Recidivism Risk Assessment: How Are We Doing and Where Are We Going?

Jay P. Singh, PhD
Full Professor

Agenda

1. What’s the problem?
2. What are we doing about it?
3. Where do we go from here?
4. What questions do you have?

“Those first few slides were truly some of the best I have ever seen in any presentation ever given at any lecture by man or beast. Not only my practice, but my life will be forever changed due to the tremendous contribution that you have just made to everyone in this room.”
Epidemiology of Violence

Epidemiology of MENTAL HEALTH and Violence

General Belief

“No one SANE could ever perpetrate such an evil act!”
Images of four unknown, seemingly normal, middle-aged men flashed on the screen of Kumper Auditorium last Friday evening, leaving the audience puzzled.

Dr. Jay P. Singh, a postdoctoral fellow in the Department of Mental Health Law and Policy at the University of South Florida, introduced the images of these four men as a few of America’s most notorious psychopaths and serial killers to open his presentation on forensic psychology, titled “Psychopaths and Serial Killers: Exploring Antisociality.”

Is this a general stigma?
Case Study: John

John is a white man with a high school education. During the last month John has started to drink more than his usual amount of alcohol. In fact, he has noticed that he needs to drink twice as much as he used to in order to get the same effect. Several times, he has tried to cut down, or stop drinking, but he can’t. Each time he has tried to cut down, he became very agitated, sweaty and he couldn’t sleep, so he took another drink. His family has complained that he is often hungover, and has become unreliable – making plans one day, and then canceling them another.

In your opinion, how likely is it that John would do something violent toward other people:

• Very likely (+4)
• Somewhat likely (+3)
• Somewhat unlikely (+2)
• Very unlikely (+1)
Case Study: Paul

Paul is a white man with a high school education. For the past two weeks Paul has been feeling really down. He wakes up in the morning with a flat heavy feeling that sticks with him all day long. He isn't enjoying things the way he normally would. In fact nothing gives him pleasure. Even when good things happen, they don't seem to make Paul happy. He pushes on through his days, but it is really hard. The smallest tasks are difficult to accomplish. He finds it hard to concentrate on anything. He feels out of energy and out of steam. And even though Paul feels tired, when night comes he can't go to sleep. Paul feels pretty worthless and very discouraged. Paul's family has noticed that he hasn't been himself for about the last month and that he has pulled away from them. Paul just doesn't feel like talking.

Case Study: Paul

In your opinion, how likely is it that Paul would do something violent toward other people:

• Very likely (+4)
• Somewhat likely (+3)
• Somewhat unlikely (+2)
• Very unlikely (+1)

Case Study: George

George is a white man with a high school education. Up until a year ago, life was pretty okay for George. But then, things started to change. He thought that people around him were making disapproving comments and talking behind his back. George was convinced that people were spying on him and that they could hear what he was thinking. George lost his drive to participate in his usual work and family activities and retreated to his home, eventually spending most of his day in his room. George was hearing voices even though no one else was around. These voices told him what to do and what to think. He has been living this way for six months.
Case Study: George

In your opinion, how likely is it that George would do something violent toward other people:

- Very likely (+4)
- Somewhat likely (+3)
- Somewhat unlikely (+2)
- Very unlikely (+1)

Case Study: Ringo

Ringo is a white man with a high school education. A year ago Ringo snorted cocaine for the first time with friends at a party. During the last few months he has been snorting it in binges that last several days at a time. He has lost weight and often experiences chills when binging. Ringo has spent his savings to buy cocaine. When Ringo’s friends try to talk about the changes they see, he becomes angry and storms out. Friends and family have also noticed missing possessions and suspect Ringo has stolen them. He has tried to stop snorting cocaine, but he can’t. Each time he tries to stop he feels very tired and depressed and is unable to sleep. He lost his job a month ago after not showing up for work.

Case Study: Ringo

In your opinion, how likely is it that Ringo would do something violent toward other people:

- Very likely (+4)
- Somewhat likely (+3)
- Somewhat unlikely (+2)
- Very unlikely (+1)
**Case Study: Robert**

Robert is a white man with a high school education. Until a year ago, life was pretty okay for Robert. While nothing much was going wrong in Robert’s life he sometimes feels worried, a little sad, or has trouble sleeping at night. Robert feels that at times things bother him more than they bother other people and that when things go wrong, he sometimes gets nervous or annoyed. Otherwise Robert is getting along pretty well. He enjoys being with other people and although Robert sometimes argues with his family, Robert has been getting along pretty well with his family.

**Case Study: Robert**

In your opinion, how likely is it that Robert would do something violent toward other people:

- Very likely (+4)
- Somewhat likely (+3)
- Somewhat unlikely (+2)
- Very unlikely (+1)

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**Pescosolido et al. (1999)**

<table>
<thead>
<tr>
<th>Vignette</th>
<th>Mean (N)</th>
<th>SD</th>
<th>% indicating very likely or somewhat likely</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcohol dependence*</td>
<td>2.85 (251)</td>
<td>0.27</td>
<td>71</td>
</tr>
<tr>
<td>Major depressive disorder*</td>
<td>2.63 (259)</td>
<td>0.28</td>
<td>65</td>
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<tr>
<td>Schizophrenia*</td>
<td>2.65 (296)</td>
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<td>Cocaine dependence*</td>
<td>3.07 (276)</td>
<td>0.74</td>
<td>87</td>
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<tr>
<td>Troubled person*</td>
<td>1.84 (267)</td>
<td>0.86</td>
<td>17</td>
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</tbody>
</table>

Note: Analysis of variance results were as follows: (1) Vignette, sum of squares=329.51, df=4, mean square=82.38, F=10.03, P<.001, and (2) Vignette, sum of squares=841.07, df=1327, mean square=0.63.

*Alcohol tolerance, withdrawal symptoms, inability to cut down or control use, change in drinking patterns.

*Major depressive disorder: depressed mood, loss of interest and pleasure, insomnia, fatigue, feelings of worthlessness, inability to concentrate, social withdrawal.

*Schizophrenia: delusions, auditory hallucinations, social and occupational impairment.

*Cocaine dependence: tolerance, withdrawal symptoms, inability to stop cocaine use, occupational impairment.

*Troubled person: habitual lying, sadness, nervousness, sleep problems with no functional impairment.
Pescosolido et al (2010)

Star (1955)

Nationally representative survey of public image of mental illness in Americans:

“Mental illness is a very threatening, fearful thing and not an idea to be entertained lightly about anyone. Emotionally, it represents to people a loss of what they consider to be the distinctively human qualities of rationality and free will, and there is kind of a horror in dehumanization. As both our data and other studies make clear, mental illness is something that people want to keep as far from themselves as possible.”
There a Relationship?

- Annual incidence of violent crime in people with SMI, on average, 4x higher than general population
- Mental illness is a consistent, but modest risk factor for violence
- Mental illness accounts for 3-5% of violence in the general population in the US
- NND for stranger homicide in schizophrenia is 35,000
- There is no clear evidence for a causal link between SMI and violence
- Demographic factors such as age, sex, and employment status are more reliable predictors of violence than mental illness
- Twice as likely to be victimized than neighbors
The Problem

1. Violence and mental illness are major public health problems

2. Prison population over 10,000,000 and increasing in 70% of countries worldwide

3. Number of forensic psychiatric beds increasing markedly

<table>
<thead>
<tr>
<th>Rank</th>
<th>Cause of death</th>
<th>Number of deaths (10^6)</th>
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<tbody>
<tr>
<td>1</td>
<td>Subsistence heart disease</td>
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<tr>
<td>2</td>
<td>Congestive heart disease</td>
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<td>3</td>
<td>Lower respiratory infections</td>
<td>4299</td>
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<tr>
<td>4</td>
<td>Diarrhoeal diseases</td>
<td>2996</td>
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<tr>
<td>5</td>
<td>Pertussis</td>
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<tr>
<td>6</td>
<td>Chronic obstructive pulmonary disease</td>
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<td>7</td>
<td>Diabetic complications</td>
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<tr>
<td>8</td>
<td>Neonatal deaths</td>
<td>1035</td>
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<tr>
<td>9</td>
<td>Road traffic accidents</td>
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<tr>
<td>10</td>
<td>Trachea, bronchus, and lung cancers</td>
<td>943</td>
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<tr>
<td>11</td>
<td>Neoplasms</td>
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<td>12</td>
<td>Self-harmed injuries</td>
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<td>Nephritis and nephrosclerosis</td>
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<td>Child and maternal deaths</td>
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<td>Premature infanticide</td>
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<td>30</td>
<td>HIV</td>
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(WHO, 2004)

Mental Illness is a Global Burden
The Problem

1. Violence and mental illness are major public health problems

2. Prison population over 10,000,000 and increasing in 70% of countries worldwide

3. Number or forensic psychiatric beds increasing markedly
### Number of Forensic Beds

#### Table

<table>
<thead>
<tr>
<th>Country</th>
<th>2002</th>
<th>2003</th>
<th>2004</th>
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<th>2006</th>
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<table>
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<th>2007</th>
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<th>2009</th>
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<tbody>
<tr>
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</table>

(Priebe, 2008)

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**HUGE demand for public protection**

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**Recidivism risk assessment**
Simple Definition

“Recidivism risk assessment is the attempt to predict the likelihood of future criminality in order to identify those at greatest need of intervention.”

(Singh, 2012)

Risk Assessment and Corrections:
Points of Contact

- Arrest
- Bail
- Presentencing
- During Custody
- Release from Custody
Risk Assessment and Mental Health: Points of Contact

Current Approaches to Risk Assessment

• “First Generation”
  — Unstructured clinical judgment

• “Second Generation”
  — Actuarial assessment

• “Third Generation”
  — Structured professional judgment (SPJ)

Unstructured Clinical Judgment

• Advantages
  — Convenient, flexible
  — Widely accepted
  — Able to inform risk management

• Disadvantages
  — Highly influenced by judgment biases
  — Predictive validity no better than chance
  — Low inter-rater reliability

“Flipping coins in the courtroom”
Actuarial Assessment

- **Advantages**
  - Objective
  - Pre-determined, invariant weights
  - Improve reliability and predictive validity
  - Speed

- **Disadvantages**
  - Decisions based on group norms
  - “Broken leg” dilemma
  - Limited utility in risk management plans

Structured Professional Judgment

- **Advantages**
  - Includes evidence-based factors
  - No weighting schemes
  - Allows for more professional discretion
  - No “broken leg” dilemma

- **Disadvantages**
  - Re-introduces judgment biases
  - Lower levels of reliability
  - More time consuming

Available Risk Assessment Tools

- VRAG
- SORAG
- SVR-20
- PCL-YV
- V-RISK-10
- VPS
- VRS
- SACJ
- ERASOR
- DASA
- HCR-20
- SCJ: Risk
- HKT-30
- SAPROF
- DRAS
- START
- SORM
- HCR:V3
- CARDS
- DRAMS
- SARN
- CIDRI
- SAR
- Static-99
- LSI-R
- PCL-SV
- COVR
- DVRAG
- RAMAS
- B-SAVER
- RRAS
- SOST
- PIC-R
- YLS/CMI
- PCL-R
- SAM
- WRA-20
- ERA-20
- RSVP
- SAVRY
- EARL-20B
- EARL-20G
- VASOR
Dynamic Risk Screening Instrument for Negative Grieving Harm Including Sexual Assault Without Engagement in Sadistic or Masochistic Events

DR-SINGH-IS-AWESOME-99

Available Risk Assessment Tools

- VRAG
- SORAG
- SVR-20
- PCL-YV
- V-RISK-10
- VPS
- VRS
- SACJ
- ERASOR
- DASA
- HCR-20
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- HKT-30
- SAPROF
- DRAS
- START
- SORM
- HCR:V3
- CARDS
- DRAMS
- SARN
- CIDRRI
- SARA
- Static-99
- LSI-R
- PCL-SV
- COVR
- DVRAG
- RAMAS
- B-SAFER
- RRAS
- SOST
- PIC-R
- YLS/CMI
- PCL-R
- SAM
- WRA-20
- ERA-20
- RSVP
- SAVRY
- EARL-20B
- EARL-20G
- VASOR
Which do I use?

Well, which one “works” the best?

The Goal at the End of the Day

1. Predict violence
   - Risk assessment

2. Prevent violence
   - Risk management
Question:
What are the major uncertainties regarding the utility of violence risk assessment tools?

Metareview

• “Review of reviews”
  – Meta-analyses
  – Systematic reviews

• Identify conflicting findings

• Systematic search
  – 40 reviews

Uncertainties

– Which tool(s) performs best?

– Actuarial tools vs. Structured Prof Judgment (SPJ)?

– Do tools perform similarly across demographics?
  • Men vs. women?
  • Whites vs. Minorities?
  • Different psychiatric populations?

– Do tools perform similarly across study designs?
  • Different lengths of follow-up?
  • Different sample sizes?
  • When tool authors are study authors?
  • Different base rates of violence?
Need for a New Review to Explore These Uncertainties

Included Most Commonly Used Risk Assessment Tools

**Actuarial**
- Violence Risk Appraisal Guide (VRAG)
- Level of Service Inventory – Revised (LSI-R)
- Psychopathy Checklist – Revised (PCL-R)
- Static-99
- Sex Offender Risk Appraisal Guide (SORAG)

**Structured Professional Judgment**
- Historical, Clinical, Risk Management – 20 (HCR-20)
- Spousal Assault Risk Assessment (SARA)
- Sexual Violence Risk – 20 (SVR-20)
- Structured Assessment of Violence Risk in Youth (SAVRY)

Overall Predictive Validity

<table>
<thead>
<tr>
<th>Violent offending (n=307)</th>
<th>Sexual offending (n=235)</th>
<th>Criminal offending (n=235)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Summary estimates (95% CI) from summary receiver operating characteristic curve</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diagnostic odds ratio</td>
<td>6.07 (4.58 to 9.06)</td>
<td>3.88 (2.36 to 6.40)</td>
</tr>
<tr>
<td>Sensitivity</td>
<td>0.90 (0.88 to 0.94)</td>
<td>0.88 (0.83 to 0.92)</td>
</tr>
<tr>
<td>Specificity</td>
<td>0.36 (0.29 to 0.44)</td>
<td>0.34 (0.23 to 0.51)</td>
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<tr>
<td>Individual study estimates (median [IQR])</td>
<td></td>
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<tr>
<td>Area under the curve</td>
<td>0.72 (0.68-0.78)</td>
<td>0.74 (0.68-0.77)</td>
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<tr>
<td>Positive predictive value</td>
<td>0.41 (0.27-0.60)</td>
<td>0.23 (0.19-0.41)</td>
</tr>
<tr>
<td>Negative predictive value</td>
<td>0.93 (0.82-0.96)</td>
<td>0.76 (0.61-0.84)</td>
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<tr>
<td>Number needed to detain</td>
<td>2 (2-4)</td>
<td>5 (2-11)</td>
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<tr>
<td>Number safely discharged</td>
<td>10 (4-18)</td>
<td>14 (5-48)</td>
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</tbody>
</table>
Uncertainties

- **Type of Tool**
  - No differences between Actuarial and SPJ tools

- **Demographics**
  - More White participants → more accurate
  - Higher mean ages → more accurate

- **Study Design**
  - Violent offending > Any offending

**Summary performance scores of risk assessment tools**

<table>
<thead>
<tr>
<th>Tool</th>
<th>First binning strategy</th>
<th>Second binning strategy</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>SAVRY</td>
<td>31</td>
<td>20</td>
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<tr>
<td>VRAG</td>
<td>23</td>
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<td>SARA</td>
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<td>T-HRAG</td>
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<td>SORAG</td>
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<tr>
<td>USE-R</td>
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<td>11</td>
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</table>

Note: First binning strategy = high risk vs. low/moderate risk binning strategy; Second binning strategy = moderate/high risk vs. low risk binning strategy. The four outcome statistics included diagnostic odds ratio, positive predictive and negative predictive values, and area under the curve. Summary performance scores were calculated by ordering tools from poorest to strongest performance on each effect estimate. Each tool was assigned a score of -1 (poorest performance) through +9 (strongest performance) on each outcome statistic. These values were then summed for each tool, yielding a composite performance score.

**USE RISK ASSESSMENT TOOLS AS THEY WERE DESIGNED TO BE USED**
Uncertainties (cont’d)

• No differences
  – Sex
  – Institutional vs. Community Offending
  – Length of Follow-up
  – Prospective vs. Retrospective
  – Sample size
  – North American vs. European
  – Publication status

Other Uncertainties...

– Which tool(s) performs best?
– Actuarial tools vs. Structured Prof Judgment (SPJ)?
– Do tools perform similarly across demographics?
  • Men vs. women?
  • Different diagnostic groups?
– Do tools perform similarly across study designs?
  • Different lengths of follow-up?
  • When a tool author is a study author?
  • Different base rates of violence?

Question:

How do risk assessment tools perform in different psychiatric populations?
Is there an authorship bias in violence risk assessment?
We know we cannot reliably assign probabilities to INDIVIDUALS.

But can we reliably assign probabilities to GROUPS?
Available Risk Assessment Tools

- VRAG
- SORAG
- SVR-20
- V-RISK-10
- VPS
- VRS
- SACJ
- PCL-YV
- ERASOR
- DASA
- HCR-20
- SCJ: Risk
- HKT-30
- SAPROF
- DRAS
- START
- SORM
- HCR:V3
- CARDS
- DRAMS
- SARN
- CIDRRI
- SARA
- Static-99
- LSI-R
- PCL-SV
- COVR
- DVRAG
- RAMAS
- B-SAVER
- RRRAS
- SOST
- PIC-R
- YLS/CMI
- PCL-R
- SAM
- WRA-20
- ERA-20
- RSVP
- SAVRY
- EARL-20B
- EARL-20G
- VASOR
Burning Questions

1. What tools are being used?

2. For what?

3. By whom?

4. Where?

5. What do you think about them?

Previous Surveys

• Conducted in US and UK
• Psychologists only
• No questions on use in risk management
• A single question on one survey on perceived utility
Burning Questions

1. What tools are being used?
2. For what?
3. By whom?
4. Where?
5. Perceived utility?

IRiS Project

Countries and Languages

1. Argentina
2. Australia
3. Belgium
4. Canada
5. Chile
6. Denmark
7. Germany
8. Hong Kong
9. Mexico
10. The Netherlands
11. New Zealand
12. Portugal
13. Spain
14. Sweden
15. Switzerland
16. United Kingdom
17. United States
**Respondent Characteristics**

- **N = 2,135**

- **Demographics**
  - 40% Men, 60% Women
  - Average age = 44 (SD = 11)
  - >50% clinical practice; <15% research

- **Professional Discipline**
  - Psychology = 40%
  - Nursing = 30%
  - Psychiatry = 17%
  - Other = 13%

**Lifetime Risk Assessment Tool Use**

- >50% of assessments aided by risk assessment tool

- Feedback on accuracy of risk assessments = 37%

- Feedback on whether mx plans implemented = 56%

- Majority of tools used because preferred

**Past 12 Months Risk Assessment Tool Use**

- >50% of assessments aided by a risk assessment tool

- **Purpose of risk assessments**
  - Risk prediction = 90%
  - Developing risk management plans = 70%
  - Monitoring risk management plans = 40%

- **Timeframe of assessments**
  - Shorter-term = 73%
  - Immediate = 58%
  - Longer-term = 54%
Use and Perceived Usefulness

• **Usefulness in risk assessment**
  1. HCR-20
  2. HEDS-JB
  3. SARES

• **Usefulness in developing risk management plans**
  1. FOTRES
  2. HKT
  3. SAPROF

• **Usefulness in monitoring risk management plans**
  1. FOTRES
  2. START
  3. HCR

Perception of Actuarial vs. SPJ Tools

<table>
<thead>
<tr>
<th>Trait</th>
<th>Actuarial</th>
<th>SPJ</th>
<th>Equal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Take longer to administer</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Are more expensive</td>
<td></td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Are more accurate</td>
<td></td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Are more reliable</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Are of greater interest to courts</td>
<td></td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Are of greater interest to MH review boards</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Are of greater interest to parole boards</td>
<td></td>
<td>X</td>
<td></td>
</tr>
</tbody>
</table>

* N = 1,703

Adapted Legal Defensiveness Scale

• Clinicians do not worry about...
  – Being sued for malpractice after a false negative
  – Being criminally prosecuted after a false negative

• Clinicians sometimes worry about...
  – Feeling legally obligated to use a structured tool
  – Feeling legally obligated to make ethically complex decisions regarding violence risk
Adapted Evidence-Based Practice Attitudes Scale

- Clinicians DO NOT believe...
  - RATs are useless
  - They know better than researchers how to assess risk
  - Clinical experience is more important than RATs

- Clinicians WOULD...
  - Try a new RAT even if it were very different from what they were used to doing
  - Adopt a new RAT if required by their supervisor, institution, or a new law
  - Be more likely to use a new RAT if training were received
Why to Read the Research Literature?

- Increase the reliability and accuracy of risk assessment tools
- Prevent “reversion to the norm” after training
- Identify updates on new tools and ways to administer existing tools

Reasons for Not Reading the Literature

1. “I do not know WHERE TO LOOK!”
2. “I do not have the TIME!”
3. “I do not have the MONEY!”
Examples of New Research
Findings from ONE MONTH in 2013

• General Recidivism
  — The LSI-R should be administered every three months to evaluate changes in general recidivism risk and the progress of rehabilitation programs.
  — A new instrument, the WSJCPA, can be used to determine short-term general recidivism risk for juvenile sex offenders.

• Violent Recidivism
  — Studies by risk assessment tool authors find more positive significant results than studies by independent research teams.
  — The predictive validity of the VRAG when used as specified by its manual has never been replicated.
  — The AUCs produced by violence risk assessment tools may overestimate utility in practice.

• Sex Offender Recidivism
  — Recidivism estimates published in tool manuals can not and should not be applied outside of the jurisdiction for which a tool was designed.
  — The Static-99R is not useful with Latino offenders.
  — The SORAG authors state that the tool should not longer be used in practice.

The Solution?
Listen on your commute!

Benefits

• Improves the accuracy and reliability of risk assessment tools

• Increases uptake and fidelity by staff

• Fulfills 100% of Continuing Education req’s each year

• Saves $76,000 and 2,600 hours annually

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• **Media**  
  — Newspapers and television

• **Government Reports**  
  — "Preventable deaths"

• **Surveys of the Public**  
  — Dangerousness stigma

• **Clinical Guidelines**  
  — APA/NICE Recommendations

Thank you

Questions?

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