Handbook of Violence Risk Assessment and Treatment

New Approaches for Mental Health Professionals

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It has been fascinating to watch the growth of scientific and clinical knowledge about violence risk assessment and management during the past 35 years. Until the 1970s, the practice of identifying the violence potential of persons with mental disorders received little research attention. In the ensuing three decades, however, research has provided a wealth of scientific and clinical knowledge about the best ways to estimate violence potential in clinical populations.

Chapter 1 of this volume provides a key to how this happened. Violence risk assessment is driven by two imperatives, whose icons are two of the most important mental health law cases of the 1970s. One was the Tarasoff case, which held that a mental health professional must do something to protect others if they are at risk of serious harm by the professional’s patient. The other was O’Connor v. Donaldson, which held that doctors could not simply lock up patients against their will for treatment purposes unless they also presented a risk of harm to others or to themselves.

Tarasoff was intended to protect society from patients’ potential violence, and O’Connor v. Donaldson was intended to protect patients from society’s potential impulse to lock them up unfairly. This conflict between the state’s interests in avoiding violence and the individual’s right to be protected from unwarranted state intervention was a classic product of the mid-twentieth-century civil rights movement in U.S. law. And it put a spotlight on the importance of identifying violence risk, which was essential for a just conclusion when such conflicts arose.

Requiring that one protect endangered people from patients’ violence, or allowing for patients’ hospitalization due to dangerousness, necessarily required that someone must identify whether a patient’s condition required either of these things. Mental health professionals, of course, were perceived as the most likely persons to have the expertise to predict violence among patients with mental illnesses. Yet, ironically,
Tarasoff and O’Connor arose at the very same time that research was revealing the dismal quality of clinicians’ predictions about their patients’ harm to others. How could society or patients be legally protected when no one could claim to be able to make a valid assessment of the likelihood of patients’ future violent behavior?

Thus began an extraordinary scientific effort to identify ways to improve estimates of future violence among patients with mental disorders, as well as among offenders with violence histories. What ensued was the rise of what has become one of the most prolific areas of research in the history of forensic psychology and psychiatry. The foundation for this enterprise was laid by several large-scale research efforts in the 1990s (described in Chapter 1) that discovered actuarial and standardized, structured clinical methods that could create at least reasonably valid estimates of the likelihood of future violence.

By the beginning of our present decade, research had turned to translating the findings of the 1990s into methods that clinicians could use in everyday practice. Practical tools were developed to structure clinicians’ evaluations of risk of violence. And variations on the methods were developed and tested for use with many special populations, including sex offenders, youth, and women.

Researchers also came to recognize that the ultimate goal of violence risk assessment was not only identifying risk, but also reducing it. Thus assessment methods were modified to offer not only risk estimates, but also indicators of the best ways to reduce the risk of patients’ future violence through treatment and clinical management of the factors that increased the risk. This involved the dynamic notion that a patient’s assessed risk level was not simply a static characteristic of the patient. It was something that could be altered—for example, by altering the factors in a patient’s environment that increased the risk. Thus an assessment of risk—if it identified such risk factors—could in itself reduce the risk, rather than simply giving the patient a risk-level label.

The requirements for mental health practitioners in this area are far different from the days when Tarasoff and O’Connor issued the challenge to violence risk assessment. Clinicians of that era could not be expected to do much more than use their clinical intuition when judging their patients’ violence potential. Today, however, using unstructured clinical speculation to assess risk of violence is incompetent practice and, in some cases, unethical practice. The practice standards of all mental health professionals hold them responsible for using the best
evidence-based practices that our research has developed and translated for their use over the past three decades.

And that is what this book prepares clinicians to do. The authors of these chapters have distilled the field’s efforts to translate our best research into best practices for estimating our patients’ likelihood of harm to others. They have written not just for those who work in forensic settings, but for all mental health professionals who work with a wide range of populations in a variety of clinical circumstances. Their perspectives cross all disciplinary lines, consistent with their own professional training in social work, psychology and psychiatry. Most of these authors themselves are practitioners who experience every day the demands of real-world clinical and forensic settings, and who are champions for the use of practical methods that have been informed by rigorous empirical research. As such, they are more than authors. They are role models for the practitioners whom they seek to assist in developing empirically-based clinical practice. Hear them, and dedicate yourself to the ideals they represent.

Thomas Grisso
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In 2006, there were 1,417,745 violent crimes reported in the United States. Of these, 17,034 were crimes resulting in the death of a victim; 92,455 were forcible rapes; and 860,853 were aggravated assaults (U.S. Department of Justice, Federal Bureau of Investigation, 2006). Statistics such as these increase the public's concern for being victimized by violent offenders and raise the concern of policy makers (Lowry, Nio, & Leitner, 2003). Highly publicized cases of extreme violence perpetrated by individuals with a history of criminal activity have led to the widespread perception that violent offenders will continue their violent behavior despite intervention. As a result, public policy has increased sanctions in the form of confinement, often without increasing rehabilitative services. The result is a significant increase in incarcerated individuals that require mental health services and ongoing management. In 1956, 550,000 individuals were treated within state psychiatric hospitals in the United States. This has declined 90% over a 40-year period; in 1996, 61,700 individuals were treated within these psychiatric facilities. During this same time period, the number of incarcerated offenders presenting with mental health needs increased dramatically. As a result, correctional facilities have become the leading provider of mental health services in the United States (American Psychiatric Association, 2004).

Ninety-seven percent of all incarcerated individuals will eventually reintegrate into society at a rate of 650,000 per year (Council of State Governments, 2005). Those released from prisons and jails are frequently at the same level of risk for future violence as when they were initially incarcerated. Forensic practitioners are often called on to assess the risk such offenders pose to the general public. As such, these practitioners are frequently caught between public perception, policy makers, and the criminal justice system.

During the past 30 years great strides have been made in the area of violence risk assessment, treatment, and risk management. The empirical
The goal of this volume is to provide practitioners with the knowledge base necessary to conduct violence risk assessments and to synthesize clinical and research data into comprehensive reports and oral testimony. There are hundreds of articles and book chapters dedicated to violence risk assessment, but far fewer address the treatment and risk management of individuals who engage in violent behavior. This volume is dedicated to both. Assessment is an ongoing process that requires practitioners to determine the current level of risk and intervene so as to prevent future violence. Therefore, included in each practitioner’s opinion regarding an individual’s level of risk for future violence, a well-formulated and comprehensive risk management plan is also necessary. To that end, each chapter in this volume addresses the issue of treatment and risk management. This task is large and requires a wealth of information from various disciplines including social work, psychology, psychiatry, sociology, and criminology, all of which are represented in this volume. All chapters are authored by leading experts in their respective fields who were asked to take what is known from the empirical research literature and apply it to clinical practice. Authors were also encouraged to consider difficult cases that often require intensive intervention and collaboration between treatment providers.

Research findings and treatment interventions germane to adult populations are often not applicable to juvenile and youthful populations, and vice versa. Forensic practitioners often work with clientele of all ages, so this volume is divided into two sections, one focusing on violence in adult populations and the other dedicated to violence among
youthful populations. This book will provide practitioners with knowledge of the developmental course of aggressive behavior throughout the life cycle, as well as appropriate risk assessment techniques and ongoing risk management strategies based on the individual’s developmental level.

Each section begins with chapters devoted to reviewing what is known about violence risk assessment in general, the etiology of violent behavior, and analysis of the relevant research literature (chapters 1–3 and 11–13). The following chapters in each section are dedicated to special populations of concern to practitioners. The adult section addresses female offenders (chapter 4), intimate partner violence (chapter 5), sexual offenders (chapter 6), neurological issues (chapter 7), and psychopathic offenders (chapter 8). The youth section addresses aggression in girls and young women (chapter 14), crossover youth (chapter 15), sexually abusive youth (chapter 16), and juvenile stalking (17).

Finally, each section concludes with two chapters dedicated to specialized treatment interventions. For adults, chapter 9 focuses on the treatment of mentally ill offenders and chapter 10 discusses the difficulties in treating the morally objectionable. For youth, chapter 18 examines skills-directed therapy and chapter 19 reviews family interventions.

Clinical examples are used throughout this volume to illustrate the process of conducting violence risk assessments, the tools used in these evaluations, and how information is translated into an overall assessment and guide for future risk management.

This book is multifaceted in order to address the needs of practitioners from various fields including social work, psychology, psychiatry, and students in these disciplines. Practitioners involved in all phases of intervention, from initial assessment to long-term treatment and risk management, will use this volume to inform their clinical practice. This book was also designed for officials—such as judges, lawyers, correctional officials, probation officers, and public policy makers—who make decisions in cases where risk for future violence is an issue. These groups will gain invaluable insights into the current state-of-the-art of violence risk assessment and risk management of violent individuals. While this volume will be useful to these diverse groups, the goal is to provide practitioners with an understanding of the current risk assessment, treatment, and risk management research literature and how to apply empirical findings to forensic practice.

Because our understanding of violence is growing rapidly, it is the responsibility of practitioners to remain current with best practices specific
to the population they serve. This volume will do so for those involved in decision making in the areas of risk assessment, treatment, and risk management of violent individuals. It is also my hope that this volume will contribute to the prevention of future violence by providing practitioners and other decision makers with the appropriate tools necessary to ensure evidence-based assessment and methods of intervention.

REFERENCES

First, many thanks to the 40 distinguished authors who worked diligently on this project. Your chapters stand alone as individual contributions to the evidence-based literature on violence risk assessment, treatment, and risk management. Together these chapters make up a comprehensive volume addressing the current state-of-the-art in these areas.

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Adult Violence
Forensic practitioners are increasingly asked to conduct assessments and evaluations for criminal justice systems, such as adult and juvenile courts, parole and probation departments, and correctional facilities, as well as for child protective services agencies, school departments, community mental health centers, and more. Although a variety of questions may be asked of the practitioner, this chapter will focus on those related to violence risk assessment. A typical question posed to the forensic practitioner is: Does this individual pose a risk to society at large, and, if so, what is the nature of that risk? As our ability to conduct violence risk assessment evaluations has improved, additional, often more difficult, questions usually follow, such as: What treatment interventions or strategies will decrease this individual’s risk? and How will we know when this individual can safely reintegrate into society?

Such questions are difficult to answer but are at the heart of forensic practice. To answer such questions requires both astute clinical skill as well as a comprehensive grasp of the empirical research literature. The goal of this chapter is to provide a historical overview of the violence risk

The authors would like to thank Paul Caratazzola, MSW, LICSW, for his helpful comments and suggestions on an earlier draft of this chapter.
assessment literature and to detail the clinical application of a violence risk assessment evaluation.

To that end, this chapter will begin with a brief discussion of the diverse types of violence risk assessment evaluations conducted by forensic practitioners. Next, two court cases that call for mental health professionals to conduct such assessments will be reviewed. This will be followed by a discussion of what is now referred to as the three generations of risk assessment literature. Risk assessment tools that are a product of this research will be examined. Next, individual risk factors found to correlate with future violence will be reviewed. Guidelines for the specification of risk assessment, treatment and risk management, and risk communication will also be presented. Finally, a forensic case will illustrate how violence risk assessment evaluations are practically conducted by the forensic practitioner.

WHAT IS VIOLENCE RISK ASSESSMENT?

The phrase violence risk assessment may have various meanings to forensic practitioners, depending on the setting in which they practice including correctional facilities, forensic hospitals, and civil psychiatric facilities. The following paragraphs provide a brief overview of the different types of violence risk assessment evaluations conducted in such settings.

In correctional settings, prison officials often request a violence risk assessment as part of assigning offenders to various levels of security. Individuals who are at high risk for violence are placed in maximum-security facilities, while those at lower risk are placed in medium- or minimum-security facilities. Also, in such settings, parole considerations often rely on the recommendations made by clinical staff responsible for evaluating an offender.

In a forensic psychiatric setting, the practitioner is most likely asked to consider an individual’s short- and long-term risk for violence and to recommend treatment strategies to mitigate such risk. Forensic practitioners are asked to assess the distal (long-term) risk an individual poses to society in the context of the need for continued hospitalization. This differs from situations in which the practitioner is asked to assess the proximal or short-term risk. The latter evaluation guides decisions around internal placement, including seclusion or segregation.

Practitioners working in civil psychiatric settings are relied upon to determine the potential risk for violence an individual poses prior
to release to the community. In this context, it is incumbent upon the clinician to consider the type of outcome behavior that is being assessed. Such factors to be examined could include violent behavior, general criminal behavior, sexual violence, risk for suicide, and treatment noncompliance.

This list illustrates the range of potential risk assessments conducted by forensic practitioners. The type of assessment, variables to be considered, and the level of potential risk vary widely among these evaluations.

Regardless of the setting, to prepare a comprehensive evaluation, the practitioner must be an authority in two areas: (1) the patient’s developmental, psychiatric, criminal, and violence history and (2) the research literature in the area of violence risk assessment and risk management. A forensic practitioner’s understanding of the research literature must be specific both to the question being asked as well to the specific risk and protective factors with which an individual presents.

**Preliminary Questions to Be Addressed**

Prior to conducting any violence risk assessment, forensic practitioners must understand the parameters of the evaluation they are being asked to conduct. To determine whether such an assessment is appropriate, the following questions must be answered:

1. **Am I qualified to conduct such an assessment?**
   Qualifications to conduct violence risk assessment evaluations vary depending on jurisdiction and local laws. However, even in cases when a practitioner meets statutory requirements, advanced knowledge of the subject area is required. A practitioner with experience in conducting violence risk assessments may deem that a particular case does not fall into his or her area of expertise depending on the nature of the case. Practitioners must be familiar with the research literature in the area in which they are conducting an evaluation. Thorough attention to this issue is critical.

2. **What is the specific question to be addressed?**
   In many cases, this may appear obvious, but, in the process of conducting the evaluation, the specific question often becomes unclear. It is the practitioner’s responsibility to clarify the specific question being asked with the referring agency (e.g., criminal court, parole board, detention facility, school department, etc.).
3. What are the parameters of the assessment and are all possible outcomes clearly defined prior to beginning the evaluation? To answer this question, the practitioner must determine with the authority requesting the risk assessment which recommendations can and cannot be fulfilled. For example, if conducting an assessment of an individual who is serving a sentence in a correctional facility, a recommendation of release to the community would not be possible.

Legal Precedent: The Need for Practitioners to Conduct Risk Assessments

This section reviews two major legal decisions that led to an increased need for practitioners to add the assessment of risk for violence to their clinical repertoire. Although the facts of each case and the topics they address are different, the outcomes support the same conclusion—mental health practitioners need to be able to assess an individual’s risk for violence. This brief review is intended to place our understanding of violence risk assessment into a historical context, not to fully explore the legal aspects of these cases.

The first case is that of *Tarasoff v. Regents of the University of California*, 1974. This case involves a clinician’s “duty to warn” an identified potential victim of the risk of potential violence and a “duty to protect” an identified potential victim. The second case is *O’Connor v. Donaldson*, 1975, which resulted in the requirement that clinicians who hospitalize an individual must demonstrate that the individual is at imminent risk to him- or herself or others due to mental illness. These two landmark cases illustrate the need for practitioners to understand the violence risk assessment literature with sufficient fluency to provide an opinion regarding an individual’s risk for future violence.

*Tarasoff v. Regents of the University of California*

In 1974, the Supreme Court of California ruled that mental health professionals are required by law to warn identified potential victims who are at risk of being harmed. Based on the facts of this case, the court concluded, “When a doctor or a psychotherapist, in the exercise of his professional skill and knowledge, determines, or should determine, that a warning is essential to avert danger arising from the medical or
Chapter 1  Violence Risk Assessment and Risk Management

psychological condition of his patient, he incurs a legal obligation to give that warning.” This ruling came in response to the murder of a young college student by the client of an outpatient therapist.

In 1968, Prosenjit Poddar was a 25-year-old student in a master’s degree program at the University of California, Berkeley (Quinn, 1984). Poddar, originally from Bengal, India, became romantically interested in a 19-year-old woman named Tatiana Tarasoff. The couple attended a New Year’s Eve party and exchanged a kiss. Poddar’s intention to pursue a relationship was later rejected by Tarasoff. Subsequently, Poddar became depressed and began to receive counseling at the Cowell Memorial Hospital, which was affiliated with the University of California, Berkeley (VandeCreek & Knapp, 1989). Poddar was initially diagnosed with paranoid schizophrenia, prescribed a neuroleptic medication, and referred for psychotherapy on an outpatient basis (Slovenko, 1988). Over the course of therapy, Poddar disclosed his obsession with Tarasoff, expressing fantasies of harming and potentially killing her. During this time, Tarasoff was vacationing in Brazil. Upon her return, Poddar arrived at her residence with a pellet gun and demanded to see her. When Tarasoff declined to see him, he shot her with the pellet gun. Tarasoff fled from the house, but Poddar eventually caught her and stabbed her to death with a kitchen knife. Poddar then went into her home and called the police (Schwartz, 1985).

The events of this case raised three critical questions: (1) Does the mental health practitioner have the ability to assess risk of potential violence? (2) If so, is it the responsibility of the practitioner to warn the potential victim? and (3) Does the public’s safety supersede the client’s right to confidentiality? Based on the facts of the Tarasoff case, the court opined that mental health professionals do have a duty to warn potential victims of violence and that public safety supersedes the practitioner’s responsibility to maintain confidentiality (see Simone & Fulero, 2005, and Kachigian & Felthous, 2004, for a thorough review of the Tarasoff case).

O’Connor v. Donaldson

The second case highlights the requirements for involuntary commitment of an individual to a psychiatric facility. Kenneth Donaldson, a 34-year-old husband and father, experienced his first psychotic break and subsequent hospitalization in 1943. While hospitalized at Marcy State Hospital in Florida, he was successfully treated with electric convulsive
therapy, recompensated, and was released. Some years later, in 1956, he was committed to Florida’s Chattahoochee State Hospital after developing delusions that he was being poisoned. He remained hospitalized for 15 years on the basis that he was mentally ill, uncooperative with treatment, and lacked sufficient insight into his condition. Donaldson persistently petitioned the courts for his release throughout his hospitalization on the basis that he was not dangerous to himself or others, and that, because he was being detained involuntarily, hospital staff were denying him his right to liberty.

In examining the facts of the case, the court concluded the following: “A finding of ‘mental illness’ alone cannot justify a State’s locking a person up against his will and keeping him indefinitely in simple custodial confinement” (O’Connor v. Donaldson, 1975). The ruling emphasized an individual’s civil rights and declared it unconstitutional to hospitalize an individual involuntarily solely on the basis of mental illness. The court further ruled that, in order to commit an individual against his or her will, the individual must be deemed to be at imminent risk of harm to him- or herself or others. From this point forward, involuntary hospitalization was driven by violence and/or suicide risk secondary to mental illness and not by the mere presence of mental illness.

This brief overview of these two landmark cases illustrates the need for clinicians—particularly forensic clinicians—to be able to conduct evaluations that address an individual’s risk for future violence. The following sections will review the violence risk assessment research literature.

VIOLENCE RISK ASSESSMENT RESEARCH

The belief that individuals who suffer from major mental illness are at greater risk to act out violently is long-standing. Historically, research has been both slow to validate these socially held beliefs and unable to draw correlations between mental illness and violence. In fact, what is now referred to as the first generation of research regarding violence and mental illness asserted that there was no connection between the two (Monahan, 1981). The following discussion describes the transition from the first to the third generation of this research, which is not only relevant for historical purposes, but useful as an aid to understanding current practices in conducting risk assessments.
The First Generation of Risk Assessment Research

The first generation of risk assessment research was concerned with predicting violent behavior in psychiatric samples. At the time, there were limited risk assessment measures, and the overall literature was sparse. Mental health professionals were charged with the difficult task of predicting which psychiatric patients would become violent in the future and attempting to prevent such violence through continued inpatient hospitalization with very limited tools. These assessments relied heavily on unsubstantiated clinical/forensic judgment based on the practitioner’s clinical/forensic experience.

Research at the time found a significant rate of overprediction (false positive predictions; Steadman & Cocozza, 1974). Such findings led a task force of the American Psychiatric Association (1974) to conclude that “the state of the art regarding predictions of violence is very unsatisfactory. The ability of psychiatrists or any other professionals to reliably predict future violence is unproved.” Due to the paucity of research literature, the ability of clinicians to successfully predict when an individual would be violent remained a significant problem. In his often cited book on the subject, John Monahan (1981) concluded,

Outcome studies of clinical prediction with adult populations underscore the importance of past violence as a predictor of future violence, yet lead to the conclusion that psychiatrists and psychologists are accurate in no more than one out of three predictions of violent behavior. (p. 92)

However, the research literature at the time had four main methodological flaws that confounded findings. First, research used heterogeneous clinical samples without a comparison or control group. Such research has very limited external validity, meaning that results cannot be applied to a population different from the one studied. Second, there was very little data regarding the base rate of violent behavior in the general population. Therefore, comparisons made between mentally ill samples could not be made with the general population with any degree of certainty. Third, the criterion for violence used in studies was typically conviction for violent behavior. Due to issues inherent in the criminal justice system, such as difficulty in gaining convictions and the effect of plea bargaining, the conviction rate for violent offenses is much lower than the level of actual violence. Therefore, conviction is a poor outcome measure for violence. Finally, because this area of study was in its infancy, very few studies used standardized measures between studies.
Rather, studies in the first generation of risk assessment literature often used subjective measures of risk, such as a clinician’s opinion.

A major contribution to the advancement of this literature was an epidemiological study of violent behavior in the general population (Swanson, Holzer, Ganju, & Jono, 1990). This study was the first to establish the base rate of violent behavior in the general population by collecting data on over 10,000 randomly selected individuals residing in the community (both mentally ill and non–mentally ill). The catchment areas used were Baltimore, MD, Raleigh-Durham, NC, and Los Angeles, CA. The findings indicate that those with affective disorders were 3 times as likely to be violent, those with schizophrenia or schizophreniform disorder were 4 times as likely to be violent, those with alcohol abuse or dependence were 12 times more likely to be violent, and those with other drug abuse or dependence were 17 times more likely to be violent. When counting the number of diagnostic categories into which each individual fell, a near linear relation was found between the number of diagnoses and violent behavior, meaning the more diagnoses an individual had, the more likely he or she was to engage in violent behavior. For example, the rate of violence for those with no diagnosis was 2.05%. The rate for those with one diagnosis was 6.81%, two diagnoses 17.51%, and three or more diagnoses 22.36% (Swanson et al., 1990).

Initially, this area of research was referred to as the “prediction of violence,” but it has since become known as violence risk assessment. The shift in terminology reflects a more accurate understanding of clinical capabilities. Clinicians assess the level of risk an individual poses by examining whether certain risk factors that increase the likelihood of violent behavior are present as opposed to “predicting” violent behavior (Grisso & Tomkins, 1996).

This research literature further progressed to ask which specific psychiatric symptoms are most statistically predictive of violent behavior (i.e., which symptoms place individuals at increased risk for violent behavior). A study comparing psychiatric patients with community controls found that psychotic symptoms were the only set of variables examined that accounted for differences between these two groups (Link, Andrews, & Cullen, 1992).

A later study found that a specific cluster of psychotic symptoms substantially increased the risk for violence (Link & Stueve, 1994). These symptoms were referred to as threat/control-override symptoms. As the label indicates, individuals who experience these symptoms feel as though they are being threatened in some way or that their internal
capacity to control their thoughts and/or behavior has been overridden by some external force. This study noted, “the threat/control override scale remains a significant predictor even when other psychotic symptoms are held constant” (p. 153). This scale included 13 items from the Psychiatric Epidemiology Research Interview (Dohrenwend, Shrout, Egri, & Mendelsohn, 1980), three of which are classified as threat/control-override symptoms.

Swanson, Borum, Swartz, and Monahan (1996) examined the relation between threat/control-override symptoms and violence. Subjects in this study who experienced these symptoms were twice as likely to report engaging in violent behavior when compared with individuals who experience other types of psychotic symptoms. Subjects who experienced threat-control/override symptoms were five times as likely to report violence when compared to individuals with no major mental illness. Those who experienced threat-control/override symptoms combined with substance use (drugs and/or alcohol) were 8 to 10 times as likely to report engaging in violent behavior when compared to individuals with no major mental illness (Swanson, Borum, Swartz, & Monahan, 1996).

Perhaps the single most important contribution of the first generation of research is our understanding of base rates. Base rates refer to the frequency with which an event occurs in the natural environment. Without knowledge of the base rate for violence, the literature struggled to show any relation between individual risk factors, such as mental illness, and violence. Let’s suppose that of 1,000 individuals, 100 become violent. In this case, the base rate of violence is 10%. Therefore, the prediction that no individual in this group will become violent would be correct 90% of the time. Alternatively, the prediction that all individuals in this group will be violent in the future would be correct only 10% of the time. To successfully predict the 10% who will become violent requires the identification of risk factors that are highly predictive of violence. Because it is very difficult to predict an event that rarely occurs, our understanding of base rates led researchers to study populations with higher rates of violence, such as criminal offenders, as opposed to groups with low rates of violence, such as civil psychiatric patients.

The Second Generation of Risk Assessment Research

Based on knowledge gleaned from the first generation of research, the second generation focused on identifying specific risk factors that increase the likelihood that an individual will engage in violent behavior
in the future. The literature began to focus on actuarial assessments of historical/static factors to assess an individual’s risk for future violence. In their 1996 article, Monahan and Steadman compared this methodology to that of meteorology. The most salient commonality between the actuarial risk assessment methodology and meteorology is the collection of large amounts of data points to determine which are most predictive of a certain outcome. For example, information gathered by a meteorologist, such as temperature, barometric pressure, and time of year, is combined to produce a statistical prediction for the chance of rain on a given day. The prediction is based on the combination of these variables and resultant precipitation in the past. Because such meteorological data have been collected for decades, the accuracy of the prediction is increased. Similarly, in the area of violence risk assessment, findings from studies that collect large amounts of data on factors that increase an individual’s risk for violence increases the predictive accuracy of individualized assessments (Borum, 1996; Douglas & Webster, 1999; Serin & Amos, 1995).

The second generation of research examined specific risk factors for future violence. As a result, actuarial tools have been developed that assign numeric value to particular risk factors. A total score on such a measure provides the forensic clinician with a percentile rank or predictive number for a specific individual.

The VRAG

The most widely researched actuarial assessment tool in the violence risk assessment literature is the Violence Risk Appraisal Guide (VRAG; Harris, Rice, & Quinsey, 1993). The VRAG was normed on a sample of 618 mentally disordered offenders from a maximum-security psychiatric institution in Ontario, Canada. Over 40 variables found to retrospectively correlate with violent recidivism were examined. Statistical analysis of the data resulted in 12 items that were most statistically predictive of violence, 9 of which were positively predictive of violence and 3 that were negatively predictive of violence.

The following nine items were positively predictive of violence:

1. A high score on the Psychopathy Checklist–Revised (PCL-R; Hare, 1991, 2003) (the PCL-R will be discussed in more detail later in this chapter)
2. Elementary school maladjustment
3. DSM diagnosis of any personality disorder
4. Young age at index offense
5. Separation from parents before age 16
6. Failure on prior conditional release
7. History of nonviolent offenses
8. Never being married
9. History of alcohol abuse

The following three variables were negatively predictive of violence:

10. DSM diagnosis of schizophrenia
11. Victim injury at index offense
12. Female victim at index offense

These 12 variables were found to be significantly correlated with violent recidivism in this sample ($r=0.459$; Harris et al., 1993). Each item has a weighted score, and the final score is the sum of all individual item scores. Based on the VRAG final score, an individual is placed into one of nine categories, one through nine. The higher the category, the higher the risk of future violence. Each category indicates a probability of violent recidivism based on 7 and 10 years post release from incarceration follow-up studies. For example, an individual in category 5 has a 35% chance of violent recidivism within 7 years and a 48% chance of violent recidivism within 10 years (Quinsey, Harris, Rice, & Cormier, 2006). In a prospective replication study with 347 male forensic patients, 11% of the patients who scored in category 2 on the VRAG were later found to commit a new violent act. Also, 42% of the patients in category 5, 70% of patients in category 7, and 100% of the patients in category 9 committed a new violent act (Harris, Rice, & Cormier, 2002).

Studies found actuarial tools to be more accurate estimates of risk than unsubstantiated clinical judgment (Borum, 1996; Douglas & Webster, 1999; Serin & Amos, 1995). Some proponents of actuarial methods cautioned against the use of clinical judgment in conducting violence risk assessments. For example, Quinsey, Rice, Harris, and Cormier (1998) asserted,

what we are advising is not the addition of actuarial methods to existing practice, but rather the complete replacement of existing practice with actuarial methods . . . actuarial methods are too good and clinical judgment too poor to risk contaminating the former with the latter. (p. 171)
Despite the contributions of the second generation of research, there are several compelling criticisms of the actuarial method. First, scores on actuarial assessment tools remain static and do not change with the passage of time. Once an individual is categorized using this method, his or her risk for future violence will not change despite treatment intervention or environmental changes. Second, providing a percentile rating of risk is not necessarily helpful to the authority that requested the risk assessment evaluation. For example, if a criminal court requests a violence risk assessment evaluation as part of a dangerousness hearing to consider whether an individual should be released from a state hospital, and the conclusion is that there is a 35% chance that this individual will become violent within the next 10 years, the court will likely ask the expert to provide a more conclusive opinion. Third, dynamic or changeable factors that may mitigate risk for future violence are not considered by the actuarial method.

The Third Generation of Risk Assessment Research

The third generation of risk assessment literature has moved from actuarial assessment of static risk factors for future violence to the method of structured professional judgment. Structured professional judgment calls for the use of structured assessment tools to guide the forensic practitioner in their assessment. This method works to understand a specific individual and identify whether risk factors are present or absent. Structured professional judgment addresses the problem of using purely static risk factors that will not change with time or intervention.

The HCR-20

The most widely researched assessment tool designed to employ structured professional judgment is the Historical-Clinical-Risk Management-20 (HCR-20; Webster, Douglas, Eaves, & Hart, 1997). The HCR-20 includes 20 items found predictive of violence in the research literature. This structured clinical guide incorporates three areas of risk factors into one tool: Historical factors, Clinical factors, and Risk Management factors. The 10 items that assess the individual’s historical/static risk factors include:

1. Previous violence
2. Young age at first violent incident
3. Relationship instability
4. Employment problems
5. Substance use problems
6. Major mental illness
7. Psychopathy
8. Early maladjustment
9. Personality disorder
10. Prior supervision failure

The five clinical items that assess risk factors related to the individual’s clinical functioning at the time of the evaluation include:

11. Lack of insight
12. Negative attitudes
13. Active symptoms of major mental illness
14. Impulsivity
15. Unresponsiveness to treatment

The five risk management items that assess anticipated risk factors in the ongoing treatment and risk management of the individual include:

16. Plans lack feasibility
17. Exposure to destabilizers
18. Lack of personal support
19. Noncompliance with remediation attempts
20. Stress

The HCR-20 and other structured professional judgment tools do not provide a specific score as is the case with actuarial tools. Rather, they require the evaluator to determine the risk level of the individual (low, moderate, or high) based on a review of these research-derived risk factors. Research on the HCR-20 finds that such risk ratings add incremental value to the numerical score when the HCR-20 is used as an actuarial tool (de Vogel, de Ruiter, Hildebrand, Bos, & van de Ven, 2004; Douglas, Ogloff, & Hart, 2003).

Comparisons between the VRAG and the HCR-20 consistently find the HCR-20 to be as effective, or more effective, in assessing risk for future violence (Douglas, Yeomans, & Boer, 2005). Because this chapter is dedicated to the clinical applicability of violence risk assessment and
not to a research-based discussion of assessment tools, space allows only for a brief discussion of these differences.

Item selection for the VRAG was based strictly on the statistical power of risk factors in the original sample of 618 mentally disordered offenders. Although these 12 items were highly predictive in the original study, replication studies have not shown such accuracy. Alternatively, selection of the 20 items that make up the HCR-20 was based on findings from the violence risk assessment literature across different samples. Clinically useful items found predictive of violence were also included. Therefore, the HCR-20 was designed to be clinically useful in various types of settings.

A recent study comparing the individual items on the VRAG and the HCR-20 found that most of the items on the HCR-20 were related to future violence, while this was not the case for the VRAG (Mills, Kroner, & Hemmati, 2007). Of the 20 items on the HCR-20, 15 (75%) were related to violent recidivism. Of the 12 VRAG items, 5 (42%) were found predictive of violent recidivism. The follow-up time was approximately 4.5 years, and the base rate for violent recidivism in this sample was 35% (Mills et al., 2007).

The MacArthur Violence Risk Assessment Study

The MacArthur Violence Risk Assessment Study was a multisite study designed to assess risk factors for violent behavior in a sample of civil psychiatric patients (Monahan et al., 2001). The goal of the original study was to improve on methodological flaws of earlier research in the area of violence risk assessment. In contrast to previous studies that used reconviction or rearrest for a violence offense as the outcome measure, the MacArthur study used more comprehensive techniques to measure actual violence. The overall sample was made up of psychiatric patients admitted to acute civil inpatient facilities in Pittsburgh, PA, Kansas City, MO, and Worcester, MA.

Inclusion criteria for the sample included the following: (1) subjects were civilly committed to a psychiatric hospital; (2) subjects were between the ages of 18 and 40; (3) subjects were English speaking; (4) subjects were White or Black (the Massachusetts site also included Latino subjects); and (5) subjects had a medical record diagnosis of schizophrenia, schizophreniform, schizoaffective disorder, depression, dysthymia, mania, brief reactive psychosis, delusional disorder, alcohol or other drug abuse or dependence, or a personality disorder. To ensure a consistent
distribution of demographic variables, such as age, gender, and race, this study used a stratified random sampling design (Monahan et al., 2001).

Over the course of the study, a total of 12,873 patients were hospitalized across the three study sites. Of these admissions, 7,740 met the inclusion criteria. A total of 1,695 patients were asked to participate in the study. The refusal rate was 20% and additional subjects were lost due to attrition, resulting in a sample of 1,136 subjects.

Three sources of information were used to ascertain the occurrence and details of a violent incident in the community: (1) interviews with the patient, (2) interviews with collateral individuals (i.e., persons named by the patient as someone who would know what was going on in his or her life), and (3) official sources of information (arrest and hospital records). Each patient was interviewed in the hospital by both a research interviewer and a research clinician in order to assess him or her on each of the risk factors. The research interviews collected historical data, while clinical interviews assessed the subject’s clinical presentation, particularly the presence of psychiatric symptoms (Monahan et al., 2001). Included in these interviews was the Psychopathy Checklist: Screening Version (PCL:SV; Hart, Cox, & Hare, 1995). The patients and collaterals were interviewed every 10 weeks over a 1-year period to determine whether there were any incidents of aggression or violence.

Over the 1-year follow-up period, 608 violent incidents were recorded. The majority of patients (72%) were not violent during the 1-year follow-up period; whereas 28% of patients were responsible for all violent incidents. Approximately half of all patients who were involved in a violent incident had numerous violent incidents, while half of the violent patients had only one such incident (Monahan et al., 2001).

The MacArthur Violence Risk Assessment Study used 134 potential risk factors for violence and statistically analyzed these variables individually as well as in groups (Monahan et al., 2001). Several risk factors were found to correlate with violence within the first 20 weeks post discharge.

MacArthur Findings

The MacArthur study found that men were more likely than women to be violent, although the difference between these two groups was not large. The types of violence women engaged in were more likely directed toward family, more likely to occur in their own home, and were less likely to result in the need for medical treatment or criminal involvement.
All measures of previous violence (self-report, arrest records, and hospital records) correlated with violence at follow-up. A history of physical abuse correlated with violence at follow-up, as well as having a parent who abused substances or had a criminal history (Monahan et al., 2001). Individuals from economically disadvantaged communities were at increased risk for violence. Black and White subjects from comparably disadvantaged neighborhoods had similar rates of violence at follow-up (Monahan et al., 2001).

Major mental illness, particularly schizophrenia, was associated with a lower rate of violence at follow-up. A diagnosis of a personality disorder was predictive of violence at follow-up. Comorbid mental illness and substance abuse was predictive of violence at follow-up. Delusions in general were not predictive of violence, but a generally “suspicious” attitude toward others correlated with violence at follow-up. Hallucinations in general were not predictive of violence; however, command auditory hallucinations to engage in a violent act increased the subject’s risk for violence (Monahan et al., 2001).

The variable with the strongest bivariate correlation with violence in the MacArthur study was psychopathy as measured by the PCL:SV. The antisocial behavior factor (Factor 2) of the PCL:SV was more predictive of violence than the interpersonal and affective factor (Factor 1) or the PCL:SV Total Score. Thinking or daydreaming about harming others correlated with violence at follow-up, particularly persistent violent thoughts. Violence at follow-up was correlated with anger as measured by the Novaco Anger Scale (Monahan et al., 2001).

INDIVIDUAL RISK FACTORS

Now that we have reviewed the three generations of violence risk assessment literature and the most studied risk assessment tools, the following section will detail some of the individual variables most consistently found related to risk for violent behavior.

Demographic Risk Factors

Demographic risk factors related to risk for violent behavior include age, gender, socioeconomic status, education, and employment.

Age has been found to be inversely correlated with violent recidivism in follow-up studies (Bonta, Law, & Hanson, 1998; Gilders,
1997; Hanson & Bussière, 1998; Hirschi & Gottfredson, 1983). In a meta-analysis of predictors of recidivism, which included over 60,000 subjects across 131 studies, young age was a significant predictor of recidivism (Gendreau, Little, & Goggin, 1996). In the epidemiological study of violence in the community, there was a negative linear relationship between age and violent behavior, meaning that, as age increased, incidents of violence decreased (Swanson et al., 1990). For example, for subjects between 18 and 29 years of age, the rate of violence was 7.34%. For those between 20 and 44 years of age, the rate of violence was 3.59%, and for those between 45 and 64, the rate of violence dropped to 1.22% and to below 1% after the age of 65 (Swanson et al., 1990).

In general, men are more likely to engage in violent behavior than women. Women make up 11% of those arrested for violent crimes in the United States, while men make up 89% (Reiss & Roth, 1993). In the epidemiological study, men reported engaging in violent acts more than twice as often as women (Swanson et al., 1990). Despite these findings in criminal populations and the general population, studies of psychiatric patients indicate no difference in the frequency of violent incidents between male and female patients during follow-up periods after release from the hospital (Lidz, Mulvey, & Gardner, 1993). In one study, clinicians' estimates of prediction were better than chance for male patients but not for female patients (Lidz et al., 1993). Such results indicate the general underestimation of female-perpetrated violence in psychiatric patients. Although similar rates of violence are found between male and female psychiatric patients, male patients' violent behavior is more likely to result in injury to the victim (Krakowski & Czobor, 2004).

Socioeconomic status is consistently found to correlate with risk for violence in both psychiatric and community samples. In an epidemiological study, individuals under the age of 45 from the lower socioeconomic group were three times as likely to be violent compared with those from the same age group in the higher socioeconomic group. This increased significantly in younger men (between 18 and 29) from the lower socioeconomic group, as 16% were violent compared with the overall base rate of 2.05% (Swanson et al., 1990). Studies that examine neighborhood context find that individuals living in areas with high concentrations of poverty are at significantly increased risk for violence (Silver, Mulvey, & Monahan, 1999). Studies that find a correlation between race or ethnicity and violence find that, when controlling for socioeconomic status, this correlation disappears (Monahan et al., 2001; Swanson et al., 1990),
meaning that race or ethnicity is not correlated with violence when socioeconomic status is taken into account.

Regarding level of education and violence, 80% of incarcerated violent offenders have not completed high school (Monahan, 1993). In studies examining violent recidivism, education level is correlated with violent recidivism (Harris et al., 1993). A meta-analysis examining risk factors for violent recidivism found that lack of education was a strong predictor (Bonta et al., 1998).

Employment problems have been associated with increased risk for general criminal recidivism (Andrews & Bonta, 1995). Unemployment has also been found to increase the risk of violence in mentally disordered offenders (Menzies & Webster, 1995). Overall, “every one percent rise in unemployment increases the mortality rate in this country by two percent, homicides and imprisonment by six percent, and the infant mortality rate by five percent” (Gilligan, 1996, p. 194). In a descriptive analysis of sentenced offenders, 44% of male and 34% of female subjects have a history of unemployment (Singleton, Meltzer, Gatward, Coid, & Deasy, 1998).

**Past History of Violence as a Risk Factor**

A history of violent behavior is a highly predictive risk factor for future violence regardless of the population being studied (Klassen & O’Connor, 1988; Monahan et al., 2001). Numerous studies find that a history of violence is the best predictor of future violence (Gilders, 1997; Swanson, 1993). In an often-cited follow-up study of forensic patients found criminally insane, historical variables were the most predictive of violent recidivism upon release from the hospital (Cocozza & Steadman, 1974). In this study, the following cluster of historical variables was predictive of violence: a history of juvenile crime, the number of previous arrests, a history of convictions for any type of criminal activity, convictions for violent offenses, and being under the age of 50 (Cocozza & Steadman, 1974). All risk assessment measures assess historical violence, and most analyses of the effectiveness of these measures find that historical items are highly predictive of violent recidivism (Grann, Belfrage, & Tengström, 2000). The HCR-20 has as many historical items as clinical and risk management items combined (Webster et al., 1997).

Although historical violence is one of the most important individual factors included in a violence risk assessment, using an individual's
criminal record as the only data point for past violence grossly underestimates actual violence. The MacArthur Violence Risk Assessment Study, which assessed violence using multiple sources, found the vast majority of violent incidents never came to the attention of law enforcement (Monahan et al., 2001). Also, very few violent incidents resulted in arrest or conviction. Therefore, it is important for the forensic practitioner to discuss historical violence with numerous collaterals, because a review of the criminal record is not sufficient. Self-reported violence has been found predictive of future violence (Klassen & O’Connor, 1988; Tardiff, Marzuk, Leon, & Portera, 1997).

Information regarding an individual’s history of violence should be ascertained prior to conducting the interview. In cases when this is not possible, the evaluator should interview the individual again when all information regarding historical violence has been collected. Each violent incident requires discussion with the individual to determine common circumstances or situations that may have led to violence. This requires the practitioner to determine the individual’s mental state at the time of each violent incident (e.g., psychosis, mania, intoxication, etc.). It is also useful to question family members or others close to the individual regarding their presentation during past incidents of violence.

The assessment of current and historical violent thoughts requires inquiry during the clinical interview. In the MacArthur study, self-reported violent thoughts were predictive of violent behavior over the first 20 weeks after discharge from the hospital (Monahan et al., 2001). The presence of violent thoughts also correlated with measures of psychopathy, anger, and substance abuse. The frequency and content of violent thoughts is important to ascertain and should be asked at numerous times during an interview to determine truthfulness of self-report. In cases when an individual endorses such thoughts or fantasies, the degree of detail or how well formulated these thoughts are should be assessed. Also, the intent to act on these thoughts requires evaluation.

**Psychopathy as a Risk Factor**

Psychopathy is a clinical construct that has been identified anecdotally for centuries, but not until the validation of the Psychopathy Checklist (Hare, 1991, 2003) and progeny has the construct been reliably measured in the empirical literature. The Psychopathy Checklist–Revised was originally validated among criminal samples (Hare, 1991). The Psychopathy Checklist: Screening Version, which was based on the PCL-R,
was normed on civil psychiatric patients as part of the MacArthur Violence Risk Assessment Study.

Research using the PCL-R and PCL:SV show similar results (Hart et al., 1995). Research using the PCL measures indicates that psychopathic individuals are more likely than their nonpsychopathic counterparts to be convicted of violent offenses. A retrospective examination of the criminal histories of a sample of incarcerated individuals found that those diagnosed as psychopathic had significantly more convictions for assault, robbery, fraud, possession of weapons, and escapes from custody (Hare, McPherson, & Forth, 1988). Psychopathic offenders also commit more violent crime than nonpsychopathic offenders (Kosson, Smith, & Newman, 1990). A prospective study of 231 inmates found psychopathic offenders were four times as likely to recidivate violently when compared with their nonpsychopathic counterparts. Sixty-five percent of those above the cutoff score for psychopathy recidivated violently, while 25% of those who scored low on psychopathy did so (Hart, Kropp, & Hare, 1988). In a sample of 169 forensic patients, 77% of those who scored above the cutoff for psychopathy on the PCL-R violently recidivated compared with 21% for those scoring below the cutoff (Harris, Rice, & Cormier, 1991).

Based on this literature, psychopathy as a risk factor for violence is well established. Most research on the PCL-R and PCL:SV finds two distinct factors: Factor 1 measures affective and interpersonal traits, and Factor 2 measures antisocial behavioral traits (for a discussion of alternative factor models, see chapter 8 of this volume). While psychopathy is highly predictive of future violence, the contribution of each of the PCL factors is less clear. This differentiation has important clinical implications in terms of the group that is most at risk for future violence. Most studies that have examined the contribution of each factor report that Factor 2 is more predictive of violence. Among psychiatric inpatients, those with high Factor 2 scores were at increased risk to engage in violent behavior, while Factor 1 scores were not predictive of violent behavior (Heilbrun et al., 1998). A recent meta-analysis examining institutional misconduct among psychopathic and nonpsychopathic individuals found the correlation between aggressive acts was stronger for Factor 2 ($r=0.21$) than for Factor 1 ($r=0.14$) (Walters, 2003).

Although psychopathy measures were not originally designed as risk assessment tools, research consistently finds psychopathy scores to be highly predictive of violence, particularly Factor 2 scores.
SPECIFICATION OF RISK ASSESSMENT

Forensic practitioners are called upon to conduct risk assessments for various types of behavior. Therefore, it is incumbent on forensic practitioners to be familiar with the state-of-the-art assessment schemes and strategies specific to the type of risk assessment evaluations they are asked to conduct. As this field progresses, the specificity of the risk assessment instruments also continues to progress. For example, several assessment tools are currently available to assess risk for sexual violence, including the Sex Offender Risk Appraisal Guide (Quinsey et al., 1998); the Rapid Risk Assessment for Sex Offender Recidivism (Hanson, 1997); the Static-99 (Hanson & Thornton, 1999); and the Sexual Violence Risk-20 (Boer, Hart, Kropp, & Webster, 1997). Forensic practitioners must remain current with the research literature in their specific area of practice. Practitioners must also have an understanding of the various risk assessment tools specifically designed for the population they are assessing.

TREATMENT AND RISK MANAGEMENT

Based on results from violence risk assessment research with both mentally disordered and nondisordered offenders, a model called risk–need–responsivity has proposed useful guidelines for the treatment of violent offenders. Research in the area of correctional treatment finds that treatment interventions that follow these guidelines are more effective than treatments that do not (Andrews & Bonta, 2003; Andrews et al., 1990). The three areas—risk, need, and responsivity—are each made up of certain principles.

- The risk principle calls for an individual’s risk level to be matched with intensity of intervention. For example, high-risk offenders should receive the most intensive treatment interventions, followed by their medium-risk and low-risk counterparts.
- The need principle addresses the individual criminogenic needs of the offender. Criminogenic needs are defined as issues directly linked to the commission of violence or other criminal activity and include antisocial attitudes, antisocial peer groups, and a pattern of criminal thinking. Specific interventions aimed at addressing these criminogenic needs that directly relate to recidivism are employed (Andrews, Bonta, & Wormith, 2006).
The responsivity principle calls for specific characteristics related to the individual’s ability to engage in treatment to be addressed. These include cognitive ability, motivation for treatment, and other issues that are not directly related to criminal behavior but may hinder treatment efforts. A lack of motivation to refrain from engaging in criminal activity is a particularly difficult issue to overcome and is common in this population. The presence of psychopathy may also hinder treatment efforts because the psychopathic individual will likely have no interest in changing his or her behavior.

Recent treatment strategies designed for difficult-to-treat populations, such as psychopathic offenders, draws on the risk–need–responsivity literature (Wong & Hare, 2006). The use of such interventions with mentally disordered offenders is supported by findings of similar risk factors for violent recidivism among mentally disordered and nondisordered populations. For example, a meta-analysis examining risk factors for violent recidivism found those that were predictive of violent recidivism in the general offender population were also predictive of violent recidivism in mentally disordered offenders (Bonta et al., 1998).

RISK COMMUNICATION

This chapter has stressed the assessment of risk factors for violent behavior. While an understanding of the research literature and ability to determine which factors increase an individual’s risk for violence are of utmost importance, the ability to communicate this risk to the authority requesting the evaluation is equally as critical. The main purpose of a violence risk assessment is to provide useful information to improve decision making, whether clinical or legal. Heilbrun, Dvoskin, Hart, and McNeill (1999) point out:

The importance of risk assessment is entirely related to the decisions which are in turn influenced by such assessments. These decisions may be legal, such as civil or forensic commitment, or clinical, such as the assignment of an intensive case manager or a change in medication. . . . The only way risk assessors can influence decisions is by effectively communicating their findings to the legal and clinical actors whose decisions they wish to influence. (p. 94)
## COMPONENTS OF RISK ASSESSMENT EVALUATION

The following information should be included in a comprehensive risk assessment evaluation:

1. Demographic/identifying information
2. Sources of information
3. Referral question
4. Notice of limits of confidentiality
5. Historical information
   a. Family history
   b. Developmental history
   c. Educational history
   d. Employment history
   e. Medical history
   f. Psychiatric history
   g. Substance abuse history
   h. Criminal history
   i. Violence history
6. Results of risk assessment measures (HCR-20, PCL-R, PCL:SV, etc.).
7. Current functioning and mental status
8. Clinical formulation and discussion
9. Recommendations

### Table 1.1

The following section details a forensic case and illustrates how findings from a violence risk assessment evaluation are communicated in the form of a written report. The vignette includes a brief overview of the case, the incorporation of risk assessment tools into a violence risk assessment, and recommendations for the ongoing risk management of this case based on the findings of the evaluation. The entire case will not be presented due to space constraints. Table 1.1 includes all areas that should be included in a complete violence risk assessment evaluation.

### CASE VIGNETTE: MR. Z

This case vignette is a conglomeration of clinical data based on the first author’s forensic experience. This vignette demonstrates the application of information presented in this chapter to a forensic case, with a focus
Identifying Information

Mr. Z is a 42-year-old divorced man. He is currently committed to a state hospital secondary to being found not guilty by reason of insanity (NGRI) for breaking and entering, kidnapping, and assault and battery. Mr. Z broke into the home of a family friend and held her and her 4-year-old daughter against their will for 6 hours. During this 6-hour period, Mr. Z was consuming large amounts of alcohol. Mr. Z assaulted the adult victim by slapping her in the face approximately five times. He has been recommitted to the state hospital for the past 8 years on an annual basis.

During the initial criminal responsibility evaluation, Mr. Z reported that he believed the victim was having a sexual relationship with his ex-wife, was supplying her with drugs, and was the reason for their divorce. This incident occurred 1 year after he was divorced. Following Mr. Z’s divorce, he lived alone in an apartment for 6 months but was evicted due to not paying his rent. He was homeless for the 6 months prior to the offense.

Risk Assessment Tools

As part of this risk assessment evaluation, two assessment tools were used: the PCL:SV and the HCR-20. These measures and how they relate to Mr. Z’s risk for future violence are discussed below. Information gleaned from clinical interviews and record review will be included in this discussion and incorporated into the overall risk assessment.

Psychopathy Checklist: Screening Version

The PCL:SV is a 12-item scale devised to assess psychopathy in civil psychiatric patients. The PCL:SV is a dimensional measure of the degree to which a given individual matches the prototypical psychopath. Items are scored on a 3-point scale: 0=does not apply; 1=item applies to a certain extent; and 2=item applies. Scores range from 0 to 24, and a cut-off score of 18 is used for the diagnosis of psychopathy. Those who score 12 or below are considered nonpsychopathic, and those who score between 13 and 17 show some psychopathic traits. The
administration of the PCL:SV entails both a clinical interview and a record review conducted by clinicians trained in its administration. As recommended by the PCL:SV manual, the PCL:SV was scored by two independent raters, and the scores were averaged to increase reliability.

Psychopathy is a clinical construct that accounts for interpersonal, affective, and behavioral characteristics. Interpersonally, individuals that are psychopathic are grandiose, manipulative, and callous. Affectively, psychopathic individuals display shallow emotions; are unable to form long-lasting attachments to others; and lack empathy, guilt, and remorse. Behaviorally, psychopathic individuals are impulsive, sensation seeking, and readily violate social norms. Research finds that individuals who score high on the PCL:SV are at increased risk for future violence and criminal recidivism.

Mr. Z’s total score of 11 places him in the 20th percentile among forensic/psychiatric patients and in the 63rd percentile among civil psychiatric patients. The PCL:SV is made up of two factors. Factor 1 is comprised of interpersonal and affective attributes of psychopathy, while Factor 2 is comprised of behavioral traits of psychopathy. Mr. Z’s Factor 1 score of 4 places him in the 18th percentile among forensic/psychiatric patients and in the 61st percentile among civil psychiatric patients. His Factor 2 score of 7 places him in the 31st percentile among forensic/psychiatric patients and in the 64th percentile among civil psychiatric patients. Based on the PCL:SV score, Mr. Z does not demonstrate significant character or behavioral traits consistent with psychopathy when compared with a forensic/psychiatric sample; however, his percentile rank when compared with civil psychiatric patients is in the moderate range.

**Historical, Clinical, Risk Management-20**

The HCR-20 is a structured clinical assessment tool designed to guide clinical judgment when conducting a violence risk assessment. This tool focuses clinical decision making around risk factors found in the research literature to increase an individual’s risk for engaging in violent behavior. Unlike actuarial assessment tools that provide a static (unchangeable) score, structured clinical assessment tools guide decision making using both static and dynamic (changeable) risk factors. Historical variables, which remain unchanged and are based on the patient’s history, comprise 10 items on the HCR-20. The clinical item
section and the risk management section are made up of 5 items per section.

Historical Items

The 10 historical items of the HCR-20 include (1) previous violence, (2) young age at first violent incident, (3) relationship instability, (4) employment problems, (5) substance use problems, (6) major mental illness, (7) psychopathy, (8) early maladjustment, (9) personality disorder, and (10) prior supervision failure. Mr. Z’s historical items of concern are discussed here.

Previous violence: Mr. Z’s criminal record indicates two convictions for assault and battery and one NGRI finding for breaking and entering, kidnapping, and assault and battery.

- The first assault and battery conviction occurred when he was 21 years old, the second when he was 32, and the NGRI finding when he was 34. Mr. Z was questioned about these incidents, and collateral sources, including his mother, were also interviewed. Mr. Z dropped out of high school at the age of 16. He moved away from home, which he described as an abusive environment. Between the ages of 20 and 21, Mr. Z reports drinking approximately six beers a day. When he was 21, neighbors called the police because Mr. Z was heard yelling in his apartment late into the night, and he would not answer his door. When police officers responded to the disturbance, Mr. Z was yelling, “The end of days is here and I will not let it end without a fight. I know who you are coming to get me. I’m not going out without a fight.” Mr. Z became assaultive toward police officers, punching them as they entered his apartment. He was subdued, handcuffed, and transferred to an inpatient psychiatric facility. Mr. Z was later convicted of assault and battery and placed on probation for 1 year.

- Mr. Z’s second conviction for assault and battery occurred when he was 32 years of age. He was homeless at the time, not involved in mental health treatment, and was not taking his prescribed medications. Mr. Z was in a bar and began arguing with another patron. The police report indicates that Mr. Z then attempted to leave the bar and was confronted by the bartender for not paying his bill of $24. Mr. Z punched the bartender and left the bar.
The police were called, and Mr. Z was later arrested. He was convicted of assault and battery and sentenced to 6 months at the county jail.

When Mr. Z was 34, he was charged with breaking and entering, kidnapping, and assault and battery. He was later found NGRI. The NGRI finding will be discussed at length below.

Young age at first violent incident: Mr. Z reports being involved in numerous violent incidents beginning at the age of 14. He stated,

I started some of the fights and other people started some of them. If I was mad I would just hit someone if I felt like it. I don’t do that now, but that’s what I did back when I was young. I was in about five or six fights in high school.

Substance abuse problems: Mr. Z has a documented history of substance abuse problems, primarily alcohol. Mr. Z reports abusing marijuana beginning at the age of 13. He reports smoking two joints per day between the ages of 13 and 15. He reports using cocaine approximately “10 times in my life.” Mr. Z began abusing alcohol at the age of 12. As an adult, Mr. Z reports drinking alcohol intermittently, at times drinking “up to 15 beers a day, and at other times I’ve been sober for almost a year at a time.” Mr. Z was consuming alcohol at the time of two of the three violent incidents described above.

Mental illness: Mr. Z’s clinical presentation is most consistent with a DSM-IV-TR diagnosis of schizophrenia, paranoid type. Historically, Mr. Z has presented with the following symptoms: paranoid and grandiose delusional beliefs, command auditory hallucinations instructing him to harm others, and disorganized thought process. Mr. Z has consistently been diagnosed with schizophrenia, paranoid type since the age of 23. He has been hospitalized on eight occasions secondary to paranoid beliefs that others were conspiring against him. All hospital records were reviewed and indicate a discharge diagnosis of schizophrenia, paranoid type.

Personality disorder: Mr. Z meets the DSM-IV-TR criteria for anti-social personality disorder. He presents with the following behavioral criteria for this disorder: failure to conform to social norms with respect to lawful behaviors as indicated by repeatedly performing acts that are grounds for arrest; impulsivity or failure to plan ahead; irritability and
aggressiveness, as indicated by repeated physical fights or assaults; and consistent irresponsibility, as indicated by repeated failure to sustain consistent employment or honor financial obligations.

**Clinical Items**

The five clinical items contained in the HCR-20 include (11) lack of insight, (12) negative attitudes, (13) active symptoms of major mental illness, (14) impulsivity, and (15) unresponsiveness to treatment.

Mr. Z has shown significant progress when examining the clinical items on the HCR-20. Mr. Z’s insight into his mental illness has improved over the course of his 8-year hospitalization at the state hospital. Upon admission to the state hospital, he denied that his delusional beliefs were due to a mental illness. Currently, he acknowledges suffering from a mental illness that he described as “paranoid schizophrenia.” Upon his admission to the state hospital, Mr. Z was frequently involved in physical altercations with other patients. Over the past 2 years, Mr. Z was involved in no such incidents. During the clinical interview, Mr. Z was asked to describe his history of aggression within the hospital. He stated,

Really, some of the fights I was in when I first got here I really don’t remember because I was out of it. I know I would start with people and would just get into fights. Sometimes they were my fault and I hit people, and other times people hit me because I was crazy and being a jerk.

Mr. Z was asked to detail his two convictions for assault and battery and how his mental illness played a role in these incidents. He stated,

I’ve been arrested three times for violent stuff. The first two times I got convicted. I did probation the first time and got six months in jail the second time. The third one is this one, and I got an NGRI for it. All three times I wasn’t taking medications, and two out of the three I was drinking. When I’m off my meds I get paranoid about people. First I stay to myself and stop talking to my friends and family. Then after a while I don’t leave the house. The problem with that is I don’t work, and I don’t pay rent, and I get evicted. When I’m homeless I usually get worse and really paranoid and eventually I do something that gets me arrested because I feel like people are coming after me, or messing with me.

When asked to describe how his mental illness was related to the offense for which he was later adjudicated NGRI, he stated,
I used to think that my wife was using drugs and having sex with other people and that’s why she left me. I thought that [the victim] was the one behind all of it. I wasn’t taking my medications at the time and I was drinking almost every day. I thought she was taking my wife to meet other guys. It’s embarrassing to say now, but I know it happened because I read the records. I thought they were going to orgies and my wife was having sex with all kinds of people. When I take my medications I don’t think crazy things like that. If I stop my medications or start drinking, I would start believing stuff like that again and would probably be violent at some point.

When asked his thoughts about this incident now, Mr. Z stated,

I wish it never happened. I feel really bad about it. I wish I could just apologize for it and it would go away, but it can’t because it was scary for her and her child. That’s what I feel worst about—that the kid will be screwed up because of what I did when I was crazy.

Risk Management Items

The five risk management items contained in the HCR-20 include (16) plans lack feasibility, (17) exposure to destabilizers, (18) lack of personal support, (19) noncompliance with remediation attempts, and (20) stress. These items provide guidance for the ongoing management of a case. The risk management items of concern for Mr. Z are discussed below, and inform the specific recommendations made at the end of this report.

- **Lack of personal support:** Mr. Z and his treatment team report that he lacks supportive family and friends in the community. He has not had contact with family and reports that he does not know where he would live if he was released to the community. Mr. Z’s violent behavior in the past appears to be related to his lack of support. All three violent incidents were in the context of either living alone for extended periods of time without support from mental health professionals or while homeless. Due to Mr. Z’s lack of community support at this time, which would assist him during a transition from the state hospital to a community setting, it is recommended that Mr. Z visit and become familiar with staff and other residents of a residential facility prior to discharge from the hospital (see recommendations at the end of this report).
- **Exposure to destabilizers**: Within the custody of the state hospital, Mr. Z has not had access to potentially destabilizing items or situations, such as alcohol or drugs. During a transition to a less secure facility, access to destabilizers will increase. To mitigate this risk, Mr. Z should be observed closely by staff, particularly during the initial phase of his transition to a less-secure facility.

- **Stress**: During a transition to a less-secure facility, patients typically experience increased stress as they become acclimated to their new environment. Mr. Z has been at the state hospital for 8 years, and a transition to a less-secure facility, while clinically indicated, will likely be stressful. Mr. Z will benefit from discussions with the staff from the residential facility where he will be transferred. This will foster a trusting relationship with staff at the residential facility prior to his transition and provide his new treatment staff with a baseline of Mr. Z’s level of functioning when he is clinically stable. It is recommended that clinical staff assess his mental status regularly upon transition to determine whether this stress has resulted in increased symptomatology, particularly paranoia.

### Conclusions

Based on this review of Mr. Z’s case, the administration of risk assessment tools, a clinical interview with Mr. Z, and consultation with his treatment team, it is my opinion that Mr. Z is at low to moderate risk for violence at this time. It is also my recommendation that Mr. Z begin to transition to a community living situation under supervision provided for by a Department of Mental Health community agency.

Mr. Z has made gains in several areas. He has shown an increased understanding that he suffers from a mental illness and how his mental illness and substance abuse is related to his history of violence. Mr. Z has also shown a good understanding of how increased symptoms of his mental illness or abuse of substances would likely result in him becoming violent in the future. He has also shown that he can manage his behavior within a hospital environment. Although it is recommended that Mr. Z begin a transition to the community, this transition should progress slowly to ensure that he builds community ties prior to release from the hospital. The potential harm if this transition occurs too rapidly is that Mr. Z does not form connections with treatment providers, becomes noncompliant with treatment interventions (medications and abstaining from substance use), resulting in the reemergence of
paranoid delusional beliefs. If this occurs, then it would be my opinion that Mr. Z is at high risk for violence. However, if treatment providers feel as though Mr. Z has formed meaningful connections, refrains from substance use, participates in ongoing relapse prevention focused on substance abuse, and remains compliant with medications, his risk of harm to others is low to moderate.

**Recommendations**

The following recommendations are made for Mr. Z’s transition from the state hospital to a community living situation under supervision provided for by the Department of Mental Health:

1. It is recommended that the facility where Mr. Z resides has 24-hour staff coverage and the ability to observe medication administration to ensure compliance.
2. Mr. Z should begin meeting with clinical staff from an identified residential facility as soon as possible to afford time for several meetings prior to his transfer. Because Mr. Z lacks outside support from family or friends, which is helpful during such transitions, a lengthy transition over several months is clinically indicated. His only social support system at this time is made up of his treatment providers. The main goal of transitional meetings is to establish Mr. Z’s trust in clinical staff from his community placement similar to his current treatment alliances with clinical staff at the state hospital.
3. It is recommended that during these meetings Mr. Z explain his history of violence and how symptoms of his mental illness and substance abuse are related to past violence. This is important because Mr. Z has a difficult time sharing information with new treatment staff. While clinical staff from the state hospital and the community agency are both present, it will afford Mr. Z the safety of sharing important clinical information with new treatment providers.
4. It is recommended that, during clinical meetings between the state hospital treatment team and community agency staff, the topic of Mr. Z’s placement be discussed, including the rules of the residential placement and the privilege system. This will alleviate Mr. Z’s anxiety regarding what to expect when he arrives at his new residence.
5. It is recommended that Mr. Z visit the residential facility prior to his discharge from the hospital. Visits should occur under the supervision of both hospital staff and staff from the residential facility. Mr. Z should visit the residence on at least three occasions—once in the morning, once in the afternoon, and once in the evening—so he is able to meet staff across shifts and see the routine throughout the day.

6. A psychiatrist with experience working with aggressive patients should be identified prior to Mr. Z’s discharge from the state hospital to allow for the psychiatrist to review records and interview Mr. Z. It is recommended that Mr. Z be seen weekly by his psychiatrist over the first 3 months of his transition to a residential facility. This allows for close monitoring of his mental status. In the case that Mr. Z becomes increasingly paranoid, a brief hospitalization is recommended for stabilization.

7. Privileges should initially be limited to supervised community access. When additional privileges are being considered, another formal violence risk assessment is recommended.

DISCUSSION

The assessment of risk for violent behavior is a complicated area and the focus of a significant amount of research over the past 30 years. Forensic practitioners and evaluators are asked to provide opinions regarding the risk of harm an individual poses in a variety of settings. Qualifications to carry out forensic assessments vary depending on jurisdiction and local laws. Even in cases when a practitioner meets statutory requirements, advanced knowledge of the research literature as it pertains to the specific risk assessment being conducted is necessary. It is also essential for forensic practitioners to clearly understand the type of evaluation they are being asked to conduct and to clarify the resources available when making recommendations with the authority requesting the evaluation. The risk assessment literature has progressed sufficiently to the point that forensic practitioners are able to assess risk for violence with greater accuracy and efficiency. Forensic practitioners are required to remain current with this rapidly growing literature, particularly in the specific area in which they practice.

The literature has progressed through three generations of research. The first focused primarily on clinical samples and found difficulty in
determining which groups or subgroups of patients were at risk for violence. The second generation examined specific risk factors for violence, resulting in the establishment of actuarial measures. These actuarial measures significantly increased predictive accuracy over subjective clinical opinion. However, these tools focus on historical data and provide a static, unchangeable score and resultant risk level. Once an individual is categorized at a particular risk level, treatment intervention and/or environmental change will not decrease this assigned risk level. The third generation of research focused on structured professional judgment, which uses risk assessment schemes to guide clinical opinion. The most widely researched structured professional judgment guide is the HCR-20 (Webster et al., 1997). Because numerous risk factors have been found to increase an individual’s risk for future violence, all should be considered in the course of an evaluation. It is further recommended that structured professional judgment tools, such as the HCR-20 (Webster et al., 1997) be utilized. Such assessment tools compel the forensic practitioner to address empirically derived risk factors found to increase an individual’s risk for violence while also individualizing each assessment.

Risk assessment is an ongoing process and is not conducted at one point in time. The ongoing risk management of a forensic case includes the introduction of intervention strategies but also requires ongoing assessment. As additional data become available, this data should be incorporated into the overall risk assessment. The forensic patient’s risk level may change over time for a variety of reasons, such as changes in the patient’s clinical presentation or new environmental stressors. As new information becomes available over time, this information is also incorporated into the ongoing risk management plan.

Risk assessments should not occur in a vacuum and require collaboration between the practitioner responsible for the violence risk assessment evaluation and other clinicians and collaterals involved in the long-term care and support of the client. The research literature on risk management shows that, to decrease violent recidivism, ongoing management of the case is required. This often begins within inpatient hospitals or correctional facilities, but outpatient oversight is required to ensure successful transitions from detention to the community.

NOTE

1. Chapter 8 of this volume is dedicated to the topic of psychopathy as a risk factor for violence; thus, psychopathy will be discussed only briefly here.
REFERENCES


