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VIOLENCE RISK & THREAT ASSESSMENT PROFESSIONALS

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Violence Risk Assessment

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An Introduction to Violence Risk Assessments

General Violence Risk: Structured Professional Judgement Approach

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Stalking Assessment & Management (SAM)

Overview of the Violence Risk Assessment Certificate

Violence Risk Assessment - From Certificate to Career

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Violence Risk Assessment

Many studies have supported the validity of using assessment instruments to enhance professional judgment, and as a result, various structured risk assessment measures have been developed. These measures improve violence risk assessments by prompting clinicians to consider empirically supported factors for general or specific forms of violence. In addition, research has demonstrated the predictive validity of multi-factor tools designed to assess violence risk; therefore, professionals are no longer required to rely on personal experience, intuition, or instinct.

This e-book will review some of these tools in detail, beginning with assessment tools for general violence risk and moving into those tailored for a narrow risk assessment. In addition, this ebook will discuss juvenile risk assessment as appropriate. Supplementarily, case studies for some of the tools are presented throughout to provide context for the reader and aid in garnering knowledge related to the respected instrument.

Amanda Beltrani

Amanda Beltrani, Ph.D., is a forensic and clinical psychologist. She obtained a master's degree in forensic psychology at John Jay College of Criminal Justice. She then earned a doctoral degree in clinical psychology with an emphasis in forensic psychology at Fairleigh Dickinson University. She completed an APA-accredited internship on the forensic psychology track at New York University-Bellevue Hospital. Dr. Beltrani has published over 15 peer-reviewed journal articles and book chapters on competency to stand trial, clinical assessment and decision making, serious mental illness, and barriers to implementing evidence-based practices. Currently, she is a staff psychologist at Kirby Forensic Psychiatric Center in New York City. She works on a secure ward, conducting forensic psychological evaluations for the Courts as well as treatment and intervention programs for patients with various psychological and legal issues. In addition, Dr. Beltrani works part-time for CONCEPT Continuing & Professional Studies, providing new or aspiring mental health professionals with information about various aspects of practice to elevate their career and professional fulfillment.

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An Introduction to Violence Risk Assessments

Violence risk assessment is a process of estimating and attempting to limit the likelihood that an undesirable event will occur. The demand for these evaluations is increasing in the legal system, workplace settings, health care, and higher education. Yet, despite the increasing frequency, there is still uncertainty surrounding what a violence risk assessment is, how it can be used, and the benefits and limitations of such assessments.

IN THIS POST

Assessment of risk is ubiquitous. Across virtually all realms of life, some level of risk evaluations are expected. The result is an entire field of actuarial science, assessing the risk that determines how much we pay for automobile insurance, homeowners' insurance, or health insurance. Moreover, physicians and nurses evaluate the risk of diseases or death, economists consider the risk of market impacts, and information technology security officers assess the risk of data breaches. Similarly, in criminal justice and mental health settings, professionals are frequently asked to evaluate an individual's potential risk of violence. Across all of these fields, predicting future adverse events is accomplished with varying degrees of accuracy.

Assessing the risk for violence or criminality is exceptionally difficult to do well. The challenges inherent in making such judgments are considerable, and the consequences of erroneous decisions are often grave. For example, failure to correctly identify individuals who pose a high risk could jeopardize public safety. Conversely, erroneously deeming individuals high risk could lead to unjustified restrictions of their liberty, public stigma, and needless expense.

What is Violence?

Violence is actual, attempted, or threatened physical harm of another person that is deliberate and non-consenting. Professionals are tasked with assessing behavior and determining if the behavior suggests an intention to cause another individual injury or fear for their safety.

To efficiently assess violence, mental health professionals must look at the act committed, the underlying reasoning for committing it, and its impact on the victim.

What is Risk?

Risk is a potential, negative outcome that is forecasted with uncertainty. As it is impossible to predict the occurrence of violence, mental health professionals are often asked to assess the *potential* for violence. Therefore, risk assessments are not conducted if an event is definitely going to happen.

Instead, the goals are to understand the future's ambiguity and the range of possible outcomes. Findings of risk assessments can guide treatment, plan interventions, and protect a patient and the public's safety.

Risk vs. Threat Assessment

Risk assessment focuses on the probability of violence. It is an estimate for an individual, who usually has a history of violence, based upon their comparison to a known group. In contrast, a threat assessment focuses on targeted violence by a subject of concern, who may not have a known history of violence, and encompasses a behavioral and profiling focus.

Violence risk assessment is complex. The goal is to determine the nature and degree of risk an individual may pose for violence, given various conditions and contexts.

- **Nature**: What type of violence might occur?
- **Severity**: How serious might the occurrence of violence be?
- **Weapon access**: Does the individual have access to the weapon? What is the lethality of the weapon?
- **Targets**: Who may be the target of violence? A family, friend, employer, or stranger?
- **Imminence**: How soon might the violence occur?
- **Frequency**: How often might violence occur?
- **Contextual**: What context, if any, does the risk for potential violence increase or decrease?
- **Likelihood**: What is the probability that violence might occur?

The ultimate goal of risk assessment research is to guide evidence-based intervention planning and facilitate communication between the various individuals and agencies involved in an individual's care. The courts, policymakers, academics, and clinicians need a framework and 'common language' to discuss risk and intervention plans.

Violence Risk Assessment Tools

Mental health and legal professionals may consider individualized information about a person, their past, current legal status, or other circumstances to inform a decision regarding a threat to public safety. The evaluation may be brief, implicit, and informal, or it may be structured with guidelines, procedures, or the use of a violence risk assessment instrument.

Given the gravity of dispositional decisions, utilizing empirically guided risk assessment tools when formulating recommendations may prove more helpful. In 2011, researchers noted that well over 120 measures had been developed to assess violence and re-offense risk, with the vast majority created for adult populations.

Violence risk is commonly evaluated through formal risk assessment measures and may consider factors such as offending trajectories, including the age of onset, severity, frequency, and personality traits. Risk assessments are used in many different contexts in the legal justice system. For example, results may impact juvenile transfer to adult court decisions, eligibility for diversion programs, sentencing, parole/probation, and disposition planning. However, despite the prevalence of available tools, risk assessment instruments may not always generalize across populations.

Risk Factors

Risk consideration focuses on individual factors and extend to family, community, and cultural factors. The prevention of violence, suicide, victimization, and other forms of harm is a goal shared by mental health professionals and justice services. However, no two individuals are alike; consequently, preventing harm is not a simple task.

The factors that lead to adverse outcomes, such as violence, suicide, and related outcomes, vary by the individual. It is, therefore, necessary to understand each individual's particular vulnerabilities and strengths related to such events. The ultimate aim is not simply to predict whether a person will experience adverse outcomes but to help guide plans to manage these risks and prevent harm.

Static Factors

There is long-standing awareness that static risk estimates are futile if the point is risk reduction. Although static risk factors can assist in evaluating risk for criminal behavior, they cannot reflect change since such factors are, by definition, "fixed" or static. Such factors are related to an individual's history, for example:

- History of prior violence
- Age of first violent event
- Conduct problems and antisocial behavior
- Adverse childhood experiences

Although historical factors associated with recidivism or desistence (i.e., static risk factors) may help assess risk, identifying dynamic risk and protective factors (i.e., criminogenic needs) are essential, as they alone are primary targets for intervention.

Dynamic Factors

In contrast to static risk factors, dynamic risk factors can reflect the change and are often the focus of treatment. Understanding the dynamic changes that occur throughout a person's life is essential to appreciate the risk of violence. Some examples are:

- Peer relationships
- Social support
- Mental illness
- Impulse control
- Attitude toward interventions & violence
- Anger
- Substance use

Methods to Assess Violence Risk

Violence risk assessment instruments have been developed to increase consistent, transparent, and accurate decisions in evaluating the likelihood of violent recidivism by considering "risk factors" associated with violence.

Actuarial Assessment of Violence Risk

Actuarial assessment tools are structured instruments designed to predict an outcome of a specific population over a particular period. Their approach to violence risk is mechanical or automated.

Risk factors on actuarial tools are selected either based on theory and experience or because they were related to an event (e.g., re-offend) in the sample that the instrument was developed. First, risk factors are scored and weighted, then combined using an algorithm to create a total score. These full scores estimate the likelihood of violence over a specific period by comparing them to rates of violence seen in the sample that the tool was normed.

The benefit of using an actuarial assessment is that human judgment biases are removed from the clinical decision-making process, giving them higher perceived usefulness in legal settings. However, the drawbacks of actuarial risk assessment tools often outweigh the benefits. Here are some criticisms of actuarial risk assessment tools.

- There is no opportunity to take into account items that are not on the tool when assessing violence risk. Therefore, things that may be conceptually or practically relevant in the actual world may not be incorporated.
- Actuarial assessment tools do not consider situations or context.
- They provide little structure for identifying the degree of intervention necessary to manage risk. And there is no information on the nature of violence (e.g., serious physical injury, sexual violence), the cause of violence, or how risk can be mitigated.

Commonly used actuarial risk assessment tools used include:

- STATIC-99
- Violence Risk Appraisal Guide-Revised (VRAG-R)
- Level of Service Inventory-Revised (LSI-R)

Structured Professional Judgment (SPJ)

Tools that use structured professional judgment are created by identifying risk factors with empirical support rather than significance only in the instrument's development sample. These measures provide definitions for each rated item and rules for how to code them. The SPJ approach allows for professional judgment when making decisions regarding violence risk. While they provide guidelines for evaluators to make decisions, they do not impose strict cutoffs or an algorithm to determine an individual's risk for violence.

Critics of an SPJ approach emphasize how the reliability and validity of evaluations are reduced by allowing for professional judgment to form part of the final decision-making process. However, the benefits of an SPJ approach highlight the utility of an SPJ approach; for example:

- SPJs are individualized; they require evaluators to consider each risk factor's frequency, severity, trajectory, and relevance when making decisions about violence risk.
- Unlike actuarial measures, SPJs assist in developing risk management plans based on understanding an individual's history, current acuity, and sometimes their plans for their future.
- Research has compared actuarial, and SPJ measures and have highlighted that the decisions made using SPJ tools have comparable ability to demonstrate accuracy in forecasting violence (validity), and ratings are consistent between evaluators (reliability). Said differently, decisions based on SPJ tools fare as well or better than decisions made using actuarial measures.

Commonly used structured professional judgment tools include:

- Historical, Clinical, Risk-20 (HCR-20)
- The Short-Term Assessment of Risk and Treatability (START)
- Structured Assessment of Violence Risk in Youth (SAVRY)

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General Violence Risk: A Structured Professional Judgment Approach

Violence is when... A person engaged in an act (or omission) with some degree of willfulness that caused or had the potential to cause physical or psychological harm to another person or persons.

IN THIS POST

General Violence Risk

Violence is not rare; it is a pervasive social problem that takes many distinct forms. Diverse professions are commonly tasked with identifying situations for increased violence risk and individuals who may pose this risk. Then, these professionals are tasked with providing necessary and appropriate recommendations to protect public safety.

Individuals without comprehensive training and experience are less able to accurately perform risk assessments for violence compared to professionals with a well-developed skill set. Therefore, individuals must consider improving their skills.

Historical Clinical Risk Management 20 (HCR-20)

The HCR-20 is the world's leading violence risk assessment instrument. It is a set of professional guidelines which aids in conducting risk assessments and developing and monitoring risk management plans. It is intended to help professionals determine the risk for psychological and physical interpersonal violence by examining 20 items related to an individual's history (H), clinical presentation (C), and risk management problems (R).

The HCR-20 does not use algorithms, cutoffs, or formulas; instead, it utilizes a Structure Professional Judgment (SPJ) approach. It aims to improve and clarify areas of risk assessments, offer guidance on summary risk ratings, and assist in the planning and implementation of risk management. This method provides structure, consistency, discretion, and flexibility. The HCR-20 guides professionals through the conceptualization of violence with an emphasis on intervention and how to manage risk.

Over the years, the authors of the HCR have modified it to reflect changes and growth within the field, making "V3" the third version. This version has been subjected to extensive clinical testing and empirical evaluation, making it more valuable than previous versions. The HCR-20 V3 integrates new insight and novel concepts, prevents evaluators from considering too broad or redundant items, and provides specifications in the assessment process.

Pros & Cons of the HCR-20

Pros

- Research has shown that the HCR-20 performs as well as any other violence risk assessment instrument, perhaps even better.
- It is used in 35 countries and has been translated into 20 languages.
- Ample research has been conducted on its reliability and validity.
- Professionals can use it to monitor a person's risk over time by reevaluating dynamic factors.

Cons

- Most research has been conducted by well-trained evaluators or authors of the tool, raising concern for potential bias (although, currently, no bias has been found).
- There are limited published studies on the HCR-20 V3 from non-Western countries.
- It is not suggested for use with juveniles (other assessment tools have been developed to consider developmental maturity while assessing risk with this population).
- It is slightly better for evaluating the risk for violence in men than in women. However, these gender differences are minor and primarily limited to historical factors.

Administration

Gathering Information

Including primary source information, collateral interviews, record reviews, and other available and relevant information.

Determine the Presence of Risk Factors

Using a multi-level response format, the evaluator reflects the certainty of their opinion.

Assess the Relevance of Risk Factors

A risk factor is relevant if it...

- Contributes to past violence
  - *For example, an individual's lack of stable housing has previously led them to engage in violent behavior to obtain means for survival.*
- Influences a decision to act violently
  - *For example, medication noncompliance may result in an individual becoming symptomatic and engaging in aggressive acts in the community.*

- Impairs one's ability to employ non-violent problem-solving techniques
    - *For example, the individual's recent acts of violence suggest a lack of problem- and emotion-focused coping strategies.*

- Is necessary to manage to mitigate risk
    - *For example, an individual's response to treatment.*

Are you interested in visualizing the administration procedure better? Then, you can download a free rating sheet that evaluators use to summarize their findings!

Qualifications for using the HCR-20

- Considerable professional skill and judgment
- Knowledge of violence
- Expertise in individual assessment - including training and experience in interviewing
- Expertise in mental disorders

Career Enhancement

Psychology is a field of life-long learning. Despite this, learning after earning a degree is often overlooked. Completing training in violence risk assessment and management propels professional development, transforming mental health generalists into specialists thanks to content from leading subject matter experts.

Research has indicated that the use of risk assessment instruments has increased. This increase has equated to increased diversity of professionals conducting these violence risk evaluations. However, the quality of these assessments fluctuates as not all evaluators are appropriately trained.

Learning the HCR-20 will set you apart from other professionals and complete evaluations in a manner consistent with best practice. In addition, you can showcase digital credentials to prospective employers and clients on platforms like LinkedIn, making you more marketable for employment in various settings. Such as in-patient psychiatric units, assisted outpatient treatment teams, and primary and secondary institutions.

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Violence Risk Assessment Case Study: Dangerousness Evaluation Using the HCR-20-V3

Forensic reports take various formats. Below is an example of some of the relevant details that would be included in the final evaluation report.

Nature of the Evaluation

Mr. Jon is a 20-year-old man admitted to a Forensic Psychiatric Center for restoration of fitness. He was charged with Assault in the 2nd Degree and other related charges based on allegations that he yelled at and punched an individual in the face. Specifically, legal records state that Mr. Jon is accused of punching a 63-year-old in the face causing substantial pain, swelling, and bruising. However, Mr. Jon's charges were dropped. Therefore, this evaluation aims to evaluate the risk factors involved regarding a possible transfer to a civil facility.

History of Violence

Mr. Jon has been arrested for violent felonies on two separate occasions. He has engaged in, attempted, and threatened acts of violence against strangers, peers, and staff in the community and institutions. There is no reliable information about Mr. Jon's history of violence as a child or an adolescent to determine if there is a pervasive pattern of violence.

IN THIS POST

History of Other Antisocial Behavior

Mr. Jon has engaged in antisocial behavior other than violence, as evidenced by previous arrests for petit larceny, criminal possession of stolen property, and obstruction of justice.

History of Problems with Relationships

Mr. Jon has a conflicted relationship with his parents; his last contact with his father was two years ago, and he last saw his mother three years ago. He has refused their involvement in his treatment. Mr. Jon's history of romantic relationships is unknown. He is socially isolated and keeps to himself on the ward.

History of Problems with Employment

Mr. Jon dropped out of school in the 8th grade, stating that school was "boring." At that time, he did not obtain employment but played video games. In addition, Mr. Jon has been homeless for the last three years. He has no significant history of employment. While he is entitled to supplemental security income benefits, he does not follow through with renewing these benefits and reported that he supported himself by panhandling.

History of Substance Use

Mr. Jon has a history of substance use, including marijuana and K2 (synthetic marijuana).

History of Major Mental Disorder

Mr. Jon has schizophrenia. When symptomatic, he experiences incoherent speech, agitated and threatening behavior, and endorses paranoid delusions. His medical records note he has been psychiatrically hospitalized at least 20 times, the first being when he was 17. He has been diagnosed with schizophrenia and schizoaffective disorder and treated with the antipsychotics as a mood stabilizer, an antidepressant, and an antianxiety medication.

History of Problems with Treatment or Supervision Response

On numerous occasions, following discharge from inpatient settings, Mr. Jon failed to continue in outpatient treatment or take prescribed medications. As a result, he was in and out of inpatient psychiatric hospitals, residential programs, and outpatient treatment for many years. He was in both Assertive Community Treatment and Assisted Outpatient Treatment. While at the current hospital, Mr. Jon required constant support to wake up, attend therapeutic groups, and for nursing to obtain his vitals. In addition, despite his medication compliance, Mr. Jon experiences only a partial response to treatment as he still endorses paranoid and grandiose delusions.

Recent Problems with Insight

Mr. Jon's insight into his mental illness, substance use, and dangerousness is impaired. He denies having a mental illness and has said that he does not need medication. He noted that he would discontinue his medication upon discharge from the hospital and "self-medicate" with marijuana. His engagement in psychotherapeutic groups is tenuous, and his treatment team describes him as "disinterested." Similarly, he lacks insight into his violent behavior and reasons for engaging in violent acts.

Recent Violent Ideation or Intent

Mr. Jon has not demonstrated frequent thoughts, plans, desires, fantasies, or urges to cause harm to others.

Recent Symptoms of Major Mental Disorder

Despite medication compliance, Mr. Jon continues to state that he works at the Federal Bureau of Investigation's law enforcement training and research center at Quantico in Stafford County, Virginia. At times, his speech is still illogical and non-coherent.

Recent Instability

Despite his current symptoms, Mr. Jon has maintained reasonable behavioral control.

Recent Problems with Treatment or Supervision Response

Mr. Jon has been partially treatment compliant. Initially, he required frequent redirection to follow ward rules and regulations and comply with expectations such as obtaining vitals, but this resistance has decreased throughout treatment. Nevertheless, Mr. Jon still lacks genuine participation in his psychotherapeutic groups. Notably, even in an intensive inpatient treatment facility taking his medication as prescribed, Mr. Jon lacks a complete therapeutic response to treatment as he continues to exhibit psychotic symptoms.

Future Problems with Professional Services & Plans

Mr. Jon has not followed through with outpatient treatment in the past. He denies having a mental illness and said he plans to discontinue his medication upon discharge. Therefore, he requires intense supervision (such as in an inpatient or residential setting) to continue to comply with appropriate professional services.

Future Problems with Living Situation

Mr. Jon wants to live independently upon his discharge; however, he does not have the financial means to do so safely, and his family is currently unwilling to allow him to live in their home. Before his incarceration, Mr. Jon was homeless for several years, supporting himself by panhandling. In addition, he has an extensive history of substance use. He would benefit from an environment that limits the opportunity to obtain and utilizes substances, as they likely are destabilizing for him. Therefore, supportive housing would be an essential and recommended requirement in the future.

Future Problems with Personal Support

Mr. Jon is estranged from his family and has limited opportunities for positive social engagement or recreation. As a result, Mr. Jon does not have a good social network, problem-solving support, or emotional support.

Future Problems with Treatment or Supervision Response

Mr. Jon's lack of insight into his mental illness is a risk factor for noncompliance with treatment in the community. In addition, he demonstrates little motivation for future treatment engagement, and at present, he likely will not cooperate with plans regarding recommended professional services.

Future Problems with Stress or Coping

While not physically assaultive, Mr. Jon was threatening toward staff during his current hospitalization on a few occasions. As a result, Mr. Jon would benefit from learning more problem- and emotion-focused coping strategies to prevent him from engaging in future violence.

Summary

Mr. Jon has a *moderate* risk for future violence. In the past, Mr. Jon has used violence to achieve his goals, such as obtaining money or drugs. From a young age, he has suffered from a psychotic illness. However, his lack of insight and poor treatment responsiveness led to years of noncompliance, which exacerbated his psychotic symptoms. He stated that he does not need medication and plans to discontinue taking his medication upon discharge from the hospital. Medication noncompliance is likely to result in Mr. Jon becoming symptomatic and engaging in aggressive acts to care for himself in the community.

Mr. Jon does not have a realistic plan for a place to live, as he desires to live independently. Further, he does not have the means to support himself. He dropped out of school at a young age resulting in little formal education, and has no meaningful employment history. Mr. Jon has used substances since he was 14 years old. In addition, he is currently estranged from his family. In the past, these factors have led Mr. Jon to engage in violent and antisocial behavior to obtain means for survival and support his substance use.

His lack of education and social support, coupled with his psychotic symptoms and extensive history of substance use, puts Mr. Jon at risk of posing a danger to himself or others if he were to be released from the hospital to the community. These risk factors would be mitigated if he remains in an inpatient psychiatric setting, where his symptoms of mental illness can be mitigated, and he can be linked to transitional housing. It is crucial that Mr. Jon achieve a better treatment response and develop insight into his mental health, need for treatment, and violence risk. With structure and support provided in an institutional setting such as a non-secure hospital, Mr. Jon carries a low to moderate risk for violence.

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Summary

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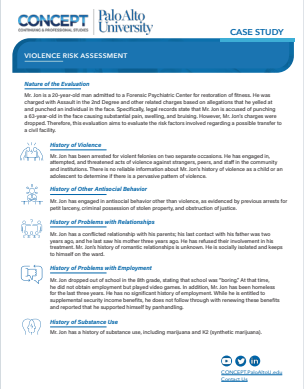
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CASE STUDY

VIOLENCE RISK ASSESSMENT

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Short-Term Assessment of Risk & Treatability (START)

The field of risk assessment has evolved from focusing mainly on risk prediction to more significant consideration of risk formulation and understanding of risk and risk management and reduction. The Short-Term Assessment of Risk & Treatability (START) is a guide that was developed to evaluate an individual's risk for aggression and their likelihood of responding well to treatment. The START moves the assessment from assessing an individual's vulnerability to violence and aggression to intervening and informing clinical interventions and the development of treatment plans. This tool guides the assessor in performing repeated evaluations and documenting treatment and management modifications as needed. Completing the START helps identify who is at risk from which person(s), under what circumstances, with what likely adverse effect(s), and over what period. The START unites research with clinical practice by relying on clinical expertise with a structured application.

Objectives of the START

- Inform treatment and risk management
- Describe individual clinical profiles
- Monitor progress and treatment outcomes
- Improve management of transitions
- Provide common language across disciplines

Administration

The START is coded to evaluate short-term risk by considering historical functioning coupled with the individual's recent and current functioning. The assessment is focused on a person's attitude, functioning, and behavior. Administration requires users to rate 20 clinical items for strength and vulnerability independently. Individuals can be high or low on strength and vulnerability for any item.

Research suggests that once familiar with the START, the time for administration is approximately 30 minutes. Research has also supported the assertion that information coded on the START is information that clinicians can readily locate or solicit - rarely, a start can not be completed in its entirety. Therefore, if a clinician cannot complete a START due to missing information, it indicates that the assessor should obtain collateral or meet with the person again, as these items reflect information that should be known about the patient for well-informed treatment.

Using a risk-needs-responsivity approach, assessors identify which items on the START are particularly relevant to the evaluee. For example, if an item is either presently or historically a particular strength that can be used in treatment (e.g., therapeutic lever), it is indicated as a key item. Similarly, if an item is a particular vulnerability that requires increased supervision and treatment planning, it would be marked as a critical item (e.g., a red flag). While there is no hard and fast rule, key and critical item ratings should be done parsimoniously.

These 20 strengths and vulnerabilities are rated to evaluate the risk of externalizing (violence towards others), internalizing (suicide, self-harm, and substance use), and high-risk behaviors (self-neglect, being victimized by others, and unauthorized absences) on a three-point scale (Low, Moderate, High). This step promotes an understanding of what factors are relevant to specific types of risk and what factors could be helpful to reduce or mitigate risk.

For use among adults (18 years & older) with:

- Mental disorders
- Substance use disorders
- Personality disorders
- Criminal justice involvement

The Difference Between the START and Other Risk Assessment Tools

Assessing protective factors, strengths, and assets can help develop a therapeutic alliance. It can be beneficial for the individuals to know that these factors are also being considered.

1. It includes ***dynamic variables***, which are beneficial to informing shorter-term decision-making.
2. ***Short-term assessments*** can inform daily practice.
3. Professionals who conduct risk assessments can make recommendations or provide ***comprehensive care***. The START does not just look at an individual's risk for violence. It also incorporates items that can improve mental and physical health.

When and Where Can the START be Used?

- **Mental Health Diversion Programs** - to keep individuals out of jails can be used as a referral tool and a tool for care planning.
- **Forensics Psychiatric Hospitals** - help guide treatment to eventually transition individuals out of what is otherwise seen as a very static setting.
- **Civil Psychiatric Hospitals** - can be completed during intake while gathering other relevant information. It is beneficial to have a plan in place for patients and baseline data to evaluate changes in stability.
- **Correctional Facilities** - beneficial for transitioning back to the community to understand what resources an individual needs to keep them and others safe.

Pros and Cons of the START

Pros

- Comprehensive: The START can improve client care and enhance community safety.
- Transparent: When completing the START, the assessor identifies how long the estimates are valid.
- Sensitive to change over time: Individuals' risk ratings change as they move through a hospital continuum (e.g., from max to minimum security).
- Good psychometrics
    - Across professions, individuals tend to get the same rating using the START.
    - Changes in dynamic risk factors are reliably associated with institutional violence.
    - Strong demonstration of convergent and divergent validity with other risk assessment measures.
    - User satisfaction: User-friendliness and clinical utility.

- Common language: During transitional points, professionals who regularly use the START can garner a comprehensive and concise picture of the patient.
- Identification of treatment targets
  - Provides a framework to ensure consistent and comprehensive evaluations and interventions.
  - Allows for the prioritization of care.
- Translated into ten different languages and used in 22 countries

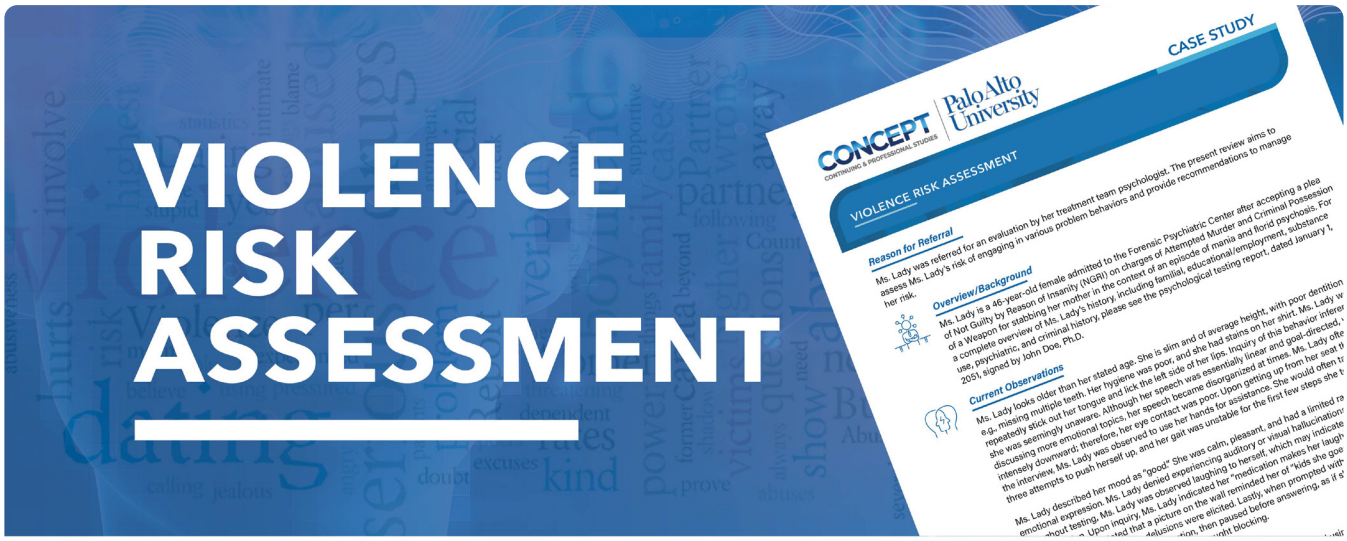
Cons

- An assessor would need to administer the START several times to see an individual's change.
- The dynamic factors may have a shorter shelf life as the dynamic factors constantly change. Regularly completing a START for all patients on an individual caseload can be time-consuming.

The Business of Practice

Violence Risk Assessment Case Study: Dangerousness Evaluation using the START

Forensic reports take various formats. Below is an example of some of the relevant details that would be included in the final evaluation report.



IN THIS POST

Reason for Referral

Ms. Lady was referred for an evaluation by her treatment team psychologist. The present review aims to assess Ms. Lady's risk of engaging in various problem behaviors and provide recommendations to manage her risk.

Overview/Background

Ms. Lady is a 46-year-old female admitted to the Forensic Psychiatric Center after accepting a plea of Not Guilty by Reason of Insanity (NGRI) on charges of Attempted Murder and Criminal Possession of a Weapon for stabbing her mother in the context of an episode of mania and florid psychosis. For a complete overview of Ms. Lady's history, including familial, educational/employment, substance use, psychiatric, and criminal history, please see the psychological testing report, dated January 1, 2051, signed by John Doe, Ph.D.

Current Observations

Ms. Lady looks older than her stated age. She is slim and of average height, with poor dentition, e.g., missing multiple teeth. Her hygiene was poor, and she had stains on her shirt. Ms. Lady would repeatedly stick out her tongue and lick the left side of her lips. Inquiry into this behavior confirmed that she was unaware she was doing it. Although her speech was essentially linear and goal-directed, when discussing more emotional topics, her speech became disorganized at times. Ms. Lady often stared intensely

downward, making poor eye contact. Upon getting up from her seat throughout the interview, Ms. Lady was observed to use her hands for assistance. It would often take her two or three attempts to push herself up, and her gait was unstable for the first few steps she took.

Ms. Lady described her mood as "good." She was calm, pleasant, and had a limited range of emotional expression. Ms. Lady denied experiencing auditory or visual hallucinations. However, throughout testing, Ms. Lady was observed laughing to herself, which may indicate internal preoccupation. Upon inquiry, Ms. Lady said her "medication makes her laugh" and, on another occasion, stated that a picture on the wall reminded her of "kids she goes to school with." No paranoid or persecutory delusions were elicited. Lastly, when prompted with a question, Ms. Lady repeated one word of the question, then paused before answering as if she was searching for the words or experiencing thought blocking (when an individual is suddenly unable to think, speak, or respond to events happening around them).

Risk Assessment Formulation

To assess Ms. Lady's risk in several domains, Ms. Lady was evaluated using the Short Term Assessment of Risk and Treatability (START). The START is a 20-item instrument inclusive of dynamic (i.e., those that can be modified with interventions and monitoring) risk and protective factors. The START is used to evaluate violence and other problem behaviors and was coded focusing on information, behaviors, and symptoms within the preceding three months since her admission. An assessment of risk was based on her projected functioning for the next three months, focusing on risk while at the Forensic Hospital.

Risk of Violence

According to her records, Ms. Lady stabbed her mother, Mrs. Lady, several times in the face, neck, and upper torso, actions that resulted in her death. In the hours before the offense, Ms. Lady had a "vision" of a child warning her to protect her mother.

Since then, Ms. Lady has engaged in various acts of violence. She reported one prior physical altercation while in jail, which resulted from another inmate threatening her. She also said she had verbally argued with other inmates while in jail but reported that she did not receive any incident reports or sanctions. Despite having a history of physical aggression, Ms. Lady has not had any violent incidents or arguments with staff or patients.

Currently, Ms. Lady poses a *Moderate* risk of violence in the hospital. While she has not been violent since she was admitted to the hospital and progress notes document, she keeps to herself and complies with ward policies and procedures. She presents a history of poor impulse control that has led to her violent behavior. Further, although limited, she could name some coping strategies for when she experiences symptoms or is triggered, including drinking water and coloring, which help her calm down. Ms. Lady reported being triggered by things in her environment, such as loud noises, but thus far has been able to cope with these situational factors adequately. Further, she appears to benefit from having social support as she reported speaking to her friend and sister on the phone throughout the week. Social support and coping skills likely protect Ms. Lady from acting aggressively in the hospital.

Risk of Being Victimized

Ms. Lady reported experiencing harmful and traumatic events during her childhood and adulthood. She described being sexually assaulted by her cousin when she was 13 years old and by a roommate for two years as an adult. Additionally, she reported a history of perpetrating and experiencing emotional abuse from her mother and aunt throughout her life. These experiences likely disrupted her normative development and learning of problem-solving skills. Additionally, Ms. Lady experienced her brother's death while being institutionalized. Treatment team members have opined that she may harbor potential "unprocessed grief and has not fully processed the loss of her mother and brother. Lastly, Ms. Lady presents as frail. She struggled to get up from her seat and was uneasy on her feet upon standing. This may suggest to others that she is an easy target, as she cannot physically defend herself or easily remove herself from the situation.

Ms. Lady presents a *High* risk of being victimized. Although the secure nature of the Forensic Hospital will ideally protect against occurrences of victimization, Ms. Lady is isolated on the ward and reports not having trust in her treatment team. Therefore, she is unlikely to report times when she may feel unsafe to staff or trusted peers. For instance, Ms. Lady detailed an event where a male patient approached her in the recreation yard and sat next to her while staring at her; she did not discuss these instances with her treatment team. Further, Ms. Lady's history includes situations where she has exercised poor judgment. For example, she reported being raped by a roommate over two years. Although she did not provide extensive details about these circumstances, her report of the occurrence does not reflect an attempt to leave this situation, which may have resulted from limited housing options, as she also reported a history of homelessness. Finally, Ms. Lady demonstrated low self-worth and appeared desensitized by trauma as she described past trauma in a monotone voice with no fluctuation in affect. These factors contribute to her risk of victimization while in the hospital.

Risk of Self-Harm and Risk of Suicide

Ms. Lady has engaged in self-injurious behavior when acutely psychotic and depressed. Ms. Lady reported numerous prior suicide attempts beginning when she was 12. During her first suicide attempt, she planned to overdose on unspecified pills but threw up in the process; she said she did not tell anyone about her attempt. During her current hospitalization, she attempted suicide by swallowing her commissary key twice. She has also refused food to the point where she has become medically unstable, requiring hospitalization. She has a long history of thoughts of suicide and self-harm, particularly in the face of stressors, for example, during periods of adjustment to incarceration and institutionalization. An extended period of stability on her medication regimen may confer some protection; however, Ms. Lady remains at risk for future suicidal thoughts or self-injurious behavior. During the evaluation, Ms. Lady denied current suicidal ideation or plans to engage in self-injurious behaviors.

Currently, Ms. Lady presents a *High* risk of self-harm and suicide. While the secure nature of the hospital will likely serve as a protective factor against her risk in these domains, Ms. Lady presents with poor impulse control and a lack of adequate coping skills. In addition, she engaged in a previous suicide attempt while hospitalized and under observation, increasing her risk of suicide in an institutional setting. She reported that she often decides to attempt suicide impulsively. Thus far, she has not demonstrated adequate coping skills to protect against such impulsivity in the hospital.

Risk of Unauthorized Leave

There is no evidence that Ms. Lady has attempted to elope from a hospital. Additionally, she reported at least a superficial understanding that she needs to adhere to the rules while in the hospital. Although she is unhappy about currently being hospitalized, she stated she usually follows the rules and plans to continue to do. Additionally, Ms. Lady has a history of homelessness, and the two individuals that provide her social support are either out of state or incarcerated at this time and thus inaccessible to her. Therefore, Ms. Lady's risk of unauthorized leave is *Low*.

Risk of Substance Abuse

Ms. Lady has a history significant of using multiple substances, including alcohol, marijuana, cocaine, ecstasy, and others. Her substance use has aggravated her psychotic and mood symptoms and violence in the past. She reported a history of engaging in physical aggression in the context of consuming alcohol; however, she indicated that none of the physical fights she has engaged in have resulted in severe injuries to anyone involved. Ms. Lady's treatment should support her in making considerable strides in understanding the link between her substance use, psychiatric decompensation, and violence. At present, she does not demonstrate a solid commitment to continuing sobriety. For Ms. Lady, substance use exacerbates her psychiatric symptoms and, subsequently, her risk for violence. While in the hospital, Ms. Lady's risk of substance use is *Low*. She is unlikely to be exposed to drugs or alcohol; however, if substances become available in contraband, she may try to obtain them.

Risk of Self-Neglect

Ms. Lady's risk of self-neglect is *Moderate*. During the current evaluation, Ms. Lady appeared not to have showered recently and had stains on her clothing. Nursing notes document encouragement to attend self-care practices such as showering and changing her clothes. Ms. Lady reported that she has been sleeping less recently and requires sleeping medication. Ms. Lady could not identify a reason for the recent change in her sleep hygiene. Ms. Lady has demonstrated medication compliance (supported by hospital records). Her self-care practices, medication compliance, sleep, and overall health should be monitored.

START-Strengths

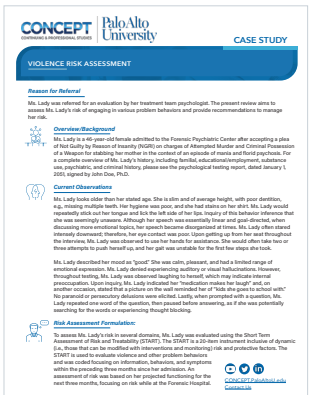
Although Ms. Lady presents several risk factors for victimization, self-harm, suicide, substance abuse, and self-neglect, she presents strengths that may lessen the likelihood of these behaviors. Specifically, Ms. Lady has complied with her psychotropic medications while at the hospital. Although she is still experiencing psychiatric symptoms, her compliance with these medications has likely helped stabilize some of her symptoms and brighten her emotional expression. Further, Ms. Lady perceives herself as having social support. She reportedly speaks to her sister daily and her friend at least once weekly over the phone. She also reported that she is looking forward to events in the future, such as the hospital BBQ.

Summary and Recommendations:

In summary, Ms. Lady presents a *High* risk of victimization and self-harm, suicide, and a *Moderate* risk of violence and self-neglect. Her risk is the presence of ongoing mood and psychotic psychiatric symptoms, impulsivity, trauma history, and lack of coping skills. She demonstrates *Low* risk in the START domains of substance use and unauthorized leave. Given Ms. Lady's ongoing psychiatric symptoms, it is recommended that she continue to meet with her psychiatrist to reassess her treatment needs/medications.

Ms. Lady will likely benefit from interventions that will enable her to cope more effectively with her low mood, irritability, and distress without self-harm. Additionally, Ms. Lady would benefit from groups that will help her to utilize current coping skills (e.g., drawing, reading) and develop new skills, regulate her emotions, tolerate frustrations, and effectively communicate her needs. She may also benefit from individual therapy that focuses on helping her to process her history of interpersonal trauma and develop trust with her treatment team to help her alleviate some of her negative emotions when she is in distress. Moreover, Ms. Lady should have the opportunity to process the losses of her brother and mother, as the lingering grief may be a destabilizing factor and increase her violence.

Violence Risk Assessment Certificate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CASE STUDY

VIOLENCE RISK ASSESSMENT

Reason for Referral

Ms. Lady was referred for an evaluation by her treatment team psychologist. The present review aims to assess Ms. Lady's risk of engaging in various problem behaviors and provide recommendations to manage her risk.

Overview/Background

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Juvenile General Violence Risk Assessments

Adolescent violence risk assessment research emerged in the late 1990s and early 2000s. Since then, many measures for assessing violence and re-offense risk in adolescents have been developed. While the use of risk assessment instruments is established as a best practice in juvenile justice systems, the selection of the specific tool most appropriate is not straightforward due to the variety of options.

IN THIS POST

Developmental Change

Assessing risk in the presence of developmental change introduces great uncertainty with juveniles. Unlike adults, who typically present with long-standing behavior patterns, adolescents have minimal life experience and may offer little reliable evidence of a stable pattern helpful in gauging risk. As adolescents' behaviors, emotional expressions, peer groups, and decision-making are inherently evolving, assessing risk within this population is akin to hitting a moving target.

Risk Assessments

Risk assessments essentially inform and guide management decisions and, as such, have often become a mechanism for denial of liberty by removing the youth from their caregivers and the community. Informed management decisions are crucial since incorrectly prescribing an intensive intervention, such as placement in correctional or residential settings for youth with relatively few risks, may result in iatrogenic treatment effects. Over-prescription of services not only depletes scarce resources but may do more harm than good. For example, when mixing individuals with few risk factors with more antisocial or sexually deviant youth, their developmental trajectory may be negatively altered. Researchers have proposed matching juveniles with tailored management plans that target individual risk and protective factors.

Adolescence is a period of significant flux that must be captured by factors capable of assessing change. The fickleness of behaviors, emotions, and decision-making during adolescence affects not just assessments of risk but also diagnostic and prognostic assessments. The challenges of assessing juveniles are myriad, including, most notably, the dynamic changes that occur with development and maturation irrespective of criminal behavior. In addition, juveniles are effectively subject to the potentially harmful, enduring effects of risk assessment, including stigmatizing labels, absent any procedural due process rights afforded by judicial review.

Decision points in which a juvenile's risk may be assessed

- Dispositional planning during family court
- Requested by legal and correctional professionals before adjudication
- For the legal system, during the adjudicatory process
- Conducted by child welfare workers responding to reports of a child that is sexually abusive or aggressively acting out
- Mental health professionals considering placement or discharge from a residential facility
- Mental health facilities and professionals receiving post-adjudication referrals for treatment
- The Sex Offender Assessment Board or judges considering registration level
- Examiners evaluating a youngster for civil commitment

These decisions hinge on reliable, valid assessments of risk and needs. An evidence-driven risk and needs assessment can provide an empirically based roadmap for informing:

- Discretionary decisions about **the safe management of juveniles**, ensuring that the most intensive and restrictive interventions and placements are reserved for those who pose the most significant risk coupled with the least restrictive placement possible to assist with positive youth development
- Community-based **aftercare planning** from correctional facilities or treatment programs
- **Treatment planning** concerning risk-relevant needs can support youth in developing prosocial, healthy relationships and lifestyles

Any progress that lays the groundwork for more effective (and more humane) management strategies, improved treatment interventions, and more accurate and informative screening tools that reduce contact with the juvenile justice or child welfare system is beneficial.

Structured Professional Judgment

Numerous juvenile risk assessment measures are available, consistent with actuarial and structured professional judgment (SPJ) approaches. Such measures differ from adult risk assessment measures because they incorporate risk factors considered uniquely relevant to juveniles. As a result of the development of such measures, risk predictions in recent years have been more accurate than before their development.

The SPJ approach helps to focus the evaluator on relevant data to gather during interviews and record reviews so that the final judgment, although not statistical, is well informed by the best available research.

The Short-Term Assessment of Risk and Treatability: Adolescent Version (START:AV)

The START:AV aims to facilitate and structure the prevention of harm. It guides each assessment of a youth's vulnerabilities that contribute to adverse outcomes and their strengths that help protect against them. The START:AV includes assessing harm to others and rule violations, for example, violence, non-violent offenses, substance abuse, unauthorized absences such as running away and school drop-out, and harm to self, including suicide, non-suicidal self-injury, victimization, health neglect. It was adapted for adolescents from the START, a well-established adult measure. Research has demonstrated that the START:AV can predict adverse outcomes and assist in intervention planning.

The START:AV Is intended for use with male and female adolescents aged 12-18 in mental health and legal settings. It has several defining characters:

- Comprehensive and Integrative Examination of Risks
- Strengths *and* Vulnerabilities
- Individualized Assessments Taking into Account Context
- Focus on Intervention Planning
- Structured Yet Flexible

The START:AV is completed using information routinely collected in any competent assessment. Therefore, it can quite easily be integrated into routine practice. The developers of the instrument emphasized the importance of collecting information on each item from multiple sources, such as the adolescent, caregivers, other collaterals, and records.

Adolescents are embedded in their environment, more so than adults. Therefore, the START:AV emphasizes relationships and the environment more than some adult risk assessment instruments. The START:AV examines various areas of functioning such as behavioral, emotional, cognitive, and interpersonal functioning. In addition, relationships and the environment are also central. Therefore, relationships with caregivers and other involved adults, relationships with peers, and considering aspects of the community are integral to a comprehensive assessment.

The Structured Assessment of Violence Risk in Youth (SAVRY)

The SAVRY incorporates risk factors related to assessing generalized violence potential in adolescent populations, ranging in age from 12 to 18 years. Based on their summary risk scores, it is designed to help categorize those likely to require more intensive monitoring and targeted interventions.

The SAVRY was developed to address the need for an instrument to assess generalized violence risk in an adolescent population. Implementation research detected violence in adolescent populations. The SAVRY was modeled after the HCR-20, and modifications were made in the item content to include risk factors derived from research and literature on child development, violence, and aggression specific to adolescence. It has 24 items that are divided into three scales:

- Historical
- Social/Contextual
- Individual/Clinical

The total score on the SAVRY has been demonstrated to be a good predictor of violence across a variety of settings and diverse populations. Researchers have also found significant correlations between the SAVRY scales and violent behavior.

The SAVRY is unique as it has protective factors that lower the violence risk. For example, prosocial involvement, strong social support, strong attachments, a positive attitude toward intervention and authority, a strong commitment to school, and resilient personality traits. In addition, research has demonstrated that the protective factor scale on the SAVRY adds to the incremental validity of the SAVRY total score, which supports the notion that protective factors should be integrated into juvenile risk assessments.

The SAVRY may offer insights into identifying youth at risk for violence and those dimensions or risk factors that may distinguish potentially violent from non-violent youth. Research has suggested that using validated assessment tools such as the SAVRY for focusing interventions on the dynamic risk factors may prove to be an effective strategy for identifying and improving outcomes for at-risk youth.

General Personality Measures

The Minnesota Multiphasic Personality Inventory MMPI-A (and MMPI-A-RF)

The MMPI was published in 1943, and by the mid-1980s, it was the third most frequently used test for adolescents. Due to concerns about the length, the norms, and the wording of the tool, the MMPI-A was developed in 1992. The MMPI-A is shorter, normed on 14–18-year-olds, and contains scales specific to adolescents. More recently, the MMPI-A-RF was created, as the length of the MMPI-A was still viewed by some as a significant disadvantage.

While the MMPI is not a risk assessment tool, it may be helpful to incorporate the MMPI-A/MMPI-A-RF in juvenile forensic evaluations. For example, in a risk assessment, considering the individual's current functioning and their response style might not be captured when using just a formal risk assessment instrument. In addition, the MMPI-A-RF has juvenile forensic comparison groups of males and females in various parts of the United States and other standard comparison groups (e.g., medical setting, school setting).

The MMPI-A-RF thoroughly assesses mental health treatment needs and potential personality/behavioral barriers. These assessment instruments also have scales that have empirical correlates and diagnostic and treatment considerations.

For example:

- The **Behavioral/Externalizing Dysfunction** scale has empirical correlates with difficulties associated with under-controlled behavior (e.g., school suspensions or running away). Elevations suggest the adolescent should be evaluated for externalizing disorders such as conduct disorder and opposition-defiant disorder.
- The **Antisocial Behavior** scale has similar empirical correlates and diagnostic considerations. Elevations on this scale also suggest that youth is evaluated for substance-related disorders and that initial targets for treatment interventions should focus on impulsive and conduct disordered behaviors.

Administration of the MMPI-A/MMPI-A-RF

- The adolescent should be 14-18 years old
- The adolescent must be able to read and comprehend the items
  - Administrations should review the instructions with the adolescent
  - Administrations should not explain test items to the youth
- The adolescent should be in an appropriately supervised environment
  - Provide a noise-free environment
  - The booklet can not go home with the youth
- The adolescent must be willing to tolerate testing
  - Establish rapport before testing

Psychopathy Checklist: Youth Version (PCL:YV)

The PCL:YV was primarily designed as a measure of psychopathic traits rather than a risk assessment tool, although it has been shown to be associated with violent behavior in several studies. Therefore, it is not surprising that research has found other assessment tools better predictors of recidivism than the PCL:YV.

Psychopathy is conceptually different from other disorders in youth, necessitating using assessment measures to tap into adolescent psychopathic traits. Currently, the most commonly used assessment instruments have been interview and file review ratings using a modified version of the PCL-R, known as the Psychopathy Checklist: Youth Version (PCL:YV).

The PCL:YV attempts to tap into the critical interpersonal and behavioral traits associated with the construct of psychopathy. Research utilizing the PCL:YV strongly suggests that psychopathic traits can be observed and measured. Using these measures has given researchers and clinicians the ability to understand specific personality correlates associated with psychopathic-like behavior in adolescents.

Like the adult PCL-R, the PCL:YV is a rating scale designed to assess the 20 core characteristics of psychopathy in youth ages 12 to 18. Psychopathy is assumed to manifest in the same way in juveniles as adults, but modifications to scoring criteria to achieve a sharper focus on adjustment. While it is based on the PCL-R, the PCL:YV items are specific to adults and added in items more appropriately tailored to youth life experiences, such as family life, school, and peer relationships.

> For example, *unstable personal relationships* replaced *many short-term marital relationships*, and items like *impression management* were added while *glibness/superficial charm* was removed.

Why Assess for Psychopathy

Developmental research on emotions and conscience suggests that psychopathy may emerge early. Research findings suggest that psychopathic features may be markers for youth at relatively higher risk for severe and prolonged antisocial behavior. Identifying those at-risk youth may also lead to earlier treatment at a time when adolescents, whose personalities are not yet fully formed, would theoretically be more amenable to treatment.

Despite the known associations between psychopathy and antisocial behavior, there are concerns about the use of this construct in adolescents. For example:

- **Insufficient evidence of this construct**
  - Unlike adults, youth cannot demonstrate a long-term stable personality
  - The ability to use good judgment, understand other's perspectives, and have a stable sense of self are all in flux, which makes it challenging to assess traits such as *lack of empathy* and *grandiosity*
- **Developmental appropriateness**
  - Some degree of delinquent behavior is developmentally normal
  - Antisocial behaviors that are associated with a psychopath may be transitory
- **Stigmatizing nature of this construct**
  - Adolescents may be mislabeled as a psychopath, and this label may be a lifelong high stigmatized burden
  - Clinicians, families, and the courts may all assume a poor prognosis for those youth identified with psychopathic traits. As a result, these youth may lose out on resources and opportunities for treatment as they're categorized as "psychopaths."

Psychopathy versus conduct disorders

- Symptom constellation beyond what is included in the criteria sets of DSM diagnoses
- Researchers found conceptual differences between psychopathy and conduct disorders: types of aggressive behaviors (e.g., reactive and proactive aggression), social skills, and intellectual and emotional functioning
- Beyond APD and its childhood variants and overt behavioral symptoms, factor analyses of the construct of psychopathy revealed an interpersonal affective facet as well as behavioral/antisocial components

Administration

- Decisions made by expert raters who are specifically trained in the measure.
- Involves a face-to-face, structured interview where raters can conduct behavioral observations.
- These evaluators meet the juvenile for the sole purpose of conducting the interview, so they are not involved with the juvenile, allowing for less subjectivity. PCL:YV ratings are based on the combination of information from various sources. Data from interviews, behavioral observation, and file reviews are integrated, making the scores less subjective than individual ratings.

Pros

- Research has found that the PCL:YV significantly predicted any general, non-violent, and violent recidivism in the aggregate sample over a 7-year follow-up
- Predicted youth recidivism for subsamples of female and Aboriginal youths
- Very few differences in the predictive accuracy of the tool were observed for younger vs. older adolescent groups

Cons

- Resource intensive and require several hours for completion and specialized training
- Limited to use with institutionalized populations for whom there is access to files of past behaviors, and even in a forensic or prison setting, the file is not always complete or accessible
- Questions about the applicability of PCL measures to noninstitutionalized populations for whom there is no history of criminal behavior or institutional files
- Research has found that the lack of long-term predictive power for the PCL:YV and psychopathy designations varied with different measures is concerning when the use of such efforts is the basis for legal or clinical treatment decisions

The Juvenile-Sex Offender Assessment Protocol (J-SOAP-II)

Although some similarities exist between sexual and non-sexual offenders, sexual offenders have some unique characteristics. Therefore, the best practice is to use specialized sexual offending tools with individuals at risk of sexual offending.

Although psychosocial and psychosexual assessments are routinely sought at the time of commitment, examinations executed to aid or assist with legal decisions typically focus on the presumptive risk posed by the adolescent. Development and testing of risk scales for juvenile sex offenders began in earnest in the mid-1990s, with the first scale reaching publication in 2000.

Beyond registration and community notification, juveniles can be civilly committed in some states under a Sexually Violent Predator (SVP) statute. SVP commitments occur after an individual has been incarcerated for a sexual offense, and thus SVP commitments do not require a recent crime to have occurred.

J-SOAP-II is a risk assessment scale routinely used to assess risk among juvenile sex offenders. *The J-SOAP Manual explicitly states that the J-SOAP has no cut-off scores (i.e., no designation of low-, moderate- or high-risk levels is provided).* Instead, users are instructed to report results as "proportions of observed risk" by dividing the rated score by the total possible score.

Pros

- Total scores on the J-SOAP-II predicted sexual recidivism with relatively equal efficacy as other youth and adult sexual risk assessment scales
- Widespread use of the scale, nationally and internationally – standardizing the assessment of risk factors
- Adequate interrater reliability

Cons

- Well over half of the items are static
- The typical 3-point ratings may optimize inter-rater reliability but at the price of sacrificing a range of severity needed for a more accurate prediction
- Low base rate of sexual offending limits predictive validity and increases the risk of making a false positive decision (e.g., saying youth is high risk when they are not)
- Scale 3 of the J-SOAP was intended to capture change as a treatment function. However, while it is theoretically essential, the research found that it was suboptimal in predictive accuracy.
- J-SOAP II does not directly assess the presence of protective factors

Want something more in depth Interested professionals are also encouraged to check out the Juvenile Forensic Assessment Certificate, a curriculum comprised of 70 hours of foundational training in forensic psychology and 80 hours of specialty training in juvenile forensic assessments!

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The Business of Practice

Intimate Partner Violence (SARA-V3 & B-SAFER-2)

Intimate Partner Violence (IPV), sometimes referred to as spousal assault, partner assault, spousal violence, and domestic violence—is the actual, attempted, or threatened physical harm of a current or former intimate partner.

IN THIS POST

What Is Intimate Partner Violence?

It is a broad definition so that any type of violence in a sexual or romantic relationship is included regardless of the relationship's legal status or the gender of the individuals involved. However, severe IPV is most often perpetrated by males against females.

IPV is different from violent crimes committed against strangers. As a result of the close relationship between the perpetrator and victim, the violence is more frequent and severe. The access and proximity of the victim and the perpetrator of IPV increase the frequency of violence. Close emotional attachment increases the severity, and intense emotions can result in extreme physical or psychological harm. IPV results in victims experiencing a profound loss of safety and security.

Intimate Partner Violence Risk Assessments

In general, violence risk assessments have multiple goals:

- Prevent Violence
- Guide Interventions
- Protect Patient Rights

Risk assessments specific to IPV are concerned with gathering information to make decisions regarding an individual's risk of *perpetrating* intimate partner violence. Evaluators are to speculate about how and why an individual would choose to commit violence and consider how past choices may impact future decisions.

An IPV risk assessment focuses on a person's decision concerning IPV. Said differently, it is to understand what someone is trying to accomplish by committing a specific act of violence against a particular victim at a certain time – but not other acts- against other victims at different times.

It is difficult for criminal justice, physical and mental health, postsecondary, and victim support professionals to determine who has the greatest need for services and which services are most needed. Risk assessments are essential for effective case management. A thorough risk assessment can answer questions such as

- Who is appropriate for what kind of treatment?
- Who is most likely to assault a partner?
- Which victims should be advised to take protective measures?
- Can a perpetrator be safely managed in the community?

The Spousal Assault Risk Assessment Guide (SARA)

Development of the SARA

Spousal Assault Risk Assessment Guide Version 3 (SARA-V3) was bred from 21 years of professional experience and scientific research. As it is the third version, it is evident that the instrument has gone through previous iterations, with the first version published in 1994. Since then, there has been a growth in awareness related to IPV. Shortly after, in 1995, SARA V2 was published. Over the following 16 years, the IPV literature expanded tremendously; therefore, the SARA V3 reflects advancements in knowledge. In addition, V3 incorporated steps to guide the formulation of violence perpetration and management based on advancements in the empirical literature on professional decision-making.

IPV Assessment Using the SARA-V3

The SARA-V3 is divided into three domains. The nature of IPV (8 factors) is related to the pattern of any IPV behavior perpetrated by the individual being evaluated. Perpetrator Risk Factors (10 factors) are related to the psychosocial adjustment and background of the evaluee. And, Victim Vulnerability Factors (6 factors) reflect the psychosocial adjustment and background of the *potential* victim.

Development of the SARA-V3 incorporated victim vulnerability factors. These items assess common hurdles to a victim's ability and motivation to utilize self-protective behaviors. These factors are critical to developing realistic and comprehensive safety plans.

- **Nature of IPV** - Characterize the seriousness of the evaluee's IPV
- **Perpetrator Risk Factors** - Characteristics of the evaluee that may be associated with decisions to engage in IPV
- **Victim Vulnerability Factors** - Characteristics of the victim that may be related to decisions to engage in self-protective behavior

Why Use The SARA For Intimate Partner Violence Risk Assessments?

Decisions about risk should not rely on unstructured clinical judgment. They should not be informal or depend on intuition or an impression. Any kind of structure is better than no structure at all.

Pros and Cons of the Sara

Pros

- Empirical support for reliability and validity
- Peer-reviewed studies, Government reports, Conference papers/presentations, Doctoral dissertations, and Master theses have all examined different aspects of the SARA
- Use with various professionals in many settings
    - Criminal justice, victim support, security, post-secondary, mental health, and medical professionals
- Translated into 10 languages and used across six continents
- For use with male and female aged 18 and over, sexual orientation, and culture
    - It may be used with the assistance and guidance of (the limited) empirical research for IPV among individuals 15-18 years old
- Can be used in conjunction with other SPJ tools if IPV has unique characteristics (e.g., if paraphilia is apparent in sexual assault evaluators can add the RSVP)

Cons

- Can not “determine” if someone has committed IPV
- The most recent version was published in 2015
- Administration can be time-consuming, it is not a screening tool
- Research is limited to indicate if the SARA is applicable with gender identities other than male and female

B-SAFER-2

Due to the widespread use of the SARA and its acceptance among mental health, correctional, and other professionals, law enforcement agencies requested a structured professional judgment tool for use in criminal justice settings. Therefore, the authors developed the Brief Spousal Assault Form for the Evaluation of Risk (B-SAFER). In some European countries, the B-SAFER is known as the Police Version of the SARA, or the SARA-PV. As intimate partner violence (IPV) literature grew and evolved, the developers of the B-SAFER created an updated edition, which was notable for including victim vulnerability factors and the usual perpetrator risk factors.

Approaches to IPV Risk Assessment

In the field of IPV, the structured professional judgment (SPJ) approach was used to develop the Spousal Assault Risk Assessment guide (SARA) and the Brief Spousal Assault Form for the Evaluation of Risk (B-SAFER). The SPJ approach bridges the gap between unstructured clinical judgment and an actuarial approach to decision-making.

- **Actuarial decision-making** is transparent, and it has demonstrated consistency and utility. One common concern raised with actuarial decision-making related to risk assessments is its focus on violence prediction rather than violence prevention.

- **Unstructured decision-making** was the most common approach to assessing risk. It is considered "intuitive" and has been praised for its efficiency (low cost, time, and resources) and adaptability (which can be used in many contexts). However, there is little empirical evidence, and it is difficult for individuals to explain how they have made a given decision.

Application of the IPV Assessment Tools

The SARA-V3 is intended for use by criminal justice, victim support, security, human resources, post-secondary, medical, and mental health professionals working in various contexts where concerns about IPV arise. It is crucial and necessary to conduct risk assessments in criminal and civil justice and health care settings. For example, risk assessments may guide arrest, charges, detention, and sentencing decisions in the criminal legal system. In a civil legal system, IPV evaluations may be critical to decisions made in divorce proceedings, to protect spouses and children, or in an occupational setting to safeguard employees from IPV that may emerge in a workplace. Lastly, health care professionals may use risk assessments to make decisions related to prioritizing or triaging a case, treatability, and to gauge treatment gains.

Evaluator Qualifications

Outside of conforming to relevant laws, policies, and professional guidelines, evaluators should have expertise in:

1. **Assessment:** Training or professional work experience
2. **Intimate Partner Violence:** coursework, work-related experience, or knowledge of IPV literature
3. **Mental Health:** Users are not required to make a diagnosis; however, factors are present that are related to mental health disorders that require familiarity

Evaluators can complete specific training programs in the SARA and the B-SAFER to gain familiarity with the user manual, critical advances in IPV knowledge, and complete practice cases and review gold standard ratings.

Professional Benefits of Being Trained to Use the SARA-V3 & B-SAFER-2

These SPJ tools guide professional assessment to efficiently consider the salient risk factors, etiology, trauma, and adverse life events of those who perpetrate or are victims of IPV. This knowledge can open the door to careers in institutions with specialized IPV support as well as advocacy programs.

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The Business of Practice

Sexual Violence (RSVP-V2 & SVR-20-V2)

Sexual violence is truly a public matter of legitimate concern, and it must be addressed comprehensively.

IN THIS POST

Specialized Violence

In recent years, several guidelines have been proposed for evaluating the risk of violence. The various risk assessment instruments' goal has shifted from predicting violence to understanding its causes and preventing its (re)occurrence. Some risk assessment tools fail to predict the risk of reoffending for **specific populations** with adequate accuracy, perhaps due to the nuances of those variations applied to different populations in different locations at other times. As there is a collection of instruments that are well validated for various groups, selecting an assessment tool should ultimately be driven by the purpose of the evaluation.

What is Sexual Violence?

Sexual violence is an act, attempt, or threat of bodily harm involving contact or communication of a sexual nature that is intentional and unauthorized.

The definition is complex, and each part can be further explained.

- **Act, attempt, or threat**: An action, whether complete or incomplete, committed by perpetrators on their own or with others' knowledge, support, or assistance
- **Bodily harm:** Actual or potential physical or psychological harm and is more than incidental or fleeting
- **Contact or communication:** An interaction, either direct or indirect, with or about other people that is taken by any means necessary
- **Of a sexual nature:** An act, attempt, or threat involving the expression or experience of sexuality
- **Intentional:** Nonaccidental; harm is intended
- **Unauthorized:** Without consent, reason, and rationale and is likely to violate the law

Assessment Tools for Assessing Risk of Sexual Violence

Sexual violence risk assessment tools have been created to aid practitioners in addressing and managing the risk posed by perpetrators of sexual violence. Generally, these assessment measures fall into the actuarial approach and the structured professional judgment (SPJ) approach.

- The actuarial approach does not incorporate clinical judgment or discretion. All components of the assessment process are structured.
- Structured professional judgment incorporates structured identification and measurement of evidence-based risk factors and clinical judgment.

Risk for Sexual Violence Protocol Version 2 (RSVP-V2)

The RSVP is a widely used set of structured professional guidelines for assessing and managing sexual violence risk. It involves an assessment of an individual's propensity for future sexual violence and formulating management strategies to reduce that risk. In 2022, the second version of the RSVP, the RSVP-V2 was published. The latest iteration of the tool includes significant updates, reflecting advances related to research, practice, and the law and incorporating feedback from diverse professionals around the world.

The RSVP-V2 includes 23 risk factors for sexual violence across two domains:

1. Nature of Sexual Violence (5 factors)
2. Perpetrator Characteristics (18 factors)

The RSVP-V2 intends to facilitate a robust management-oriented risk assessment. It emphasizes psychological functioning (e.g., problems with self-awareness, deficits in coping), and its administration guides determining if an individual risk factor is relevant, identifying scenarios of possible sexual violence, and developing management plans based on these scenarios.

The factors that are included for sexual violence risk assessment using the RSVP-V2 are:

- **Empirically Valid**: They are related to future sexual violence according to the scientific and professional literature
- **Practically Useful**: They help make decisions about and monitor the institutional and community management of individuals who have engaged in abusive sexual behavior
- **Legally Acceptable**: They are not discriminatory
- **Parsimonious**: They are reasonably comprehensive and minimize redundancy

Prevalence of Sexual Violence

- The prevalence of sexual violence has long been challenging to establish, partly due to the reluctance of victims to disclose their victimization. Reliance on reports to law enforcement to understand gender-based violence results in information loss.
    - Self-report research has found that individuals who engage in sexual violence are approximately twice as likely to avoid detection than to be apprehended for the crime.

- Research has found that Annual Security Reports, published by the department of public safety, undercounted incidents of sexual misconduct on college campuses.
    - The primary outcome of individuals reporting sexual violence was providing victim services, not perpetrator management and treatment.
- Decades of victimization surveys have identified that rape, sexual assault, domestic violence, dating violence, and stalking—are significant problems among college students.
    - 25% of college women experience a sexual assault during their college career
    - 32% experience dating violence
    - 34% experience attempted or completed unwanted kissing, sexual touching using physical force, the threat of physical force, or verbal coercion

Risk Factors for Sexual Violence

Risk factors on the RSVP-V2 are largely similar to other assessment tools. However, specific attention must be paid to *sexual deviation* as this is a unique risk factor for sexual violence. Paraphilic behaviors are behaviors that are viewed as outside of the typical range of sexual behaviors, and therefore, sexually deviant. The DSM recognizes eight forms of paraphilias: *Exhibitionism, voyeurism, pedophilia, sexual masochism, sexual sadism, transvestic fetishism, fetishism, and frotterurism.*

- **Paraphilia**: A specific mental disorder where the focus of sexual arousal is problematic. It ought to be thought about in particular ways.
    - Paraphilia starts in childhood and is evident by puberty. Then, in the late teens and early 20s, apparent patterns begin to emerge, and after that, most people's arousal patterns do not undergo dramatic or rapid change.
    - Paraphilias are given specific names, and many paraphilias are not specific
    - Individuals may have multiple or co-occurring paraphilias, but they are usually related.
    - Paraphilia cannot simply be inferred because of behavior. For example, an individual may be aroused despite the relationship, an age difference, or a non-consensual encounter, not because of it.
        - What evaluators have to do is talk to people about their thoughts.
        - What are the thoughts that you have when you think about sex?
        - What do you think about when images of sex pop into your head?
        - When do you have fantasies? What are they?
        - When you have physical urges, what do you do?

Importance of Using an Instrument in Sexual Violence Risk Assessments

- **It helps to mitigate bias in judgment.** Research has found that when human resource officials, equal employment opportunity officers, and jurors make predictions of subjective sexual harassment, they may overestimate the importance of sexual objectification.
- **Risk judgments made using SPJ guidelines appear to have an accuracy equivalent to that of risk judgments made using actuarial tools**.Improve clinicians' ability to predict the chance that an individual will behave violently.
- **The laws regulating the process of violence risk assessment have become much more developed. Some statutes explicitly require that specific instruments are administered in a risk assessment.** For example, Virginia's Sexually Violent Predator statute mandates using a specific instrument and specifies the cutoff score that allows further proceeding in the commitment process.

Administration of the RSVP-V2

Generally, administration is the same as for the HCR-20, SAM, or the SARA. It involves:

1. Gather the case information and chunk it in terms of risk factors
2. Think about the presence of risk factors and rate them
3. Think about the relevance and changes in risk factors over time and rate them. "Recent changes" are described as changes within the last year.
4. Develop a formulation of sexual violence perpetration
5. Identify possible scenarios of sexual violence, such as "What are we worried they are going to do?"
6. Develop scenario-based management plans, such as "What do we think we need to do to prevent it?"
7. Form conclusory opinions, including "How are we going to communicate this?"

Qualifications for Administration of the RSVP-V2

- Familiarity with the literature. Rely on books and articles to keep up to date on the fundamental subject matter by reading recent reviews and summaries of the literature.
- Expertise in assessment.
- Ability to develop a logical and compelling argument using the relevant and present risk factors. Research has found improvements in accuracy after training for clinical decision-making, general violence risk assessment, and sexual violence risk assessment.
- No research supports that years of experience make someone better at formulating an argument, **meaning that younger clinicians and clinicians new to the field of sexual violence risk assessment have even footing.** Literature on expertise does suggest the longer someone has been doing something, the faster and more efficient they get– but this does not improve the **quality** or the **accuracy** of the opinion they can provide.

Pros and Cons of the RSVP-V2

Pros

- The RSVP was the first SPJ tool to incorporate steps for management plans explicitly.
- It is a comprehensive assessment requiring treatment and management consideration to minimize an individual's risk of (re)offend. Research states that adding additional risk assessment instruments is redundant.
- The assessment is individualized, complex, and dynamic and helps with prevention via planning
- Re-assessments allow for monitoring of change
- Research supports the utility of the tool in practice:
    - **Interrater reliability** – ratings are reliable across raters
    - **Concurrent validity** – ratings correspond with those made with widely used actuarial sexual violence assessments
    - **Predictive validity** – evaluations predict sexual recidivism with accuracy
- It can be used with male and female individuals over the age of 18. Differences between genders can be seen in the scenarios for sexual violence, not in terms of the risk factors.

Cons

- Methodological issues and limitations in sexual offender and sexual violence research include:
  - Limited exploring sexual violence with various gender and sexual identifies
  - Methodological variability makes it difficult to combine or compare results across studies
- Most research is on version one.

Sexual Violence Risk-20 V2

Before the publication of the Risk for Sexual Violence Protocol (RSVP), the SVR-20 was the **only** SPJ tool used to assess the risk of sexual violence in adults. The SVR-20 has been used in many different research studies around the world. It has been the focus of considerable discussion and debate and subjected to qualitative and quantitative (meta-analytic) review. Despite the interest in the tool, the authors decided it was important to develop a new version of the SVR-20 in light of advances in the field of sexual violence risk assessment. Therefore, the SVR-20, similar to the RSVP, is also on its second version, titled the SVR-20 V2.

Sexual violence risk assessment is complex and the process is continuous. The risk assessment has multiple phases and stages, many stakeholders, and several goals. Sexual violence risk assessment can be characterized as an endeavour that is complex. It requires coordination of many professionals, over an extended period. While the RSVP-V2 is best for individuals with specialized or advanced expertise, the SVR-20 V2 is sometimes much easier for people to use if they do not have specialized training or are not doing treatment-oriented assessments.

The SVR-20 is not as focused on the formulation as the RSVP-V2. Instead, evaluators broadly identify the risk factors and then develop management plans. So it is a little bit more straightforward than the RSVP-V2.

The SVR-20 V2 has 20 basic risk factors in 3 domains:

1. Psychosocial adjustment
2. Sexual offending
3. Future plans

The SVR–20 V2 structures professional risk judgments. No exact procedure is provided for translating the ratings on the items into an overall evaluation of risk. Instead, evaluators are directed to use their professional judgment to rate the risk as low, moderate, or high. Lastly, scores on the SVR–20 V2 are not linked to expected recidivism rates. However, the risk factors on the tool are empirically associated with the likelihood of recidivism and the the nature, severity, imminence, and frequency or duration of recidivism.

The SVR-20 V2 allows evaluators to craft appropriate and realistic plans for evaluees, as research has found that having a concrete plan is a key factor in helping individuals desist from reoffending. The SPJ approach is flexible and person centered. Meaning that plans are tailored to the evaluee's needs and include targets such as a residence, employment, family relationships, and relationships with correctional and health care professionals.

Relevant Trainings

For more information on the RSVP-V2 and SVR-20 V2 check out CONCEPT's trainings by Dr. Stephen Hart, whose expertise is in the field of clinical-forensic psychology, with a special focus on the assessment of violence risk and psychopathic personality disorder.

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The Business of Practice

Stalking Assessment & Management (SAM)

Despite its nebulous nature and varied legal and clinical definitions, researchers and clinicians are referring to the same phenomenon when they use the term “stalking.”

IN THIS POST

Specialized Violence

Several guidelines have been proposed to evaluate violence risk. The various instruments’ goal has shifted from predicting violence to understanding its causes and preventing its (re)occurrence. Some risk assessment tools fail to “predict” the risk of reoffending for **specific populations** with adequate accuracy, perhaps due to the nuances of those variations applied to different populations in different locations at other times. As there is a collection of instruments that are well validated for various groups, selecting an assessment tool should ultimately be driven by the purpose of the evaluation.

What is Stalking?

Stalking is “unwanted and repeated communication, contact, or other conduct that deliberately or recklessly causes people to experience reasonable fear or concern for their safety or the safety of others known to them.” Although the legal definition of stalking varies by jurisdiction, common aspects include multiple acts of unwanted pursuit, a reasonable level of threat, and the victim experiencing fear.

Although stalking may not always lead to physical assault, victims of stalking endure a wide range of negative consequences, including emotional and psychological distress such as feelings of fear, humiliation, and depression, as well as adverse social and financial effects. Moreover, stalking has long been recognized as a social problem as victims are often forced to alter their lives, such as avoiding social activities, relocating residences, or changing employment.

Stalking offenders appear to be far more heterogeneous than early research had suggested. Yet, currently, there is little knowledge of mental health interventions helpful in reducing or eliminating stalking behavior. However, past research on stalking highlighted several characteristics that would appear to support DBT as an ideal intervention for this population.

Stalking Assessment and Management (SAM)

Risk assessment on stalking is relatively new. The recency of increased attention makes assessing and managing this behavior a challenging task to do effectively. However, a few instruments have been developed to assist professionals in managing this problematic behavior. In particular, the Stalking Assessment and Management (SAM) is a risk assessment instrument aimed at preventing future stalking behavior by assessing and managing offender and victim vulnerability factors.

Given the widespread use of violence risk assessment, it is essential that instruments used to assess risk be evidence-based and rigorously tested to ensure an appropriate standard of reliability and predictive validity. Structured Professional Judgment (SPJ) assessments provide the most individualized evaluation of risk and management needs (compared to clinical judgment and actuarial). A critical feature of the SAM and other SPJ tools is that they allow raters to observe ongoing changes through reassessments, which helps evaluators tailor their recommendations as necessary.

The Prevalence of Stalking

Few forms of abnormal behavior have aroused as much interest from criminal justice and mental health professionals over the past quarter century as stalking. Once considered a rare phenomenon limited to celebrities and public officials, the high frequency and often-severe repercussions of stalking behaviors are now well established.

Stalking prevalence:

- 8-20% of the U.S. and Canadian populations
- 75-80% of perpetrators are male; 75-80% of the victims are female
- 75% to 80% of stalkers had a previous relationship with the victim; 50% of which were romantic

Several studies have demonstrated stalking after an arrest or criminal charge approaches or exceeds 50% for stalking offenders and rates of violence between 18% and 40%.

The large volume of stalking offenses creates difficulty for law enforcement in determining which perpetrators pose a more significant threat to reoffend and which require more intensive intervention and management. It is essential that mental health professions aid in the prevention and assessment of stalking behaviors.

How is Risk of Stalking Different from General Violence Risk?

Evaluating the risk of stalking is a particularly unique task; therefore, an evaluation of general violence may be insufficient, and a more focused approach to assessing stalking behaviors is required. Some specific aspects of stalking that differ from regular violence are:

1. The perpetrator is often someone known to the victim.
2. Seemingly harmless behaviors, such as receiving gifts or an unexpected visit to the victim's workplace, may appear threatening to a victim of stalking.
3. Stalking is not a discrete event but is prolonged over time - ranging from two months to one year.

The SAM includes three domains, each including ten individual factors:

- **Nature of Stalking Behavior**: Assesses the stalker's pattern of offending behavior to determine the level of seriousness
- **Perpetrator Risk Factors**: Evaluate the historical background and psychosocial adjustment of the offender
- **Victim Vulnerability Factors:** Consider the historical background and psychosocial adjustment of the victim

Professions that would benefit from using the SAM

The frequency, diversity, and severity of stalking cases make it difficult for police and other professionals to determine who has the greatest need for services and what services are needed most. Therefore, the SAM uses a structured professional judgment approach that assists decision-making across criminal justice, forensic mental health, courts, and other service providers.

- **Criminal Justice (correctional and police officers)**: Assists decision-making about an offender's sentencing, release, treatment, and management in the community.
- **Forensic Mental Health:** Aids in decisions regarding sentencing, release, and supervision conditions for individuals with stalking offenses.
- **Victim Services:** Identifying particular areas of difficulty for victims of stalking.
- **Treatment Providers:** Stalking recidivism and stalking-related violence can be reduced through effective intervention, measuring the change in offenders who have received an intervention.

The SAM is appropriate for evaluating perpetrators who:

- Have exhibited stalking behavior in the past
- Are over the age of 18
- Have only one victim

Administration of the SAM

1. Individual factors are coded as:

- Current and Previous Presence
- Relevance for Future Risk

2. Identifying and describing risk scenarios for future stalking.

- The evaluator considers the nature, severity, imminence, frequency, and likelihood of potential future risk scenarios that the perpetrator may commit.These might reflect a repeat, a worst-case, or a twisted scenario.

3. Recommend management strategies for each of the risk scenarios identified.

- Evaluators are asked to identify monitoring, treatment, supervision, victim safety planning, and any case-specific considerations for risk management.

4. Provide summary risk judgments for case prioritization.

5. Rate risk for continued stalking and risk for serious physical harm.

6. Rate reasonableness for victim's fear.

7. Rate the urgency of action required.

8. Evaluators then record the timeframe within which a re-assessment should be scheduled.

Pros and Cons of the SAM

Pros

- The items are comprehensive and sensitive to the diverse experiences reported by stalkers and victims of stalking.
- It is a valuable tool for police and mental health professionals.
- It has international support.
- It has good psychometrics.
    - Risk factors were related to higher overall risk ratings.
- The SAM identifies stalking-specific factors that general violence measures fail to assess.

Cons

- Further research is required to establish the validity of the SAM more confidently; however, the extant findings remain promising.
- While it is strongly encouraged, evaluators are not required to complete a specific training program to use the SAM, so they may not be receiving equivalent knowledge and training essential to form accurate and informed decisions.

Training

Users of the SAM are responsible for ensuring that their evaluation conforms to relevant laws, regulations, and policies. Therefore, to improve the consistency and usefulness of professional decisions, users should receive specialized training in stalking, administration, and interpretation of the SAM, and in professional decision-making regarding violence risk.

- While the effects of training require further investigation, research on the SAM demonstrates its utility and validity in assessing stalking in research and law enforcement settings.
- Evaluators using the SAM risk assessment tool should have experience with stalking offenders or victim populations, and have expertise in stalking.
- Mental health professionals are responsible for maintaining their competency to use risk assessment tools reliably and accurately.
- The ability to correctly use a given risk assessment tool and communicate the results of that assessment requires evaluators receive appropriate training and practice.

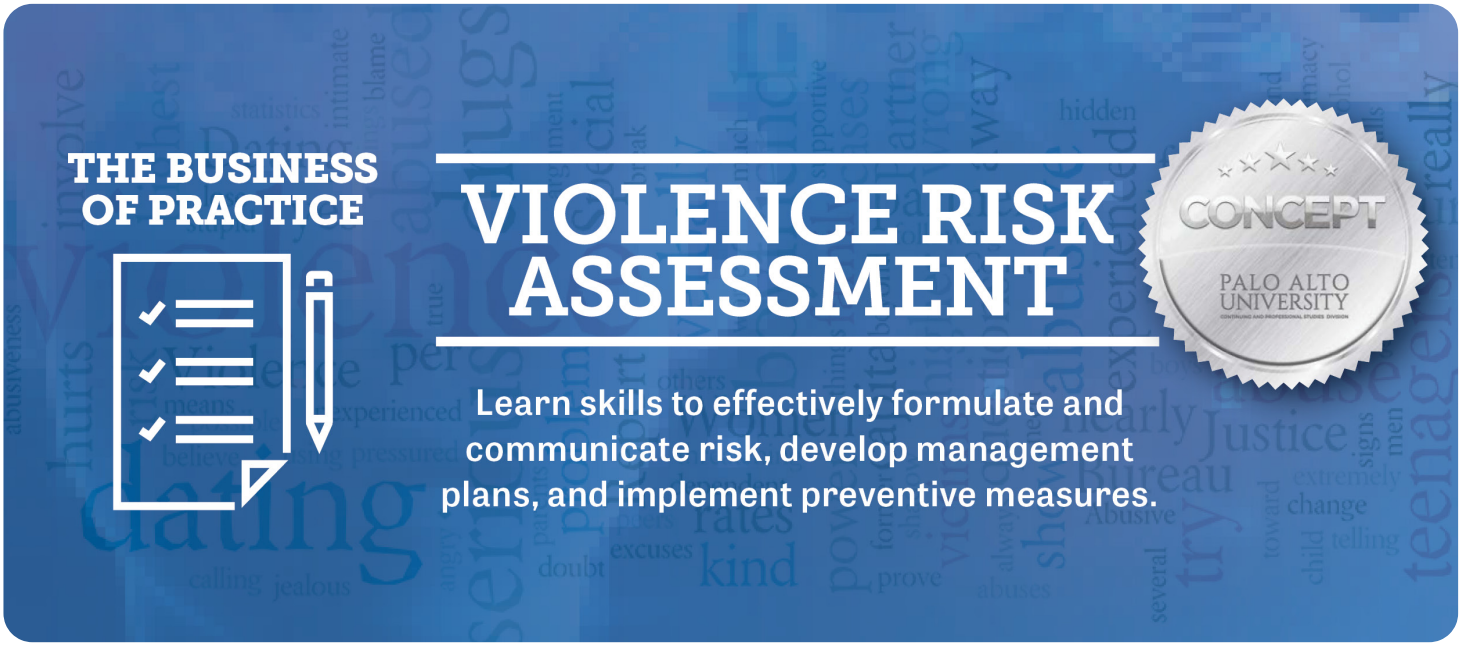
For more information on the SAM check out CONCEPT's trainings by P. Randall Kropp, PhD, whose expertise is in the field of clinical-forensic psychology, with a special focus on the assessment and management of violent offenders.

Want something more in-depth? CONCEPT offers a 40-hour course on the Foundations of Violence Risk Assessment and Management that incorporates the SAM amongst other tools, such as the HCR-20, SARA, and RSVP.

The Business of Practice

Overview of the Violence Risk Assessment Certificate

This certificate aims to enhance professional decision-making associated with violence risk and learn skills to effectively formulate and communicate risk, develop management plans, and implement preventive measures.



IN THIS POST

What is the Goal of the Violence Risk Assessment Certificate?

This certificate aims to enhance professional decision-making associated with violence risk and learn skills to effectively formulate and communicate risk, develop management plans, and implement preventive measures. Courses will guide trainees through foundational and critical concepts, research, and cultural influences on risk assessment and management.

Professionals will demonstrate the clinical proficiency crucial for many employment settings, such as community mental health agencies, forensic hospitals, correctional facilities, state hospitals, security, medical facilities, primary, secondary, and post-secondary institutions, social service, human resource settings, and many more.

Why Get Specialized Training in Violence Risk Assessment?

Develop Confidence & Skills

Build your confidence when making decisions about cases that involve violence risk, and develop your skills when communicating and collaborating with others about these cases.

Implement best practices

By undergoing meaningful professional development, clinicians will learn about best practices in screening, assessing, and managing violence risk to help prevent future harm and protect against potential liability.

Make sure your expertise is recognized

Your employer, clients, and the courts want to know what makes you qualified to assess, opine, and testify about violence risk. So for each on-demand training program, you complete, you will earn a badge representing your credential, which can be shared digitally on platforms like LinkedIn.

What Does The Violence Risk Assessment Certificate Entail?

Violence risk assessors will hone their skills through engaging, interactive, and instructive training programs. Professionals will learn how to conduct assessments, from data collection to implementing data-driven interventions. The result is the ability to utilize violence risk assessment and management techniques to their fullest capacity.

Throughout the ten courses, assessors will learn high-level skills related to case formulation, report writing, expert testimony, and best practices supported by researchers and practitioners worldwide. In addition, with over 80 hours of specialized violence content, such as sexual violence, stalking, and intimate partner violence, your niche knowledge, and skillset will undoubtedly set you apart from, and above, other professionals.

What Makes This Certificate Distinct?

A distinguishing factor of this certificate is clinicians will learn specific tools and strategies for assessing general and specialized violence. The programs within the certificate provide the opportunity for multi-modal learning. This certificate program will provide trainees with a copy of the PowerPoint, additional journal articles, and other supplemental material to enhance the course content. Participants will also receive a downloadable transcript of the training, to highlight, follow along, or reference in the future as a guide when conducting an assessment or studying for board certification.

In addition, trainees will complete various case studies using the skill set they are cultivating. Practitioners will implement the risk assessment strategies discussed and gain practical experience identifying relevant variables related to an individual's risk for a specific type of violence.

The Business of Practice

Violence Risk Assessment - From Certificate to Career

The public, credentialing organizations, the legal system, school systems, and various other stakeholders expect and need mental health and legal professionals to have competency in violence risk assessment.

IN THIS POST

Training in violence risk assessment and management is often lacking, and research has demonstrated that less training and experience is associated with inaccurate violence risk assessment.

Empirical research was the root of dramatic changes in attitude toward violence risk assessment and management, and now it is understood that a professional's level of training is directly related to the accuracy of violence risk assessment. Failure to correctly identify individuals who pose a high risk could jeopardize public safety. Conversely, erroneously deeming individuals high risk could lead to unjustified restrictions of their liberty, public stigma, and needless expense.

Violence Risk Assessment Learnings

- How to document and evaluate evidence for and against a given risk factor to facilitate balanced assessments and assist with justifying opinions
- How to conduct behavioral violence risk and threat assessments and implement management strategies for public safety

How Can The Violence Risk Assessment Certificate Enhance My Career?

Higher Quality Work

- Training significantly contributes to the overall success of violence prevention, threat management, and risk assessment.
- Explicit knowledge of the scientifically supported (and unsupported) uses of an evidenced-based assessment instrument permits proper application, leading to increased accuracy in predicting risk.
- A highly trained and experienced evaluator gives the consumer of the risk assessment confidence in the opinion provided and increases the chance that they will retain that professional for future evaluations.
- Provide timely and appropriate referrals to support services and coordinate collaborative intervention plans with various resources to minimize or resolve concerns.

Development & Implementation

- Practitioners can use the theory, assessment tools, and implementation techniques to develop feasible guidelines for monitoring, to assess, and handling violence risks and threats.
- Employ data-driven interventions, monitor progress, update risk status judgments, and make decisions concerning privileges, conditional release or release on parole, revocation of release, and more.

Disseminate Knowledge

- Clinicians and legal professionals can educate other members of a multidisciplinary team on violence risk and the guidelines for assessment.

What Career Can I Have After Earning The Violence Risk Assessment Certificate?

In addition to experience conducting violence risk assessments, most types of employment in the field want an individual to possess knowledge of violence prevention and intervention techniques. This understanding, coupled with theoretical and practical knowledge of interpersonal violence, sets practitioners aside from their colleagues.

Consultation

- Evaluate threats of violence and violent behavior that impact an environment and make time-sensitive recommendations to erode violence and increase safety and perceptions of safety.
- Provide a comprehensive methodology for institutions and organizations to drive efforts to reduce incidents of violence, injuries stemming from those incidents, and the severity of injuries.

Some common questions clients ask are:

1. Does an individual pose a risk for violence? If so, under what conditions are they likely to commit violence?
2. What risk factors are related to an individual's potential for violence while receiving mental health treatment in the least restrictive environment?
3. What is an effective way to intervene with preventive measures to manage the risk for violence in post-secondary institutions?
4. How can violence risk be mitigated in the workplace?
5. What would increase an individual's risk of engaging in physical or sexual violence, stalking, intimate partner violence, or harm to themself? And, how should risk be managed?

Psychiatric Inpatient Units

In mental health care, violence risk assessment is a routine part of clinical services, particularly in psychiatric hospitals. Research on violence risk assessment techniques and tools has found that the use of assessment tools helps manage violence and aggression in psychiatric facilities. In addition, using prediction models and risk tools learned while earning this certification can assist clinical decisions and improve linkage to violence-reducing interventions such as medication optimization and follow-up frequency.

Community Services

In 2020, the FBI reported that hate crimes were the highest in 12 years, meaning that violence motivated by bias against a race, ethnicity, religion, sexual orientation, gender, and gender identity has increased - instilling fear across entire communities.

Violence risk assessment and management professionals in the community can provide comprehensive services to individual clients, families, and communities impacted by violence.

While some violence has an identified motive, this is not always the case. However, professionals who can provide comprehensive psychiatric evaluations can give other professionals and the community a better understanding of violence and its contributing factors. This certificate will teach professionals essential skills to accurately and soundly convey their findings from an assessment to individuals outside the field.

Another community-based service is assisted outpatient treatment (AOT), also known as outpatient commitment (OPC). AOT/OPC is when an individual with serious mental illness is court-ordered to comply with treatment in the community. Currently, 44 states have statutes allowing these programs, and research has demonstrated that they decrease violent behavior. Within these systems, mental health professionals are tasked with conducting initial and ongoing psychiatric assessments, including the risk of harm to themselves or others.

Primary & Secondary Schools

Data from the Center of Homeland Defense and Security show that gunfire incidents on U.S. school grounds have sharply increased in recent years. Columbine, Uvalde, Sandy Hook, Parkland, and many others have impacted multiple systems. As a result, students, staff, and families worldwide are now keenly aware that this form of violence could happen to anyone. This unsettling reality has been the catalyst for school districts and other associated professionals to examine how to evaluate threats and handle high-risk situations closely.

Post-Secondary Institutions

Violence in post-secondary institutions is a problem that has gained much attention over the last decade, partly due to tragic cases involving students, staff, faculty, and community members. As a result, significant advances have been made to understand the nature of this problem and establish teams to address it.

Workplace Violence

Risk assessment professionals working in industrial and organizational settings often work with companies to address employees' behaviors of concern. These behaviors may include verbally threatening others, engaging in threatening behaviors, physical violence, stalking or unwanted pursuit, sexual violence, or other activities that violate the company's policies.

Interested In Violence Risk? Here Are Some Next Steps...

- Earn the certificate
- Attend other trainings outside the scope of this certificate
- Attend conferences
- Subscribe to academic journals