RISK ASSESSMENTS IN THE TEXAS CRIMINAL JUSTICE SYSTEM

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Over the years the criminal justice system throughout the United States has relied on psychiatrists and psychologists to make predictions regarding future violence. In earlier years this question was framed as "predicting dangerousness" and the answer was often a simple "yes" or "no." With little or no scientific basis for these "crystal ball readings," predictions were frequently wrong. Follow-up studies on patients released who were considered dangerous sometimes indicated false positive rates higher than 80%. The field research conducted in the area was so poorly controlled that it is impossible to determine any exact percentages. It seems clear, however, that the potential for violence was overestimated in many cases.

Over the last 20 years, the volume of data collected in regard to the prediction of violent behavior has increased exponentially. The field has graduated from the prediction of dangerousness, a dichotomous question, to assessment of risk, an estimate of the probability of violent behavior given specific circumstances over a particular time period. From risk *assessment* there developed models for mental health professionals to engage in risk *management* (efforts aimed at reducing each factor precipitating risk to a level allowing the individual to function in the least restrictive environment). Although it results in far-from-perfect prediction, the plethora of new data has allowed mental health professionals to provide much more valuable information regarding risk.

Risk assessments by mental health professionals are often requested because they are required by statute or because they may otherwise be helpful to a decision-maker. The assessments generally address the circumstances under or environments in which an

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individual can function without presenting a significant threat to others.

Probation

When a court is considering whether to place an individual on probation or to opt for incarceration, a mental health professional may be asked to assess risk given the specific circumstances and whether some form of mental health treatment might ameliorate that risk (Tex. Code Crim. Proc. Art. 42.12).

Parole

In this case it is the Texas Board of Pardons and Parole deciding if the person's release from incarceration will pose a significant risk. Professional risk assessments in such cases are often requested by attorneys. (Tex Code Crim. Proc. Art. 42.18)

Juvenile Court

A juvenile court may request a risk assessment at any time during the proceedings. Such an evaluation is commonly requested either in determining the need for continued custody following an initial detention or in the process of determining the most appropriate disposition. In cases in which a juvenile is considered for transfer to adult criminal court, however, a complete diagnostic study must be ordered. (Tex. Fam. Code §54.02[d]) As part of the study the probability of adequately protecting the public must be addressed.

Sexually Violent Predators

In 1999 the Texas state legislature passed a law allowing for the outpatient civil commitment of certain sexual offenders who have completed their prison sentences. (Tex. Health & Safety Code Tit. 11, § 841) Under this statute expert assessments are performed on a significant number of offenders scheduled for release and on a smaller number on whom petitions for commitment are actually filed. One element of these evaluations involves determining whether the individual presents a significant risk of reoffending sexually once released.

Incompetency and Insanity

Mental health professionals are almost always involved in the evaluation of individuals believed to be incompetent to stand trial (Tex. Code Crim. Proc. Art. 46.02) or to have been insane at the time of the offense (Tex. Code Crim. Proc. Art. 46.03). If the defendant is found not competent and not restorable to competency or not guilty only by reason of insanity, however, further evaluations may be needed to determine if and under what circumstances the individual poses an ongoing risk to society and, thus, requires commitment (Tex. Health & Safety Code Art. §571).

Sentencing

An assessment of risk can be considered at the time of sentencing in any criminal case and may be requested by either party. (Tex. Code Crim. Proc. Art. 42.12 §9) In capital cases, however, the jury is required to determine whether, "there is a probability that the defendant would commit criminal acts of violence that would constitute a continuing threat to society" if the defendant is not executed (Tex. Code Crim. Proc. Art. 37.071).

RISK ASSESSMENT AND CASE LAW

Although the issue of psychiatrists and psychologists assessing risk of violence has been the subject of great debate in the mental health and legal communities for decades, the courts have generally remained open to such testimony.

Barefoot v. Estelle

In 1983, a case from Texas reached the U. S. Supreme Court involving a capital murder defendant who challenged the use of psychiatric testimony on the issue of his future dangerousness. The American Psychiatric Association filed an *amicus curiae* brief indicating its best estimate that psychiatric predictions of long-term future dangerousness were wrong two out of three times. Nonetheless, the Court ruled that psychiatrists could continue to testify on this issue as to do otherwise would be like asking the Court to "disinvent the wheel" (*Barefoot v. Estelle*, 1983, p. 896). In ruling against Mr. Barefoot, the Court declared that, "Neither petitioner nor the Association suggests that psychiatrists are always wrong

with respect to future dangerousness, only most of the time" (*Barefoot*, 1983, p. 901).

Daubert v. Merrell Dow Pharmaceuticals & E. I. Dupont de Nemours & Co.v. Robinson

Since the Barefoot decision, neither the federal courts nor Texas state courts have sought to exclude mental health testimony in regard to risk. Courts have, however, attempted to place more stringent requirements on experts and the evidence they present in court. In *Daubert v. Merrell Dow Pharmaceuticals* (1993) the U.S. Supreme Court declared that the judge, as gatekeeper, must determine whether a proffered expert has the requisite knowledge, skill, experience, training, or education, and whether the evidence (including the evaluation methodology) on which he or she relies meets certain suggested criteria:

- reflects a theory that has been or can be tested;
- has been subject to peer review or publication;
- has a known potential error rate; and/or
- has been accepted in the relevant scientific community.

Although *Daubert* was only applicable to federal cases, the Texas Supreme Court endorsed similar criteria in *E. I. Dupont de Nemours & Co. v. Robinson* (1995). Courts in Texas have become increasingly conscious of *Daubert* issues. Although the specific criteria are suggested and not absolute, any evaluator conducting a risk assessment should give them careful consideration.

PREPARATION FOR ACCEPTING AND CONDUCTING A RISK ASSESSMENT

Clarify the Exact Purpose of the Evaluation

The question, "Is he dangerous?" is very unclear. Over what period of time is the risk to be assessed? Is it risk in a structured or unstructured environment? What will be the circumstances under which the harm might materialize? Is there any leeway to alter those circumstances? Is the decision-maker concerned about a particular type of violence, for example sexual violence, spousal abuse, or child abuse? Is the issue only physical violence

or does it also mean criminal recidivism in general? Must the particular risk be connected to a mental illness or mental abnormality?

Evaluate the Specific Competences Required

Both the American Academy of Psychiatry & the Law Ethical Guidelines for the Practice of Forensic Psychiatry (1995) and the Specialty Guidelines for Forensic Psychologists (1992) declare that forensic practitioners must limit their evaluations to areas in which they have the necessary specialized expertise. Having expertise in the broad general practice of psychiatry or psychology does not mean one is necessarily an expert in evaluating children, in evaluating sex offenders, in evaluating persons with mental retardation, and so forth. Risk assessment is fast becoming a specialized pursuit. A number of scholars have addressed the issue (e.g., Monahan & Steadman, 1994; Monahan, Steadman, Silver, Appelbaum, Robbins, Mulvey, Roth, Grisso, & Banks, 2001; Quinsey, Harris, Rice, & Cormier, 1998; Webster & Jackson, 1997). In the last decade alone an immense collection of book chapters, journal articles, and monographs has been established offering more specific guidance.

Consider Potential Conflicts of Interest

As discussed in greater detail in the article on Report Writing elsewhere in this issue, both the ethical standards for forensic psychiatrists and those for forensic psychologists caution practitioners in regard to dual relationships. One dual relationship often overlooked by risk assessors is that of therapist-forensic evaluator. Both sets of ethical principles encourage mental health professionals to avoid taking on the role of therapist and forensic evaluator in the same case for good reason:

- a therapist should be allied with a client and working in the client's best interest, not as an objective evaluator;
- a therapist normally develops relationship based on trust and does not scrupulously verify what a client reveals;
- a therapist normally promises a client a certain level of confidentiality that cannot be maintained in a forensic evaluation.

Gather Relevant Research Data

In performing forensic work, evaluators must be cognizant not only of factors predictive of risk, but also of those that may have a certain protective value (Rogers, 2000).

- Be mindful that this is an active and rapidly changing science. Old assumptions are being debunked on a regular basis.
- Be certain the research relied upon pertains to the particular individual, population, and target of the risk. Cultural competence should be carefully considered.
- Be certain the data would apply under the particular circumstances. For example, assessing risk within a prison environment may depend on very different factors from those associated with assessing risk in the community.
- Explore websites devoted to specific areas of risk assessment. For example, the MacArthur Foundation has an excellent website on risk and mental disorder (www.macarthur.virginia.edu); Robert Hare's website is valuable to those interested in psychopathy (www.hare.org); and the Solicitor General of Canada maintains current research on sex offender risk (www.sgc.gc.ca).
- Consider contacting major experts.

Gather a Sufficient Collateral Data Base

One of the primary features that distinguishes a forensic evaluation from a clinical one is the need for extensive *collateral information*. No statement made by the individual being assessed can simply be taken at face value. Outside of a decision made in response to an immediate emergency (the type of decision typically made in the ER), a risk assessment *cannot* be conducted without adequate collateral information. If a psychiatrist or psychologist is asked to perform an evaluation of risk absent collateral information, the request should be declined. If a mental health professional is asked for her or his "clinical impression" of someone's level of risk based only on contact with the individual, an appropriate answer would be: "I have no clinical opinion on that

issue, because I have not been able to conduct the necessary assessment."

To be sufficient, there must be enough collateral information to verify key facts. Even official documents (e.g., police reports, medical reports, documentation prepared by correctional institutions) can contain errors. A risk assessment based upon inaccurate information can be dangerous both to the individual and to the public.

Attorneys frequently wish to be helpful to evaluators seeking information, but do not know what is needed or where it might be obtained. The following is a list of commonly useful documents and potential sources:

- Presentence investigations and reports of prior functioning while under supervision (probation officers);
- Information, indictment, police reports, witness statements for current and past offenses (district attorney);
- Reports of behavior while institutionalized (TDCJ, county jail);
- Past criminal history (district attorney);
- Reports of past mental health treatment or evaluations (defense attorney);
- Reports of special programs attended, such as substance abuse or sex offender treatment programs (defense attorney, TDCJ);
- School records, especially in the case of youthful offenders (defense attorney);
- Collateral interviews can be helpful with family members or care-givers (generally check with attorney before proceeding).

CONDUCTING THE ASSESSMENT

Once a sufficient collateral data base has been assembled, the evaluator will generally proceed to interview the individual who is being evaluated.

Interviewing and Ethics

The ethical guidelines for both psychiatrists and psychologists indicate that every effort should be made to conduct a clinical interview with the individual as part of any risk assessment. Nonetheless, there may be circumstances under which this is not possible (e.g., the person refuses to speak with the evaluator or refuses to answer important questions). Given an adequate data base, a risk assessment can still be formulated. It is, however, essential to report this limitation *clearly*.

Ecological Considerations

It may be necessary to conduct the interview in a jail or other correctional facility. Arrangements made in advance specifying your requirements can be helpful. Although the interview may need to be under some type of observation, this can generally be done in such as way as to allow for confidentiality. Handcuffing behind the back can be a problem, given that interviews are often lengthy.

Consent and/or Disclosure

Whether an evaluation requires the informed consent of the individual being evaluated or simply the disclosure of certain information depends upon the circumstances. As discussed in greater detail in this issue in the article on Report Writing, generally, if an evaluation is court-ordered or required by statute, the individual has few choices—the evaluation must be completed with or without the person's cooperation. If, on the other hand, a mental health professional is conducting an assessment at the request of an attorney, the person's informed consent will be necessary. In either case, there are certain key pieces of information that need to be disclosed. Disclosure should be done in writing and reviewed verbally to be certain the information is understood. Disclosures would ordinarily include:

- the identity and professional affiliation of the evaluator;
- the purpose of the evaluation;
- the limits of confidentiality;
- who is likely to have access to the evaluation results;
- the potential consequences of the evaluation;

- a clear statement that the evaluator is not a treating clinician.

An individual's right to consult with counsel prior to any evaluation varies somewhat with the type of study being done. Although the ethical guidelines decry performing evaluations if counsel has not been appointed, the state takes the position that in some cases, for example the initial phase of SVP evaluations, this right is not absolute. It is best to check with the appropriate attorney or state agency before assuring those being evaluated that they have an absolute right to consult with an attorney beforehand.

In addition to the clinical interview, the mental health professional has the option of utilizing more formal structured assessment techniques such as psychometric testing and actuarial instruments. Whether or not any of these options is selected, it is very important that evaluators are aware of what is available and make an informed choice that could be defended if challenged in court.

Psychological Testing

The traditional psychological test battery, often including personality and cognitive testing, may be of very limited value in the context of a risk assessment. Broad, general personality inventories such as the MMPI-2 and the MCMI-III have not been validated to predict violence, either general or specific. Evaluators conducting risk assessments should take special care to verify the validity of any test used for the particular purpose. Problems arise when forensic evaluators confirm long-held myths about test results or suggest illusory correlations.

Psychometric Expertise

It is also essential that an evaluator fully understand the psychometric properties of any testing instrument applied. Current reviews are available that discuss the most recent testing statistics and terminology (Douglas & Webster, 1999).

Actuarial Approaches

Over the last two decades a number of actuarial formulas have been developed to predict various types of risk. Some have

been the subject of extensive research and active debate in the field. Respected researchers have opined that risk assessment should be totally based on actuarial formulas, and asserted that such a procedure is superior to any clinical judgment (Quinsey et al., 1998). Others have decried reliance on these methods, saying that the day will never come when clinical judgment can be replaced by statistical calculations (Litwack, 2000). Still others have suggested that an integration of the two approaches may produce the most valuable results (Hanson, 1998). Incorporation of actuarial techniques into risk assessments has some definite advantages:

- Published actuarial techniques have a research base that has been or can be peer reviewed. This can assist an evaluator facing a *Daubert* challenge regarding methodology or scientific basis for findings regarding risk.
- An actuarial result can be used to anchor a risk assessment. In other words, it is a starting point to which can be added other data relating to the specific individual. It would never be presented as ***the*** answer, but simply as one important piece of data the evaluator considered.
- The actuarial approach is one method of comparing risk levels between offenders. This can be important in those endeavors where, for example, only those at highest risk will be considered for certain restrictions (e.g., SVP evaluations).

Actuarial devices as a whole also have limitations that should be carefully considered:

- All actuarial instruments developed to assess risk require the availability of accurate, extensive records. Real world situations may be extremely variable in this regard. To utilize one of these devices absent adequate collateral information would risk inaccuracies that impermissibly compromise the underlying science and may work a grave injustice to the parties involved.
- Courts may be confused by statistical information. In fact, some judges may be loath to admit such data, saying they are interested in this specific individual and not statistics about the general population.

- On the other hand, courts may be overly impressed with the specificity of the number, equating it with precision. There may be considerable confusion between the terms "scientific" and "actuarial."
- All instruments have been normed on a particular population and it may be difficult to match an individual to be evaluated with a research population. If an instrument is used, great care should be taken to ensure that the match is close and to inform the court of discrepancies. Using an instrument with a member of an ethnic minority may raise issues in this regard.
- Most actuarial instruments currently available rely almost completely on static variables, such as historical factors things that are very unlikely to change with treatment or circumstances. Therefore, if recommendations are being made for reducing the risks, other methods will need to be utilized.
- Actuarial instruments are themselves static, that is they apply the same set of factors over time and across populations. Although many of these factors have been well researched and found to be predictive of risk in particular areas, there is no reason to believe they are exhaustive or that they are (in the same combination) equally predictive of risk from one individual to the next.

A summary of psychometric and actuarial instruments currently used in conducting risk assessments is included in the appendix following this article. This is not intended as an endorsement of any particular instrument. It is simply a catalogue of what is available.

Reliance on Diagnoses in Risk Assessment

A diagnostic formulation is often routinely included by psychiatrists and psychologists in mental health evaluations. Such a formulation may be essential to a risk assessment if the statute or question raised by the court requires it. For example, in SVP evaluations statute requires that the potential for violence be related to a "behavioral abnormality," which in practice is generally

a *DSM* diagnosis. However, the use of such diagnoses in a forensic context has certain limitations:

- The *DSM* specifically cautions mental health professionals that a clinical diagnosis may not equate to what the legal community views as "mental disorder" or "mental abnormality;"
- The manual further cautions that no diagnosis carries with it specific implications regarding behavioral control. Current research does provide support for some basic premises regarding mental disorder and risk for violence.
- Despite earlier declarations that there was no relationship between mental disorder and violent behavior, more recent research has tended to illustrate some relationship (Monahan & Steadman, 1994).
- Substance abuse appears to be a critical factor, as those dually diagnosed have much higher rates of violence than persons diagnosed only with a major mental disorder (Steadman, Mulvey, Monahan, Robbins, Appelbaum, Grisso, Roth, & Silver, 1998).
- A personality disorder diagnosis is more predictive of violence than any of the major mental illnesses (Hodgins, 2000).
- Base rates for violence, however, within any diagnostic category tend to be quite low. Therefore, it would be difficult to say that any particular diagnosis is predictive for a specific individual.
- Antisocial Personality Disorder is often associated with risk for violence. However, the diagnosis is generally based upon the individual's history and may add little more than a label. In addition, research estimates that between 50 and 80% of incarcerated males may qualify for this diagnosis; making its discriminant value very limited.
- The research base has gone beyond diagnostic categories to investigate specific symptoms (Swanson, Borum, Swartz, & Monahan, 1996). Special attention has been given to delusions, particularly those with paranoid content (Appelbaum, Robbins, & Monahan, 2000; Appelbaum, Robbins, & Roth, 1999; Monahan & Steadman, 1994). Other inves-

tigators have explored hallucinations, particularly those involving commands (Hersh & Borum, 1998; McNeil, Eisner, & Binder, 2000; Monahan & Steadman, 1994; Rudnick, 1999).

Although nomothethic data can be helpful in determining the role of a mental illness in violence potential, a thorough risk assessment needs to explore the connection between the psychopathology and violence displayed by the particular individual. This requires a careful review of the person's past violent episodes.

- Was the individual's behavior consistent with a delusional belief?
- Is there evidence the person was experiencing command hallucinations?
- Were there obvious motives for the violence unrelated to the mental abnormality?
- Did all of the individual's past violent behavior appear to stem from the diagnosed psychopathology?
- To what extent did substance abuse contribute to the events?

Consider Psychopathy

Psychopathy is *not* an official diagnosis listed in the *DSM*, is *not* the same thing as Antisocial Personality Disorder, yet was *more strongly* associated with violence than any other risk factor studied through funding by the MacArthur Foundation. Mental health professionals seriously involved in any risk assessment endeavor must understand its significance (Cooke, Forth, & Hare, 1998).

In the early part of the 20th century Hervey Cleckley (1941) used the term "psychopath" to describe a certain aberrant personality style, often correlated with severe criminal tendencies. Although various versions of the DSM later inferred that psychopathy was simply an archaic term for Antisocial Personality Disorder, the diagnosis evolved into something quite different from Cleckley's conceptualization. The criteria for Antisocial Personality Disorder describe the majority of people who have substantial his-

tories of criminal behavior. In fact, as noted previously, research demonstrates that upwards of 80% of incarcerated males meet the diagnostic criteria (Cunningham & Reidy, 1998). Psychopathy, as defined by Cleckey, relates to a much more select group of individuals.

Robert Hare (1991, 1996, 1999) has devoted much of his long career to refining and clarifying the construct of psychopathy. As conceptualized by Hare, psychopathy includes both behavioral and affective/interpersonal factors. It would apply to fewer than 25% of the male prison population, but that particular population would likely exhibit the highest rates of chronic criminality, as well as violence. Hare has developed and refined the Psychopathy Checklist-Revised (PCL-R), a psychometrically reliable and valid instrument with which to assess psychopathy. Features characteristic of psychopaths include:

- Glib and superficial charm
- Grandiose sense of self-worth
- Need for stimulation/proneness to boredom
- Pathological lying
- Conning and manipulation
- Lack of guilt or remorse
- Shallow affect
- Callous lack of empathy
- Parasitic lifestyle
- Poor behavioral controls
- Promiscuous sexual behavior
- Behavior problems from an early age
- Lack of realistic, long-term goals
- Impulsivity
- Irresponsibility
- Failure to accept responsibility for their actions
- Many short term marital relationships
- Juvenile delinquency
- Revocation of conditional release
- Criminal versatility

Psychopathy, as measured by the PCL-R has been found to be among the best predictors of future violent behavior in the mental health risk assessment armamentarium (Hemphill, Hare & Wong, 1998; Salekin, Rogers, & Sewell, 1996; Serin & Amos, 1995). The MacArthur Violence Risk Assessment Study found psychopathy to be more predictive of violence than any other variable the group assessed (Skeem & Mulvey, 2001). It has been found to be significantly predictive even where diagnosed in conjunction with substance abuse or a major mental disorder (Hill, Rogers, & Bickford, 1996; Rice & Harris, 1992).

Given its high degree of positive predictive power, psychopathy cannot be ignored by professionals conducting risk assessments. In the case of SVP evaluations, testing for psychopathy is specifically required by statute in Texas. If, however, an evaluator intends to assess psychopathy for risk assessment purposes, several issues merit careful consideration.

The "gold standard." At the time of this writing, the PCL-R is the "gold standard" for assessing someone for psychopathy**.** The current research base connecting psychopathy with risk is based upon psychopathy as measured by the PCL-R. Therefore, given the potentially serious consequences of a risk assessment, it would be of ethical concern if someone were to append the label "psychopath" to an individual absent PCL-R evaluation.

Specialized training required. The instrument can provide reliable results only if those using it are properly trained. Although no specific workshop is essential for this purpose, a good number are regularly offered throughout the country. For court purposes, Hare recommends that ideally two parties score the PCL-R independently and average the results. Texas attorneys are becoming very well informed about the PCL-R and questions regarding specific training can be expected.

Appropriate populations. As with any assessment tool, the evaluator must make certain the person being assessed is representative of the population on which the instrument was normed**.** In

the case of female defendants or some ethnic minorities, research with the PCL-R remains limited.

Applicable setting. The great majority of the research on psychopathy and risk for violence has been conducted in the community and therefore, it may not be predictive of risk in a particular structured environment.

Low scores. Low scores are not the opposite of high scores**.** Although a high score on the PCL-R is suggestive of psychopathy, which in turn is an important factor predictive of risk, a low score should not be interpreted as equating to low risk. It simply means that psychopathy is one risk factor the person does not have.

The situation. Risk assessment may vary with the situation**.** Violence is often contextual. It is important to consider the circumstances in which the individual is apt to be functioning.

Time. It is important to determine the time period over which one is expected to assess risk. The more time elapses, the more changes may occur, and the less likely it becomes that a risk assessment will be accurate.

Similarity. If the future circumstances of an evaluee are similar in some ways to those in which past violence has occurred, a careful analysis of factors that may have triggered the violence should be made.

Structure/support. Circumstances may be modified if the individual is to spend time in a structured or semi-structured environment. Special provisions for regular monitoring of the person's behavior may also apply, such as intensive parole supervision or random drug testing. Support systems available prior to incarceration may no longer be there or new support systems may have been created.

Access to victims. Offenders may have a preferred victim or class of victims. For example, child molesters tend to victimize children; others may have a particular target (or group) against whom their aggression is directed. If the individual will no longer

have the access to victims they did in the past, risk may be reduced. Conversely, if access is suddenly available, say through release from prison, then risk may increase.

Treatment availability/effectiveness. Some of the factors believed to be causative relative to violence can be addressed through treatment. For example, if someone's violent behavior has been a product of a psychotic delusion, risk may be reduced markedly with psychotropic medication. On the other hand, some commonly-recommended treatments - various types of sex offender treatment come to mind -have no proven effectiveness when it comes to reducing risk of violence.

Treatment compliance. No treatment can affect behavioral changes unless is it received. Many treatments require administration on a regular basis. If an effective treatment is available, the evaluator must further assess the likelihood the individual will comply under the expected set of circumstances.

RISK MANAGEMENT

Beyond risk assessment, the forensic evaluator may be called upon to establish plans for the management of risk. The risk management model (Heilbrun, 1997) involves not only identifying factors that contribute to risk, but also formulating a strategy whereby the factors can be reduced. The individual is allowed to function within the least restrictive environment while, at the same time, presenting minimal risks to the public. Such an effort must go beyond the static risk factors specified in the research and included in numerous actuarial instruments. There must be a thorough exploration of dynamic (changing) elements that are most likely to alter the level of risk over time. The forensic mental health professional is most likely to be asked to assist in this endeavor in the context of a continuing court jurisdiction over an individual having the authority to monitor and ensure compliance:

- diversion
- probation
- parole

- conditional release
- outpatient commitment

In devising an effective risk management plan, the professional should not consider any treatment the goal of which is simply to reduce the individual's distress or enhance self-esteem. Rather, the goal is to address the specific factors identified that elevate risk. Principles of risk management include the following:

- The risk factors identified should be linked specifically to the strategies proposed.
- Consideration should be given to any appropriate medical or psychological interventions (e.g., medication, psychotherapy), but cannot be limited to these. "Treatment" to reduce risk may include a plethora of other services and restrictions (e.g., geographical restrictions, semi-structured living environments, skill training, drug and alcohol testing, restricted victim access, access to weapons, reporting requirements).
- Effective plans generally identify a centralized entity charged with ongoing monitoring and enforcement.
- A system of communication between mental health authorities and the criminal justice system should be established to ensure that noncompliance can be quickly identified and remediated.
- Mechanisms should be in place that allow for immediate intervention to ensure public safety.
- There must be a balance among individual rights, the need for treatment, and the public safety, and this must be clarified explicitly from the outset.
- The limits of confidentiality should be clear to all concerned.
- For a plan to be successful, the subject of the risk management must be involved in the planning process.
- A professional recommending a risk management plan must ensure that the services and conditions to be imposed are reasonably available.
- Factors that contribute to risk, but are not apt to be amenable to change or intervention, should also be identified to

the decision-making authority. For example, with the tools currently available, psychopathy has been found to be extremely resistant to change.

- There should be a mechanism in place for regular reassessment and modification of the plan.

REPORT WRITING

A number of texts are currently available that address the basic issues salient to constructing a general forensic report (e.g., Borum & Grisso, 1996; Melton, Petrila, Poythress, & Slobogin, 1997; Weiner, 1999). Additional literature addressed issues specific to communicating about violence risk (Heilbrun, O'Neill, Strohman, Bowman, & Philipson, 2000; Slovic, Monahan, & MacGregor, 2000). Much controversy still exists as to whether risk is best communicated in terms of frequencies, percentages, or categories like high/moderate/low. Some general principles, however, can be put forth:

- Construct the report for the specific audience, generally a legal decision-maker, and according to its specific purpose.
- Focus on the issue at hand and include only information relevant to that issue. Information not salient to the risk assessment or management plan may be more prejudicial than probative. Ethical guidelines on this matter remind evaluators to respect the individual's right to privacy as much as possible given the circumstances, and to avoid trampling on 5th Amendment rights.
- Routinely include the reason for referral, sources of collateral information, documentation of the confidentiality warning, and procedures employed.
- Organize tightly and integrate data in a manner understandable to the layperson.
- Be certain that any opinions/conclusions reached are well explained and prominently linked to the data presented.

CONCLUSIONS

Given the research attention paid to risk assessment over the last two decades, the mental health professions have a great deal to contribute to decision-makers in this field. To maximize this contribution it is essential to: (a) stick closely to our scientific base, (b) collect the necessary collateral data and verify it, (c) consider the individual and the potential circumstances facing that individual, and (d) fairly acknowledge the limitations of our risk assessments.

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Received: February 2006
Accepted: June 2006

Suggested Citation:

Conroy, M. A. (2006). Risk Assessments in the Texas Criminal Justice System [Electronic Version]. *Applied Psychology in Criminal Justice, 2*(3), 147-176. .

APPENDIX

RISK ASSESSMENT INSTRUMENTS

A. Hare Psychopathy Checklist-Revised (PCL-R)

This instrument was developed by Robert Hare and his colleagues to assess the psychopathic personality as characterized by Hervey Cleckley and not necessarily the antisocial personality envisioned in the DSM-IV. It is a combination of interview and review of collateral information. It generally takes several hours to complete. To assure reliability the author recommends rather extensive training before using the instrument. This is one of the few instruments on the market with very promising predictive validity regarding violence.

Reference: Hare, R. D. (1996). Psychopathy: A clinical construct whose time has come. *Criminal Justice and Behavior, 23*, 25-54.

Source: Multi-Health Systems, Inc.
908 Niagara Falls Blvd.
North Tonawanda, NY 14120-2060

Web Address: www.hare.org

B. HCR-20

The Historical/Clinical/Risk Management Scheme was developed on the basis of an earlier instrument (the Dangerousness Behavior Rating Scale). It is a checklist rather than a test and includes 20 items: 10 historical, 5 clinical, and 5 future risk management. It was designed for clinicians working with persons suffering from mental and personality disorders, whether or not they also have criminal histories. It correlates moderately with the PCL-R and the VRAG, but does measure slightly different constructs.

Source: Webster, C. D., Douglas, K. S., Eaves, D., & Hart, S. D. (1997). *HCR-20: Assessing risk for violence* (version 2). Vancouver: Mental Health, Law, and Policy

Institute, Simon Fraser University.

Reference: Webster, C. D., Douglas, K. S., Eaves, D., & Hart, S. D. (1997). Assessing risk of violence to others. In C. D. Webster & M. A. Jackson (Eds.). *Impulsivity: Theory, assessment, and treatment* (pp. 251-277). NY: Guilford Press.

C. Level of Service Inventory-Revised (LSI-R)

This instrument was researched and developed for use in risk and needs assessment for general offenders. It is for use with persons sixteen and older for treatment planning and placement. It consists of a structured interview and expert rating form and generally takes from 30 to 45 minutes to complete. A screening version (LSI-R-SV) has been constructed, as well as a computer application.

Reference: Andrews, D. A., & Bonta, J. (1995). *LSI-R: The Level of Service Inventory-Revised.* Toronto, Ontario, Canada: Multi-Health Systems, Inc.

Source: Multi-Health Systems, Inc.
908 Niagara Falls Blvd.
North Tonawanda, NY 14120-2060

D. Minnesota Sex Offender Screening Tool – Revised (MnSOST-R)

The MnSOST-R is a 16-item inventory developed for use by the Minnesota Department of Corrections. As developed in 1996, it is based upon actuarial data and very different from the original MnSOST protocol developed in 1991, which was primarily based on clinical observations. The instrument includes 12 static and four dynamic variables and was designed to be completed by persons such as case managers. Suggested cutoff scores are provided and matched with expected rates of recidivism. Given this is a relatively new instrument, research has been limited and done primarily by those who developed it.

Source: Minnesota Department of Corrections
CD/SO Services Unit

1450 Energy Park Drive, Suite 200
St. Paul, MN 55108-5219

Reference: Epperson, D. L., Kaul, J. D., & Hesselton, D. (1998, October). *Final report of the development of the Minnesota Sex Offender Screening Tool –Revised (MnSOST-R).* Presentation at the 17th Annual Research and Treatment
Conference of the Association for the Treatment of Sexual Abusers, Vancouver, B. C., Canada.

E. Rapid Risk Assessment for Sexual Offense Recidivism (RRASOR)

This is a brief actuarial scale created from four variables found through meta-analysis to independently predict recidivism among sex offenders. These include prior sexual arrests (most heavily weighted), age, targeting of male victims, and whether any victims were unrelated to the offender. Taken together these variables still correlate only moderately with sex offender recidivism.

Source: Hanson, R. K. (1997). *The development of a brief actuarial scale for sexual offense recidivism* (User Report No. 1997-04). Ottawa, Ontario, Canada: Department of the Solicitor General of Canada.

Reference: Hanson, R. K. (1998). What do we know about sex offender risk assessment? *Psychology, Public Policy, and Law*, *4*, 50-72.

F. Sex Offender Risk Appraisal Guide (SORAG)

This is a 14-factor risk assessment instrument developed by the Canadian research group responsible for the VRAG. In its current form, it includes administration of the Hare Psychopathy Checklist-Revised and the penile plethysmograph. It necessitates collection of accurate historical data, but can be completed without substantial cooperation by the offender. It is designed to assess the probability that a sex offender is apt to recidivate.

Reference: Quinsey, V. L., Harris, G. T., Rice., M. E., & Cormier, C. (1998). *Violent offenders: Appraising*

and managing risk. Washington, DC: American Psychological Association.

G. Spousal Assault Risk Assessment Guide (SARA)

This instrument was developed by the risk assessment research group at Simon Fraser University in British Columbia. It recognizes that persons who principally assault their spouses are a heterogeneous population, but also may be quite different from those who engage in other types of assault. It is brief, having 20 items and two summary ratings. It has four sections and a five level scoring system. It is not a test, per se, but rather a checklist to assure that all pertinent information is considered.

Source: Kropp, P. R., Hart, S. D., Webster, C. D., & Eaves, D. (1995). *Manual for the Spousal Assault Risk Assessment Guide* (2nd. ed.). Vancouver: British Columbia Institute on Family Violence.

Reference: Kropp, P. R., & Hart, S. D. (2000). The Spousal Assault Risk Assessment (SARA) Guide: Reliability and validity in adult male offenders. *Law and Human Behavior, 24*, 101-118.

H. Static-99

This instrument combines items from the RRASOR and the SACJ-Min. Studies thus far indicate that its predictive accuracy exceeds that of either of the previous instruments alone. It is based completely on static variables including prior sexual offenses, unrelated victims, stranger victims, male victims, age, never married, non-contact sexual offenses, prior sentences, current non-sexual violence, and prior non-sexual violence. It is designed to measure long-term risk potential. An additional revision is already under development.

Source: R. Karl Hanson, Ph.D.
Corrections Research
Department of the Solicitor General of Canada
340 Laurier Ave. West
Ottawa, Ontario, Canada

Reference: Hanson, R. K., & Thornton, D. (1999). *Static-99: Improving actuarial risk assessments for sex offenders*. (User Report 99-02). Ottawa: Department of the Solicitor General of Canada.

Web Address: www.sgc.gc.ca

I. Structured Anchored Clinical Judgment (SACJ-Min)

Also known as "the Thornton," this instrument was designed to assess the risk of sex offender recidivism on the basis of a stage approach. Stage One considers official convictions, Stage Two potentially aggravating factors, and Stage Three treatment variables (usually only available on those who have been in a sex offender treatment program.) Available research is limited and conducted primarily by the developer.

Source: David Thornton
Offender Behaviour Programmes Unit
Room 701, HM Prison Service, Abell House
John Islip Street
London SW1P4LH

Reference: Grubin, D. (1998). *Sex offending against children: Understanding the risk*. Police Research Series Paper 99. London: Home Office.

J. SVR-20

The Sexual/Violence/Risk instrument was developed by the risk assessment researchers at Simon Fraser University in British Columbia. It is a checklist designed to assess the risk of future sexual violence by examining psychosocial adjustment, past sexual offenses, and future risk management options.

Source: Boer, D., Hart, S., Kropp, R., & Webster, C. (1997). *Manual for the Sexual Violence Risk B 20.* Simon Fraser University: Mental Health, Law, and Policy Institute, Burnaby, British Columbia.

K. Violence Risk Appraisal Guide (VRAG)

This approach was developed by Christopher Webster, Grant Harris, Marnie Rice, Catherine Cormier, and Vernon Quinsey in Canada. It was originally published as the Violence Prediction Scheme. It includes administration of the Hare Psychopathy Checklist-Revised. It has been validated primarily on populations of violent offenders.

Source: Quinsey, V. L., Harris, G. T., Rice, M. E., & Cormier, C. A. (1998). *Violent offenders: Appraising and managing risk*. Washington, DC: American Psychological Association.

L. Youth Level of Service/Case Management Inventory

This is a guide developed at Carleton University to assist those tasked with the management of potentially violent juveniles. It is divided into nine sections and includes prior offenses, family circumstances, education, employment, peer relationships, substance abuse, personality variables, interests, and attitudes. It is designed as an aid and not a psychometric instrument.

Reference: Hoge, R., & Andrews, D. (1996). *Assessing the youthful offender*. NY: Plenum Press.

M. Iterative Classification Tree

This is an approach being studied by the MacArthur group. Unlike most currently available risk assessment instruments that are based upon main effects linear regression models, this approach utilizes a decision tree. The developers argue that the typical linear regression model is a "one size fits all" approach, assuming that the same risk factors are applicable to everyone and applicable to the same degree. Using a decision tree allows the evaluator to include a wide range of variables (the project used a total of 134). Software is now available that is expected to make the approach user friendly. The research is specifically targeting the population with serious mental illness.

References: Monahan, J., Steadman, H. J., Silver, E., Appelbaum, P. S., Robbins, P. C., Mulvey, E. P., Roth, L. H., Grisso, T., & Banks, S. (2001). *Rethinking risk assessment: The MacArthur Study of mental disorder.* Oxford: Oxford University Press.

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N. Structured Assessment of Violence Risk in Youth (SAVRY)

The design of the SAVRY is modeled after existing assessment protocols for adult violence risk (e.g., the HCR-20), but the item content is focused specifically on risk in adolescents. It is composed of 24 items (Historical, Individual, and Contextual) drawn from existing research and professional literature in adolescent development and on violence and aggression in youth. An additional five protective factors are also provided. The Individual and Social/Contextual sections emphasize dynamic risk/needs factors.

Source: Randy Borum, Psy.D., ABPP
Department of Mental Health Law & Policy
Florida Mental Health Institute
University of South Florida
13301 Bruce B. Downs Blvd.
Tampa, FL 33612
borum@fmhi.usf.edu

O. Juvenile Sex Offender Assessment Protocol (J-SOAP)

The J-SOAP is a structured clinical judgment protocol that allows clinicians to rate 23 variables divided into four separate scales. The J-SOAP evaluates both static factors (Sexual Drive/Preoccupation and Impulsive-Antisocial Behavior) and dynamic factors (Intervention and Community Stability) and was designed to address variables associated

with both general offending and sexually offending behavior. The J-SOAP is intended for use with males, has clear operational definitions of each risk factor, and provides a sound conceptual organization of the static and dynamic scales.

Reference: Prentky, R., & Righthand, S. (2001). *Juvenile Sex Offender Assessment Protocol* (unpublished test manual).

P. Estimate of Risk of Adolescent Sexual Offense Recidivism (ERASOR)

The ERASOR is intended for use with males between 12 and 18 years who have previously committed a sexual assault. Therefore, the ERASOR may be the instrument of choice when there is a documented history of sexually offending behavior. The ERASOR items reflect sexual, intrapersonal, interpersonal, and family functioning. ERASOR items are organized into the following categories: Sexual Interests, Attitudes, & Behaviors, Historical Sexual Assaults, Psychosocial Functioning, Family/Environmental Functioning, and Treatment. Similar to the J-SOAP, all items have operational definitions associated with different levels of risk, however, the scales are not clearly organized into static and dynamic scales.

Reference: Worling, J.R., & Curwen, T. (2001). *The "ERASOR" Estimate of Risk of Adolescent Sexual Offense Recidivism Version 2.0*. Unpublished test manual. SAFE-T Program, Thistletown Regional Centre: Ontario.