of factors that might reasonably affect the decision to contract with the examiner for purposes of completing a risk assessment. • Do not provide risk assessments on the basis of contingent fees when the service includes expert testimony or the provision of affirmations or representations relied upon by third parties.	

	• Psychologists are responsible for ensuring that informed consent was attained. (Standard 3.10) • Offenders must be informed of the nature, purpose, and uses of evaluation even if they refuse to participate. (Standard 3.10)	• Should offer a portion of risk assessment services on a pro bono or reduced fee basis when public interest or welfare of clients may be inhibited by limited resources. • Recognize and seek to minimize dual role relationships. • Ensure informed consent to include the client's legal rights, purposes of the risk assessment, nature of the evaluation, intended use of results, and who employed the examiner. • Inform legal authorities of sources of conflict between the psychologist's professional standards and requirements of legal standards.
Assessment	• Use techniques sufficient to substantiate your findings. (Standard 9.01) • Provide opinions only after conducting an evaluation of an individual (attempt to see them in person for purposes of your risk assessment and rely on file reviews or collaterals only when offenders will not participate in the evaluation). (Standard 9.01) • Use tests for their designed purpose and in the designed manner (in light of the research). (Standard 9.02) • Use tests that are reliable and valid. (Standard 9.02) • Use tests that are language appropriate. (Standard 9.02) • Release raw test data to qualified professionals if release permits it. Test data includes "raw and scaled scores, client/patient responses to test questions or stimuli, and psychologists' notes and recordings concerning client/patient statements and behavior during examinations." (Standard 9.04)	Guideline VI. Methods and Procedures. Forensic psychologists: • Maintain current knowledge of scientific, professional and legal developments within the area of violence risk assessments … use that knowledge, consistent with accepted clinical and scientific standards, in selecting data collection methods and procedures for the evaluation. • Make available all data that form the basis for their evidence or risk assessment evaluation. • Avoid undue influence upon their methods, procedures, and products of risk assessment resulting from financial compensation or other gains. • Do not complete risk assessments on individuals not adequately represented by legal counsel. • Seek data/records from third parties only with prior approval of the relevant legal party. • Are aware of hearsay exceptions and other rules governing expert testimony. • Have an affirmative duty to ensure that their written products and oral testimony conform to the Federal Rules of Procedure (12.2[c]) or its state equivalence.

(*continued*)

TABLE 1.1. (*continued*)

Ethical standard	*Ethical Principles of Psychologists and Code of Conduct* (American Psychological Association, 2002)	*Specialty Guidelines for Forensic Psychologists* (Committee on Ethical Guidelines for Forensic Psychologists, 1991)	Criteria met/ not met
	• Use current tests, strategies/techniques. (Standard 9.08) • Psychologists are responsible for protecting the integrity and security of all test materials including test manuals, instruments, protocols, and test questions/stimuli. (Standard 9.11)		
Confidentiality	• Psychologists have a primary obligation to take reasonable precautions to protect confidential information obtained during the course of a risk assessment evaluation while recognizing that limits to confidentiality exist. (Standard 4.01) • Psychologists discuss with offenders the limits on confidentiality regarding the results of the risk assessment. (Standard 4.02) • When consulting with colleagues regarding a risk assessment, psychologists do not disclose confidential information and disclose information only to the extent necessary to achieve the purpose of the consultation. (Standard 4.06)	Guideline V. Confidentiality and Privilege. Forensic psychologists: • Are aware of legal standards that may affect or limit confidentiality or privilege attached to the risk assessment. • Inform clients of the limitations to the confidentiality of the risk assessment. • Make every effort to maintain confidentiality with regard to any information that does not bear directly upon the legal purpose of the risk assessment. • Provide clients access to information and results of the risk assessment with a meaningful explanation of the information.	

Communications	• Psychologists are responsible for the accuracy of the results, even if those results are obtained from test scoring and interpretation services. (Standard 9.09)	Guideline VII. Public and Professional Communications. Forensic psychologists: • Make reasonable efforts that results of their risk assessment are communicated in ways that will promote understanding and avoid deception. • Ordinarily avoid making detailed public statements about a violent risk prediction. • Have an obligation to all parties when testifying in legal proceeding to present their risk assessment findings, conclusions, evidence, or other professional products in a fair manner. • Actively disclose all sources of information utilized in a risk assessment. • Are aware that their essential role as expert to the court is to assist the trier of fact to understand the evidence or to determine a fact in the prediction of violence risk.

instructions, test items, or scoring procedures (i.e., such that the test is no longer truly standardized). Ignoring the effects of low base rates (lower base rates are present in the prediction of sexual and violence risk over general recidivism risk) will result in misclassifying many offenders as violent. As noted above, Mills et al. (2010) found that clinicians lack understanding of base rates as they pertain to risk for future violent behavior and, more important, overestimate the likelihood of violence risk.

In addition to these common pitfalls, there are other potential blindspots unique to the ethical practice of forensic mental health:

- *Promising too much.* Many clinicians encounter this pitfall unintentionally. Many clinicians enter the field because of a desire to help others, and it is this desire to be helpful that can unwittingly lead to promises that exceed what one can offer. This seems an easy pitfall to avoid: even early career clinicians know that they should not promise an opinion before an assessment is conducted. However, it is easier to be caught in a situation of promising to provide a service he or she is not qualified to perform. For example, you may agree to conduct a violence risk assessment only to learn that one of the issues to be assessed is risk for fire setting, which is a unique outcome that very few could attest they have expertise in assessing. Thus, although it may seem obvious, clinicians must never promise an outcome. Limit the guarantees you give to the specific type of evaluation you will conduct; the nature of the report you will submit to the attorney, court, or parole board; and the expected time frame for completion of the evaluation and report.

- *Substituting advocacy for scientific objectivity.* When conducting any forensic evaluation, including assessment of violence risk, accuracy takes precedence over understanding or appreciating the assessed person's view and recommending what may be in his or her best interest (Goldstein, 2003). The critical issue is for forensic examiners to recognize their role in providing accurate assessments of risk for future violent behavior, regardless of their personal beliefs or attitudes toward an assessed person.

- *Letting values overshadow empirically based findings.* Forensic examiners cannot allow their personal values and beliefs to interfere with the assessment process. For example, if you are requested to conduct a risk assessment for future violent behavior in the criminal sentencing phase of a capital murder trial, any beliefs you have about the death penalty cannot interfere with your evaluation or the opinions you provide to the court. We all have our biases; however, it is your ethical responsibility to ensure that your biases do not impede your assessment or color the results and the opinions you put forth. It is better to decline an assessment if you suspect your biases or personal beliefs may enter into the assessment process.

• *Doing a cursory job*. Violence risk assessment requires substantial time. Clinicians involved in this line of professional service should commit themselves to the time necessary to complete a comprehensive evaluation. It is not uncommon, in our experience, for a thorough risk assessment to require 20 or more hours of work by the time one has read previous investigative reports, interviewed collateral informants, and conducted assessment and testing procedures. Doing a cursory job and providing opinions based on an evaluation that is not thorough contradicts ethical obligations of forensic psychologists, including the guidelines for using appropriate methods and procedures ("maintain professional integrity by examining the issues at hand from all reasonable perspectives, actively seeking information"; Committee on Ethical Guidelines for Forensic Psychologists, 1991).

Dual Roles as an Ethical Pitfall in Violence Risk Assessments

The issue of dual roles is sufficiently important and in our experience occurs frequently enough to warrant additional elaboration as a potential ethical pitfall. A common question presented to professionals involved in violence risk assessment is whether clinicians can ethically provide forensic treatment and conduct a violence risk assessment with the same person. It is optimal, in multistaff settings or where specialized resources are available, that the treatment and assessment reporting responsibilities be separated. A conflict can readily arise for a clinician who conducts a violence risk assessment *after* providing treatment because the therapeutic alliance the clinician has formed with the assessed person will make it hard for him or her to remain objective. Even when the assessment is conducted first, a conflict can arise because the clinician is going to be remunerated for the subsequent treatment. Clearly dual-role conflicts need to be avoided wherever possible.

When logistics or resources prohibit a separation of treatment from assessment roles (i.e., when dual roles are unavoidable, such as in correctional or forensic facilities with one clinician), clinicians need to take explicit steps to reduce potential conflict. It is the clinician's ethical obligation to cause no harm and minimize the negative consequences where dual relationships are unavoidable. Further, it is imperative that the multiple responsibilities that stem from dual roles be communicated to the assessed person as part of the informed consent process. For example, if a clinician providing therapy may later have to provide a report on how successfully that therapy addressed the issue of violence, then this needs to be explicitly stated ahead of time, before treatment begins. Multiple roles and responsibilities are often unavoidable and are professionally and ethically appropriate when there is no viable alternative and when the clinician understands and prepares for them (Heltzel, 2007).

Examples from general and criminal justice-oriented clinical arenas

illustrate how difficult it can be to serve dual roles, but also how it is feasible. *Tarasoff* issues present a prime example from general (noncriminal justice) clinical practice. Since the *Tarasoff* ruling, it is clear that clinicians involved in the provision of therapeutic services have a responsibility to assess when a client poses a risk for harm to others. When a clinician conducts an assessment in a criminal justice setting, he or she usually has multiple responsibilities, which may include ensuring the personal safety of the client (such as suicide potential), ensuring public safety (such as disclosure of escape plans), actual treatment, and conducting assessments for a variety of purposes. Not every assessment situation will require the clinician to pay attention to all these possible responsibilities, but the clinician needs to be aware of the potential for conflicting roles (and allegiances), and ensure that he or she is fulfilling these roles. Given that the list of responsibilities for clinicians continues to expand, the best practice (legally and ethically) is to formulate risk assessment endeavors not according to roles, but according to responsibilities. Doing so will make it clear how you separate your work as a therapist from your work as a forensic evaluator. The primary responsibility when conducting a violence risk assessment is to make it thorough and objective.

CONCLUSION

This chapter introduced you to a specific type of clinical assessment: the violence risk assessment. We assume the clinician brings with him or her an understanding of general clinical practice and the obligation to professional standards, knowledge, competency, and ethical practice. We have covered in general terms why violence risk assessments are conducted. This enterprise is not without controversy, but we hope to have demonstrated that there is an important and arguably an essential role for the clinician in the assessment of violence risk. We have introduced the difference between clinical/therapeutic assessments and violence risk assessment and the advances in risk assessments over the past several decades. Advances in risk assessment continue, so clinicians can expect the "state of the art" to change over time—which is all the more reason to remain current in the field when risk assessment is a part of your practice. Finally, we provided you the opportunity to assess your own readiness for violence risk assessment through a review of the ethical standards of practice. The next chapter examines the risk factors associated with different specific violent outcomes.