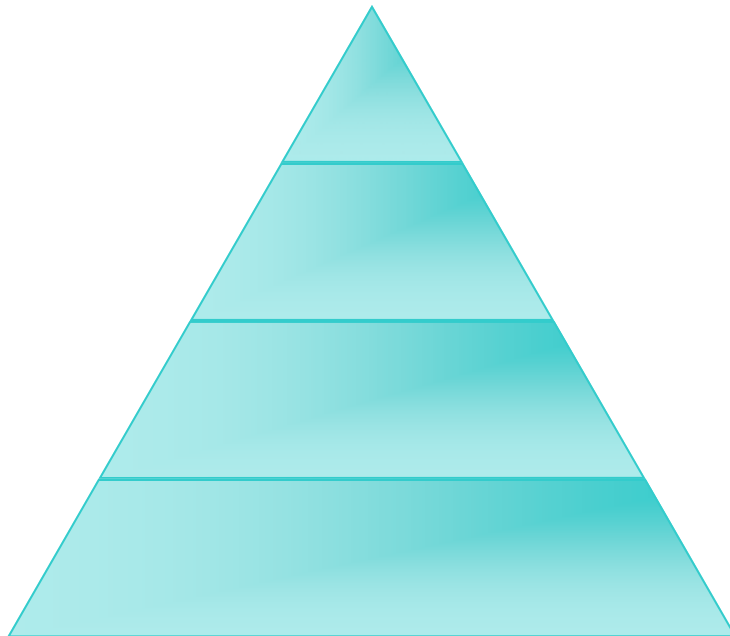




Current Practices in Assessing Risk for Violence

Neil Gowensmith, Ph.D.
Forensic Services Director
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State of Hawaii

Outline



Managing and reducing risk

Specific settings and instruments

Risk assessment:
History, methodologies, and primary risk factors

Base rates of violence and recidivism

Outline

- Base rates for violence and recidivism
- Assessment of violence risk
 - History and types of assessment
 - Best predictors of violence
 - Specific settings and instruments
 - Hospital, jail, community
- Communicating results
 - Management and reduction of violence risk

Base rates of violence and recidivism



Base rates of violence in the mentally ill population

- MacArthur Violence Risk Assessment Study
 - Monahan, et al. (2001)
 - Largest-scale study of violence and mental illness
 - Found higher rates of violence in mentally ill population than previously believed
 - Violence in mentally ill at same levels as non-mentally ill neighbors*
 - * Higher rates when substance abuse was indicated

Base rates of violence / recidivism

- General population: Estimated at about 2-5%
- SPMI violence rates
 - Estimates range from 8-13% for general SPMI
 - 12-28% for those released from an inpatient hospital setting
- Forensic SPMI violence
 - Estimates range from 20-40%
- Recidivism of non-psychiatric offenders released from correctional facilities
 - Estimates range from 20-50%
- Recidivism of mentally ill offenders released from corrections or hospitals
 - Estimates range from 20-50%

Base rates of violence in the mentally ill population

- Percentage of violent subjects and frequency of violent acts are typically underestimated in most studies (Mulvey & Shaw, 1994)
 - Compared subject self-reports and collateral reports of violent incidents
 - Collateral data reported only 25% of the incidences reported by the self-report of subject
 - Subject reported only 34% of the incidences reported in collateral reports

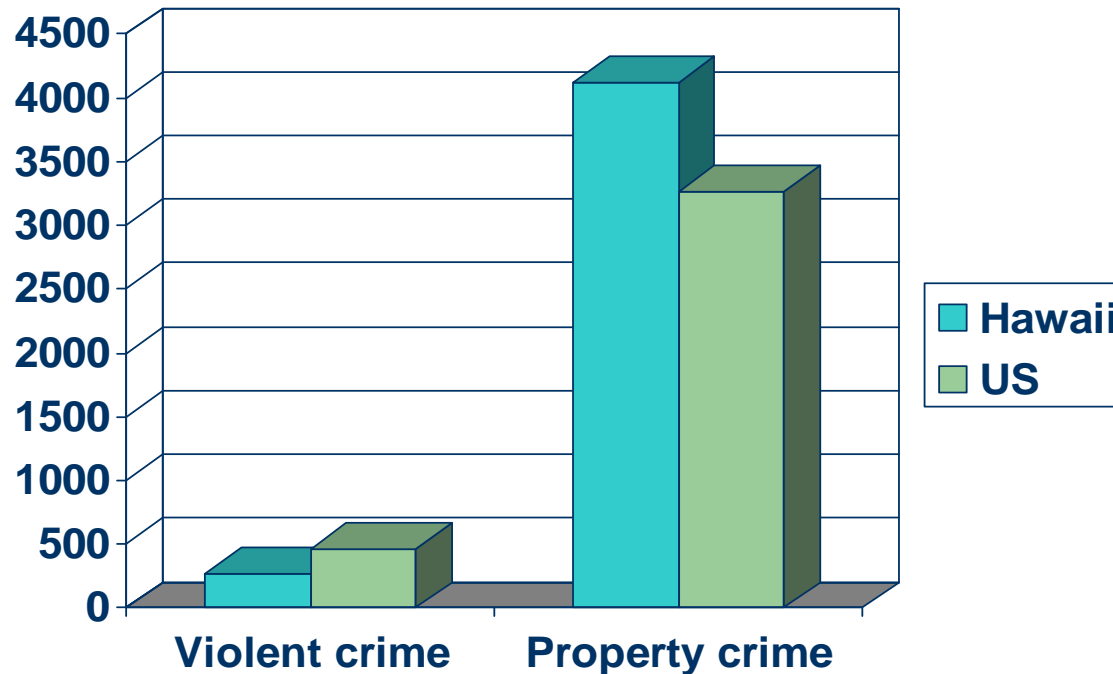
Hawaii Crime Rates (2007)

- All index crimes:
 - 4395 offenses per 100,000 residents
 - Down 3.2% from 2006, down 17.8% from 1997

* Index crimes:

- Violent: Murder, Forcible Rape, Aggravated Assault and Robbery
- Non-violent: Burglary, Motor Vehicle Theft, Larceny-theft
- Tracked separately: Arson
- Source: State of Hawaii Dept of Attorney General

Hawaii vs. US Crime Rates (2007)



Crime rates reflected are offenses per 100,000 residents

Offenders under community supervision

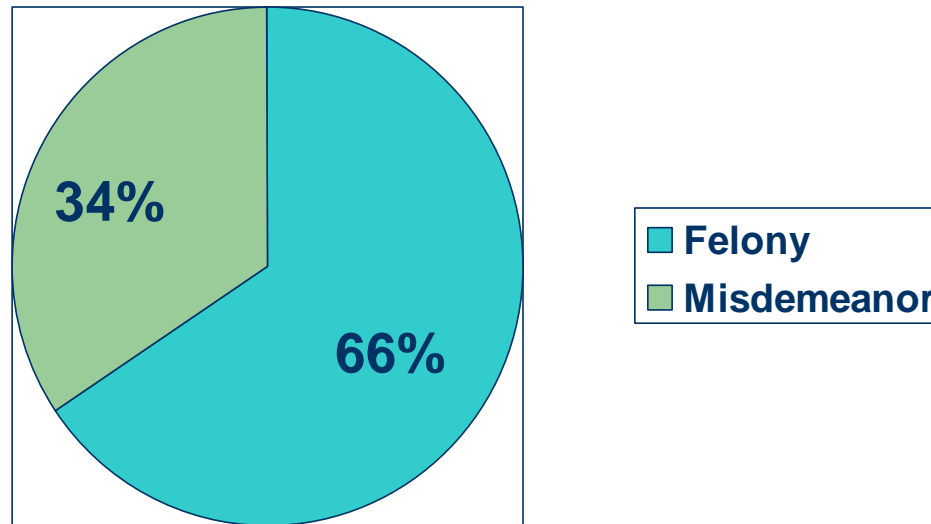
- Prevalence rates
 - Probation
 - US: 4,237,023 (2006) – 1868 per 100,000 adults
 - HI: 18,598 (2006) – 1870 per 100,000 adults
 - Parole
 - US: 798,202 (2006) – 352 per 100,000 adults
 - HI: 2316 (2006) – 233 per 100,000 adults
 - CR
 - US: approx 3000-7000 – approx 3 per 100,000 adults
 - HI: approx 450 – approx 50 per 100,000 adults

Forensic hospitalization in Hawaii: Examiners versus the court

- When court finds someone unfit:
 - Hospitalize at 90%
 - Examiners recommend hospitalization at 88%
 - Same basic ratios for those unlikely to ever be fit
- When court acquits
 - Hospitalize at 80%
 - Examiners recommend hospitalization at 80%
- Court grants CR 73% of time
 - Examiners recommend 68% of time

Conditional Release in Hawaii

Percentage by level of offense



Successful community tenure rates of CR consumers in community

Annual percentage rates of CR consumers who are not hospitalized through the criminal court:

2006: 87.4%

2007: 85.5%

2008: 87.2%

Re-arrest rates for CR consumers in 2007

- 11% of CR consumers re-arrested in 2007
- Breakdown by level of new criminal offense
 - 19% new felony charges
 - 49% new misdemeanor charges
 - 32% new petty misdemeanor charges
- High re-arrest rate
 - National and local SPMI population: 15%
 - AMHD population: 4%
 - National norms for CR populations: 2-5%
 - Perhaps the high number of misdemeanor CRs are responsible for a greater proportion of reoffending
 - 20% recidivism rate in misdemeanor CRs
 - 8% in felony CRs

Violence risk
assessment:
A big
challenge



Assessing Risk for Violence

- Common scenarios for assessing risk
 - Clinical practice
 - In court
 - Sentencing
 - Placement decisions
 - Release decisions
 - In corrections
 - Parole hearings
 - Placement decisions
 - In police psychology

Risk Assessment: General Observations

- We know more than we have ever known
- We still have more unknowns than knowns

Humiliating beginnings

- “Neither petitioner nor the [American Psychiatric] Association suggests that psychiatrists are *always* wrong with respect to future dangerousness, only *most* of the time.”
 - Justice White in his majority opinion in *Barefoot v Estelle*, 463 US 880 (1983)

Humiliating beginnings

- Monahan (1981):

When clinicians predict violence, they are correct no more than *1 in 3 times*

Humble reality

- Although "it's been known for a very long time that psychologists and psychiatrists are not very good at predicting violence, ... they are better than chance... in recent years the science has improved considerably."
(Monahan, 2007)
- Best practices put violence risk prediction in the 70% and higher range

Risk assessment

- What is violence?
 - HCR-20: “Actual, attempted, or threatened harm to a person or persons” (Webster et al., 1997)
 - Can be short-term or long-term
 - Most clinical, correctional, police determinations are short-term
 - Most court-ordered determinations are long-term
 - Long-term determinations are the focus of this presentation

Risk assessment

- What are we trying to answer?
 1. Which empirically-based factors correlate with or predict violence for the subject?

Risk assessment

- What are we trying to answer?
 1. Which empirically-based factors correlate with or predict violence for the subject?
 2. *Where*: What conditions make the subject more likely to be violent?
 3. *What*: What type of violence is the subject capable of?
 4. *When*: How frequent is the violence likely to be?
 5. *Who*: Who are the likely targets of violence?
 6. *How*: How severe is the damage likely to be?
 7. *Which*: What interventions will mitigate risk?

Risk assessment

Approaches to Risk Assessment



Standards of Admissibility

- Derived by scientific method: Daubert v. Merrell Dow Pharmaceuticals (1993), Kumho Tire v. Carmichael (1999)
- Federal Rules of Evidence, Rule 702:
 - 1) the testimony is based on facts or data
 - 2) the testimony is the product of reliable principles and methods
 - 3) the witness has applied the principles and methods to the facts of the case

Four Approaches to Risk Assessment

- Unstructured Professional Judgment
- Anamnestic Risk Assessment
- Actuarial Instruments
- Structured Professional Judgment

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Unstructured professional judgment

- Clinical judgment
 - Intuition
 - Often based on therapeutic experience with the person
 - No formal risk assessment testing or systematic analysis
 - Will utilize psychological testing, interview data
 - Formulation of risk is based on above “data” & clinician’s understanding of violence and personal experiences
 - Served as primary assessment mechanism until the 1980s
 - Still widely prevalent today

Unstructured professional judgment

- Clinical methods
 - Estelle vs. Smith (Texas)
 - Smith on death row
 - Psychiatrist: Smith is a “very severe sociopath who is going to go ahead and commit other similar or same criminal acts given the opportunity to do so.”
 - Data used to make this determination:

Unstructured professional judgment

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 - US Supreme Court:
 - “Psychiatrist operating at the brink of quackery”



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Unstructured professional judgment

- Clinical assessment pros and cons
 - Pros:
 - Anyone can do it
 - Judges and juries are persuaded by clinical information and anecdotes
 - Cons:
 - It doesn't work
 - It's rarely admissible in court anymore

Unstructured professional judgment

- Clinical methods increasingly discredited throughout the 1980's
 - Move from predictions of “yes/no” to assessments of “under what circumstances”
 - This led to improved methods for assessing long-term risk for violence

Four Approaches to Risk Assessment

- Unstructured Professional Judgment
- **Anamnestic Risk Assessment**
- Actuarial Instruments
- Structured Professional Judgment

Anamnestic methods

- Improved clinical methodology
 - Using real scenarios to inform assessment
 - Individualized to person and context
 - What happened to cause the person to be violent in the past?
 - Identification of specific triggers or stressors, or of emerging patterns of violence, are the priorities
 - Try to generalize to other similar situations

Anamnestic measures

- Pros:
 - Provides very useful and relevant information
 - High construct validity, improves predictions
 - Individualized assessments
- Cons:
 - Situations may not generalize or be outdated
 - Does not rely on actuarial data
 - Low predictive validity when used in isolation

Four Approaches to Risk Assessment

- Unstructured Professional Judgment
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Actuarial Risk Assessment

- My, how the pendulum swings
 - Reaction to clinical approach
 - Purely empirical
 - Based on statistical tables
 - Statistical analysis of which factors predict violence
 - No room for clinical intuition
 - Predict likelihood of violence within a specified time frame

Actuarial Risk Assessment

- Use of statistical formulas to classify categories of risk based on presence or absence of risk factors that distinguish between samples of violent and non-violent persons

Actuarial Risk Assessment

- Examples of actuarial testing measures
 - VRAG (Violence Risk Assessment Guide)
 - Mentally ill offenders
 - COVR* (Classification of Violence Risk)
 - Non-forensic psychiatric inpatients
 - Static 99 / RRASOR (Rapid Risk Assessment of Sexual Offense Recidivism)
 - Adult Male Sex Offenders

Actuarial Risk Assessment

- Violence Risk Assessment Guide (VRAG) (Quinsey et al., 2006)
 - Most well-known actuarial measure for mentally ill offenders
 - Normed on psychiatric offenders released to community and monitored for several years
 - 12 weighted factors that are scored using historical records
 - Attempt made to eliminate clinical guesswork

Actuarial Risk Assessment: VRAG

1. Psychopathy	7. Never married or lived common law
2. Elementary school maladjustment	8. DSM diagnosis of schizophrenia
3. Age at index offense	9. Severity of victim injury in index offense
4. DSM diagnosis of a personality disorder	10. Failure on prior supervised release
5. Separated from parents before age 16	11. History of alcohol abuse
6. Criminal history for non-violent offenses	12. Male victim in index offense

Actuarial Risk Assessment

- Actuarial measures pros and cons
- Pros:
 - Superior to clinical methods
 - Better predictions of violence than clinical intuition
 - High validity
 - VRAG: AUC of approximately .70
 - High reliability
 - Can show trail of evidence supporting conclusions
 - Admissible in court

Actuarial Risk Assessment

- Actuarial measures pros and cons
- Cons:
 - Discounts all clinical info (even though it may be relevant)
 - Not predictive for an individual, but for peer group
 - People and juries may not understand it
 - How to incorporate findings / predictions into treatment planning or risk reduction strategies?

Customized Actuarial Risk Assessment

- The Classification of Violent Risk (COVR)
 - An outcome of the MacArthur Study of Mental Disorder and Violence (Monahan et al., 2001)
 - Estimates the risk of an acute civil psychiatric patient becoming violent to others over the next several months after discharge into the community
 - Uses a classification tree method
 - If x is true, then y...if x is not true, then z...
 - Provides categories of risk with individualized factors
 - Predictive validity is generally higher than other actuarial methods
 - Easy to administer

Four Approaches to Risk Assessment

- Unstructured Professional Judgment
- Anamnestic Risk Assessment
- Actuarial Instruments
- **Structured Professional Judgment**

Structured Professional Judgment

- Current standard practice: Combination of clinical, actuarial, and anamnestic methods
 - Determining under what conditions someone may be more or less likely to be violent
 - As opposed to “yes / no” predictions of violence
 - Using actuarial factors to guide predictions of risk, but using other contextual variables to customize the assessment

Structured Professional Judgment

- Popular measures:
 - Level of Service Inventory - Revised (LSI-R)
 - Primary actuarial measure for non-mentally ill offenders (usually used for sentencing and parole decisions)
 - Psychopathy Checklist - Revised (PCL-R)
 - Primary measure for psychopathy, which is highly correlated with recidivism and risk of violence
 - Structured Assessment of Violence Risk in Youth (SAVRY)
 - For adolescents 12-18 years old
 - HCR-20 (Historical, Clinical, and Risk Management)
 - Primary risk assessment measure for mentally ill offenders

Structured Professional Judgment

- HCR-20
 - Excellent risk assessment measure
 - For risk for violence in mentally ill individuals
 - Three components
 - Historical items (H)
 - Clinical items (C)
 - Risk management items (R)
 - 20 items total

Risk assessment: HCR-20

- Historical items (aka “actuarial” items / “past”)

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

Risk assessment: HCR-20

- Clinical items (aka “present”)

1. Lack of insight
2. Negative attitudes
3. Active symptoms of major mental illness
4. Impulsivity
5. Unresponsive to treatment

Risk assessment: HCR-20

- Risk management items (aka “future”)

1. Plans lack feasibility
2. Exposure to destabilizers
3. Lack of personal support
4. Noncompliance with remediation attempts
5. Stress

Structured Professional Judgment

Pros:

- Grounded in actuarial variables
- Good validity (.70+ AUC)
 - Combination of static and dynamic factors increases power
- Flexible enough to consider clinical variables
- Allows for different scenarios to be considered
 - Risk in scenario one vs scenario two
- Risk assessment informs risk management
 - How to keep this person and other people safe?

Structured Professional Judgment

Cons:

- Not enough research on methods yet
 - Very few outcome studies
- No specific predictions of violence

Risk Assessment Varies Based on Context

- Petriola (2007)
 - Short-term risk assessment will rarely depend on formal probabilistic assessment
 - Long-term risk assessment *should* depend on formal probabilistic assessment

Risk
assessment:
Best predictors
of violence



Maui, Hawaii Storm Clouds

Don Briggs

Factors in Violence Risk Prediction

- What predicts violence?
 - There are particular factors which do predict violent behavior better than others
 - No factor or group of factors predicts violence perfectly
 - Best predictions come from combining static factors with dynamic factors

Factors in Violence Risk Prediction

- What predicts violence?

Top three predictors:

- Previous violence
- Substance abuse
- Psychopathy

Factors in Violence Risk Prediction

- What predicts violence?
 - History
 - Past violence / offenses
 - Both violent AND non-violent offenses increase risk
 - Violence at young age
 - Conduct disorder / delinquency
 - Leads to antisocial personality disorder

Factors in Violence Risk Prediction

- What predicts violence?
 - Personality variables
 - Psychopathy
 - Especially Factor 2
 - Some studies show it's a better predictor of violence by itself than other more elaborate measures
 - Not using the PCL-R in risk assessment can be tantamount to professional misconduct (Edens et al, 2001)
 - Pervasive anger (McDermott et al., 2008)
 - Antagonism, social deviance (Skeem et al., 2005)

Factors in Violence Risk Prediction

- What predicts violence?
 - Clinical factors
 - Substance abuse
 - Without question
 - Some symptoms of major mental illness
 - Inconsistent findings
 - Specific psychotic symptoms
 - Paranoid delusions
 - Persecutory delusions
 - Command hallucinations for violence
 - Thought control / thought insertion

Factors in Violence Risk Prediction

- What predicts violence?
 - Demographic variables
 - Male
 - Young age
 - Violence tends to decrease after age 50

Factors in Violence Risk Prediction

- What predicts violence?
 - Time
 - First 5 months out of a psychiatric hospital (Monahan et al, 2001)
 - 27.5% of discharged mental patients from civil commitments report some incidence of violence during first year
 - First 12 months out of jail / prison

Factors in Violence Risk Prediction

- What predicts violence?
 - Contextual factors
 - Poor social support networks
 - Criminal associations, neighborhoods
 - Weapon availability
 - Victim availability
 - Can be that the person is violent to lots of people
 - Can be that previous victims are still around

Risk Assessment

Inpatient
Settings



Violence Risk Assessment: Inpatient

- Elbogen, Huss, Tomkins & Scalora (2005)
- Clinicians tend to underutilize formal assessment in lieu of clinical assessment
 - Clinical assessment is a poor predictor
 - Authors encourage the following:
 - Making historical, static information available
 - Reviewing historical info regularly (ie, tx planning)
 - Making risk assessment findings clear
 - Communicate findings to front-line staff

Violence Risk Assessment: Inpatient

- McDermott, Edens, Quanbeck, Busse, & Scott (2008)
- What predicts inpatient violence?
 - Aggression to staff
 - Anger
 - Affective dysregulation
 - Aggression to other patients
 - Clinical factors
 - Implications
 - Utilize HCR-20, with special care for C and R items
 - Provide additional measure of anger (NAS-PI) and clinical symptomology (BPRS)

Violence Risk Assessment: Inpatient

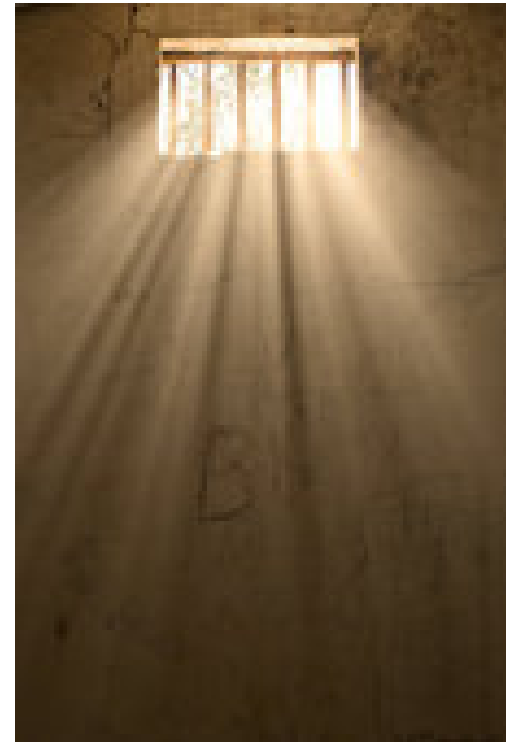
- Ogloff & Daffern (2006)
- Dynamic Appraisal of Situational Aggression
 - Instrument to predict inpatient aggression / violence
 - Highlights anger traits and symptomology
 - Uses 2 HCR-20 items (Negative attitudes, Impulsivity)
 - Irritability
 - Verbal threats
 - Sensitive to perceived provocation
 - Easily angered when requests are denied
 - Unwillingness to follow directions

Violence Risk Assessment: Inpatient

- Measures that utilize strengths (preventative factors) as well as risks
 - CERF-R (Current Evaluation of Risk and Functioning Revised)
 - Lambert et al, 1999
 - Requires multi-disciplinary input
 - Scores on risks (physical, sexual, substance, leaving treatment, etc)
 - START (Short-Term Assessment of Risk and Treatability)
 - Webster, et al, 2006
 - Measure for mentally ill which highlights both risk factors and protective factors (strengths)

Risk Assessment

Correctional
Settings



Violence Risk Assessment: Correctional Settings

- Level of Service Inventory–Revised (LSIR)
 - Andrews & Bonta (1995)
 - Static and dynamic factors
 - Uses:
 - Placement decisions within institutions
 - Level of supervision and recommendations for care post-release
 - Identification of risk management areas
 - Used by correctional facilities, parole, and probation nationwide

Violence Risk Assessment: Correctional Settings

- Level of Service Inventory–Revised (LSIR)
 - Good rates of predictions of recidivism
 - Best predictions are for general recidivism
 - LS/CMI (Andrews et al, 2004) specifically adds items for violence prediction
 - LSI-R predicts well for both short-term and long-term inmates (Manchak, Skeem & Douglas, 2008)
 - Dynamic factors of LSI increase predictive validity significantly
 - Especially financial stress & substance abuse

Violence Risk Assessment: Correctional Settings

- Inventory of Offender Risks, Needs and Strengths (IORNS)
 - Miller (2006)
 - Predicts general and/or violent criminal behavior upon release from correctional facility
 - Utilizes static, dynamic, and protective factors (strengths)
 - Cognitive/behavioral regulation, anger regulation
 - Education / training, environmental resources
- Psychological Inventory of Criminal Thinking Styles (PICTS)
 - Walters & Mandell (2007)
 - 80-item self-report measure
 - Good predictor for total incident reports, major incident reports, and aggressive incident reports in a correctional setting
 - Predicts severe incident reports best

Risk Assessment

Community Settings



Violence Risk Assessment: Community Settings

- Structured Professional Judgments
 - Best rates of violence prediction
 - Allow for risk management, not just assessment
 - HCR-20
 - START
 - SAVRY
 - CERF-R
 - SORM (Grann, 2005) – for felons

Violence Risk Assessment: Community Settings

- Brown, Armand, & Zamble (Feb 2009)
- Reassessing dynamic risk factors over time increases predictive power of post-release predictions of recidivism

Violence Risk Assessment: Community Settings

- Brown, Armand, & Zamble (Feb 2009)
- Reassessing dynamic risk factors over time increases predictive power of post-release predictions of recidivism:
 - Most predictive variables when reassessed:
 - Substance abuse
 - Social support
 - Negative affect
 - Perceived problem level
 - Employment
 - Single, or with unsupportive partner

Violence Risk Assessment: Community Settings

- Implications
 - Treatment providers and supervising officers should continually reassess offenders on the above variables
 - Focus on building stability first, then on early detection of particular triggers
 - Self-reported information from the offender is critical (perceptions of stress, support, problem level, etc.)

Communicating risk assessment results



Communicating Results of Risk Assessment

- Considerations for inpatient settings (Petrila, 2007)
 - Unstructured risk assessment is legally problematic
 - To limit liability, a secure hospital must:
 - Have a coherent plan for risk assessment at the clinical level
 - A structure for administrative review of such decisions, especially regarding potential discharges
 - Assure that discharge plans address risk questions
 - Good charting and second opinions are still the best defense tools

Communicating Results of Risk Assessment

- Probation, parole, and CR supervision:
 - Improving Outcomes for People with Mental Illnesses under Community Corrections Supervision: A guide to research-informed policy and practice.
 - Council of State Governments Justice Center, New York
 - <http://consensusproject.org/downloads/community.corrections.research.guide.pdf?>

Communicating Results of Risk Assessment

- Current best practices are to include:
 - Risk assessment
 - Empirically-based estimates / categories of risk
 - Provide rationale for methods and results
 - Provide probabilities and base rates when possible
 - Utilization of structured professional judgments
 - Grounded in actuarial data / risk factors
 - Utilizing dynamic factors to individualize assessment
 - Provide specifics when possible
 - Previous patterns or circumstances of violence
 - Likely targets, severity of violence, violence typologies

Communicating Results of Risk Assessment

- Current best practices are to include:
 - Risk management strategies
 - How might risk be mitigated or prevented?
 - Dynamic factors (clinical and risk management items)
 - Strengths-based data
 - Provide comparative scenarios when possible
 - How risk factors and mitigation change across scenarios
 - Discharge from conditional release vs. remaining on CR, for example

Step 1: Describe likely scenario	Step 2: Develop management strategies	Step 3: Determine priority
<p>Nature</p> <ul style="list-style-type: none"> • What kinds of violence might this person commit? • Who are the likely victims? • What is the likely motivation? 	<p>Risk factors</p> <ul style="list-style-type: none"> • What events or circumstances might increase or decrease the patient's violence risk? 	<p>Priority</p> <ul style="list-style-type: none"> • What level of effort or intervention will it take to prevent this person from committing violence?
<p>Severity</p> <ul style="list-style-type: none"> • What would be the harm (physical or psychological) to victims? • Is it likely the violence might escalate to life-threatening levels? 	<p>Monitoring required</p> <ul style="list-style-type: none"> • How can we monitor warning signs? • What events or circumstances should trigger a re-assessment? 	<p>Immediate Action</p> <ul style="list-style-type: none"> • What steps should be taken immediately to prevent violence?
<p>Imminence</p> <ul style="list-style-type: none"> • How soon might the violence occur? • Are warning signs to suggest the violence risk is increasing or imminent? 	<p>Treatment</p> <ul style="list-style-type: none"> • What treatment (biological, social or psychological) could help to reduce the violence risk? 	<p>Case review</p> <ul style="list-style-type: none"> • When should the case be scheduled for routine review? • What should trigger early review?
<p>Frequency/duration</p> <ul style="list-style-type: none"> • How often might the violence occur – once, several times, frequently? • Is the violence risk chronic or acute (i.e., time-limited)? 	<p>Supervision</p> <ul style="list-style-type: none"> • What supervision or surveillance could be used to manage this patient's violence risk? 	
<p>Likelihood</p> <ul style="list-style-type: none"> • In general, how frequent or common is this type of violence? • How frequently has this person committed this type of violence? • How likely is it that this person will commit this type of violence? 	<p>Victim safety planning</p> <ul style="list-style-type: none"> • What steps can be taken to protect likely victims? 	<p>* Reference:</p> <p>Maden, A. (2007). <u>Treating violence: A guide to risk management in mental health</u>. New York: Oxford University Press.</p> <p>(table based on Webster et al., 1997)</p>

It can be done!



Risk Assessment: Recap

- We know more than we have ever known
- We still have more unknowns than knowns

Recommending reading

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