Guide for use of the TDMHSAS Dynamic Risk Assessment Checklist - RAC (Updated 9-2016)

The TDMHSAS Periodic Dynamic Risk Assessment Checklist (RAC) is designed to assist forensic mental health evaluators with the task of assessing dynamic risk factors for violent recidivism. It is best suited for use with mentally ill service recipients. It has been designed to address common logistic problems that often limit the depth and breadth of risk assessments that evaluators are nevertheless legally mandated to perform in many clinical settings. Ethical use of the RAC requires a licensed mental health professional who has sufficient forensic-clinical experience and training with the intended population of evaluatees, or one who is supervised by a clinician who has had such experience and training. The RAC assesses only dynamic factors, factors related to risk of violence that can change over time. Therefore, the RAC should be used in combination with a measure of static risk variables (e.g., VRAG) and should not be used alone to determine a person's risk of future violence. Static factors continue to be the most robust predictors of future violence and, based on our current state of research, should always be considered in addition to the dynamic factors assessed by this checklist. Furthermore, the focus of this checklist is on the risk of violence towards others, not toward self – which may be a different set of factors in need of evaluation.

A review of the voluminous literature on risk assessment or risk management is not included in this guide. Users of this guide must make their own diligent study of it. No manual or guide is a substitute for thorough study of the literature on violence risk assessment/prediction.

DISCLAIMER: *The RAC is not a substitute for clinical judgment and/or decision-making, but rather a tool for organizing and summarizing important dynamic risk data. As it has not yet been empirically investigated, it provides no quantitative measure of current risk nor does it yield any actuarial estimates of future risk.*

Types of Factors in Risk Assessment.

Although there has been a great deal of research on what human factors, traits or situational variables are statistically related to future dangerousness, there is no one accepted theory that can serve as a scientific explanation for why (how) some persons are at greater risk than others. At this stage of development, risk assessment is largely a matter of: (1) identifying known violence risk factors; and (2) integrating the risk-factor data in a clinically meaningful manner in order to identify potentially hazardous circumstances (situations) in which the potential for violence may be realized.

Researchers and clinicians distinguish two kinds of risk factors, static factors and dynamic factors. Static factors, as their name implies, refer to relatively enduring characteristics of the person. Dynamic factors are those more fluid aspects of the person or situation that may wax and wane on their own; or which may be altered through deliberate intervention or treatment. For convenience, static factors can be conceptualized as baseline (chronic) risk factors, while dynamic factors can be conceptualized as ambient (acute) risk factors. In reality, some static factors may undergo change with the simple passage of time, or they may be neutralized through clinical intervention. Also, dynamic factors may represent repetitive features of the person's psychosocial history, or common hazards associated with the person's lifestyle.

Risk factors, whether static or dynamic, can be combined in either an actuarial or clinical manner. The RAC makes no conceptual distinction between actuarial factors versus clinical factors. From the clinician's point of view, all factors, including demographic/statistical factors, are important variables that need to be taken into account in any clinical formulation. What determines whether one is following an actuarial versus clinical method is not the data but the manner in which the data is combined. When a mechanical algorithm or a formula is used, the method is, at least implicitly, an actuarial one. When the factors are woven together into a narrative or clinical explanation about the person, then the method is a clinical one. Both actuarial and clinical methods have a place in risk assessment, albeit the outcome literature provides much greater support for the predictive accuracy of actuarial approaches.

Structure of the RAC

The RAC contains 21 items. These are all dynamic risk factors. Most of the items are established in the research as variables for predicting future violence or criminal recidivism. Several of the more clinical items (e.g., 8-13), although not as empirically well established as the other risk factors (e.g., substance abuse), were nevertheless included on the checklist on rational, clinical grounds. These items have high face validity as clinical factors related to future violence.

The purpose of including the dynamic factors assessed by this checklist as part of a comprehensive risk assessment is to:
(1) Assist the clinician in conducting a thorough and systematic assessment of dynamic risk variables,
(2) Assist the clinician in identifying important qualitative patterns or scenarios in which risk may be especially high for particular evaluatees that may change across time,
(3) Identify those aspects of risk that are targets for intervention or management.

Individual items on the RAC were written so that they can be readily coded by a knowledgeable mental health professional. The last section of this guide provides scoring criteria for each item. In many cases, however, the clinician will still need to exercise considerable professional judgment to score certain items. This is unavoidable, as some clinical constructs (e.g., insight) cannot be operationized without redefining the construct in an overly narrow manner. For some items, additional scales or checklists are suggested to assist in scoring an item. Use of these additional checklists/scales is optional and only listed to alert the reader to the literature available. In many cases, the items can be scored with a good history and adequate records. In addition, there is overlap among items on the RAC (e.g., # 8, # 9, # 10) as the contents of some of the items are related to each other. Careful consideration of the scoring criteria is required to determine the differences among these items.

The four-column checklist system of the RAC recognizes the practical limitations that attend most risk assessment evaluations. It asks raters to decide: (1) whether there is enough information to assess a risk factor; and (2) how certain they are about the presence (absence) of a risk factor (beyond a reasonable doubt, or preponderance of the evidence).

The RAC recognizes that sometimes there will be insufficient information to decide whether a risk factor is definitely present or absent. Indeed, the amount and type of missing information is an important qualifier of the evaluator's opinion. Evaluators are not private detectives, nor law enforcement investigators. Unlike attorneys or judges, evaluators cannot force the disclosure of testimony or records. Risk evaluators necessarily work under the temporal and financial limits set by those who employ them. Therefore, responsibility for the quality of the final work product, the evaluator's risk assessment, is shared by numerous parties: judges, attorneys, social service agency administrators, law enforcement, database managers, records custodians, etc. One of the evaluator's unique responsibilities is informing these other party(s) what information is actually required for a good evaluation. A second related responsibility is the unabashed reporting of missing information that could have changed the evaluator's opinion had that information been available.

The RAC deliberately emulates the law regarding the "quantum of proof" necessary to determine the existence (or non-existence) of a risk factor. Risk factors are either present (or absent) beyond a reasonable doubt, present by a preponderance of the evidence, or unknown due to insufficient information. This rating scheme encourages evaluators to specify the evidence for (or against) the existence of the risk factor. It also asks them to weigh that evidence. Finally, it encourages evaluators to support their ratings/opinions with facts and reasons that will stand up in court. This is especially important for those RAC items that are based on clinical diagnostic formulation (e.g., #2), pure clinical rating (e.g., # 4, # 8), or prognostication (e.g., # 21).

Conducting a Risk Assessment Using the RAC: Basic Requirements

Importance of an adequate database. Conducting a good risk assessment not only requires skillful clinical evaluation but also good information. Anyone who conducts risk assessments on a routine basis needs to get organized in the way that they collect, store, and access data. The most sensible way to do this is to create a structured risk assessment database. Careful inspection of the RAC items provides valuable insights about what sort of data needs to be collected in order to perform a good dynamic risk assessment. Static risk variable measures (e.g., VRAG) provide valuable insights about the type of data needed for this type of assessment. The RAC can be scored from the kinds of records and clinical interview/test data

typically available to a motivated evaluator; provided that that there is enough information and it is organized in some rational manner.

Knowing where the database is weak. The first step in filling-out the RAC is to determine what information is missing. There is no magic cut-off regarding the amount of information necessary to use for the RAC. If a lot of information is missing, then the first question to ask is what would it take to obtain the missing information. If too much information is missing, and if this deficiency cannot be remedied, then the evaluator may need to decline giving any opinion regarding the issue of future risk. If the amount of missing information is substantial, but not enough to warrant the refusal of an opinion, then the examiner will need to qualify his or her opinion by pointing out the specific limitations in the database.

The RAC can actually help the evaluator appraise the quantitative and qualitative limitations in the dynamic risk database, and thereby, justify a commensurate limit on the scope of the opinion. For example, in cases involving short, in-jail or inpatient evaluations of criminal defendants, some aspects of risk may be assessable (e.g., the dynamic factors), while others (many of the static risk factors) may not be assessable due to missing history or absence of reliable information. This has practical implications for the evaluator's opinion; namely, the evaluator may be able to render an opinion about acute risk (over the next few days or weeks) but may be unable to render an opinion about risk over longer intervals.

Item Coding: General Considerations

The material below provides instructions and guidelines for coding the RAC items. By the time the evaluator is filling-out the RAC, most, if not all, of the available risk assessment data will have been gathered and organized.

Some sources of information are generally regarded as more reliable than other (e.g., official records). Judging the reliability of unofficial information sources is a particularly important but difficult task, for which there is no simple advice. It is usually best to base important coding decisions on evidence that has been corroborated by independent sources. This is not always possible. Consequently, it is strongly recommended that the evaluator not only code the RAC item as accurately as possible, but that s/he also keep a separate list of the sources consulted in coding the item, along with any concerns about the reliability of those sources. For such situations, the reader is reminded that the "1/2" column has been provided as a way for the evaluator to code the <u>likely</u> presence of a risk factor when it is less than fully substantiated by the evidence.

Dynamic risk factors are generally coded on the basis of present or recent (e.g., past month) mental condition. Active symptoms of mental illness and substance abuse need to be identified and explored using traditional clinical methods such as clinical interviewing, testing, behavioral observation, review of recent records and collateral interviewing. Many items are based primarily on clinical judgment. For these items, it is strongly recommended that the clinician justify his or her coding decisions with clinical reasons.

It may be difficult to get the information necessary to definitively code some of the risk factors that relate to the evaluatee's future plans. Although dynamic risk factors relate mainly to the present and future, they are not blind to the past. Thus, the evaluatee's history of response to outpatient treatment, to community supervision, to probation and/or parole, can be very important in coding some dynamic risk factors. Also, it is important to set aside a portion of the clinical interview in order to ask the evaluatee about what his or her plans would be under different hypothetical scenarios. When available, a social worker can often provide useful information regarding after-care plans: the evaluatee's level of participation in the planning process; the evaluatee's attitude toward the proposed plans; and the likelihood that the particular plan components can actually be implemented, given available community resources.

The assessment of dynamic risk factors also depends on high-quality clinical interviewing and behavioral observation, in addition to the above listed sources of data, e.g., past history, records, collateral interviews. However, it is frequently necessary for the evaluator to rely on third parties to obtain recent behavioral information since the evaluatee may be motivated to control symptom presentation during forensic clinical interviews. For some items (e.g., #1, #15 , #16), conditions of hospitalization or incarceration may give a misleading impression of risk factor presence or absence. For such items, the evaluatee's score should be based on a reasonable <u>inference</u> about whether the risk factor would be present if the evaluatee were not hospitalized or incarcerated. For this purpose it is often helpful to examine the status of the risk factor during the month <u>prior</u> to hospitalization/incarceration and, based upon known or probable post-release conditions, to project the likely status of the risk factor in the environment to which the evaluatee is being released. Also, it should be

recognized that stressful conditions of incarceration may exacerbate the severity of mental symptoms (or at least their presentation to others), giving the evaluator the impression that the mental disorder is more severe than it really is. Again, focusing on the month before incarceration can help the evaluator make a more accurate rating of the risk factor in the community.

Coding Guidelines: Item by Item

1. **Craving or desire for substance use**. There is a large body of research that establishes substance use as a risk factor for violence. For this item, substance use includes the use of alcohol/drugs (including abuse of prescription drugs), but does not include nicotine and caffeine. This item requires that the evaluator identify the abused substance(s). This is done for several fairly obvious clinical reasons. Some drugs are a greater risk factor for future violence than others (e.g., PCP, stimulants). Some drugs can produce more cognitive impairment than others (e.g., organic solvents, Ecstasy, phencylidines, toxic mushrooms). Some drugs are more addictive than others (e.g., heroin, crack-cocaine). Also, some drug use is more expensive to maintain than others. Drug abusers/addicts who maintain an expensive drug habit often must engage in high-density property crimes and drug offenses (manufacture, sales and distribution) in order to support their habit.

   Because abusers often deny or minimize the severity of their problem, it is often necessary to access third-party information in order to make an accurate assessment. Prior substance abuse treatment and psychiatric hospitalization records are often helpful in these regards (e.g., evaluatee was recently hospitalized for psychiatric disorder triggered by relapse on drugs). The evaluatee's recent, current, and likely future substance use pattern in the community is the target of assessment for this item. If the evaluatee is in a controlled environment (e.g., hospital) without easy access to substances, a clinical judgment must be made about the likelihood that the evaluatee would be abusing substances if they were available (e.g., statements that they wish they could get their hands on some drugs, statements from staff that the evaluatee has solicited them for drugs, frequent requests for PRN benzodiazepines, abusing prescribed medication, etc.). Obviously, if the evaluatee is using drugs while in a controlled environment, this is certainly evidence for a score of "+." A score of "+" means that the evaluatee presently has an active substance use problem beyond a reasonable doubt with a significant risk of relapse upon release to the community. A score of "1/2" means that there is a preponderance of clinical evidence that the evaluatee has an active substance use problem. Do not score this item "-" unless you are sure beyond a reasonable doubt that the evaluatee does not presently have a substance use problem (e.g., never abused substances, has been in remission for years as documented by multiple sources). If there is little or no information in the database about the evaluatees substance use habits, then score this item "N/I."

2. **Active symptoms of a <u>major</u> axis I mental illness**. For purposes of the RAC, a major axis I mental disorder is one characterized by psychotic symptoms, severe thought disorder (disorganized, illogical, disconnected quality) and/or severe disturbance in affect (resulting in behavioral disinhibition). The precise diagnosis, or underlying cause (functional vs. organic) is not as important as the severity of the symptoms, which need to be severe enough to have a major impact on the evaluatee's thinking, emotions, and <u>behavior</u>. The symptom(s) must be active (meaning ongoing), or recently observed (past month).

   The particular symptoms that qualify scoring the risk factor as "+" need to be listed in the space provided. It is recognized that the evaluator will sometimes have less than definitive information about whether an evaluatee is suffering from a particular serious symptom (e.g., a service recipient who is unwilling to report or admit auditory hallucinations). Here it is recommended that the evaluator code the symptom as "1/2." In the case of most severe mental disorders, the evaluatee will suffer from more than one severe symptom. However, in some instances—delusional disorder being the best example—the clinical presentation may be mono-symptomatic. When the disorder is one in which only one severe symptom is required for DSM diagnosis, a single symptom is enough to code this factor "+." For disorders with polythetic diagnostic criteria (most DSM diagnoses), it is necessary that at least one of the severe symptoms be established "beyond a reasonable doubt". Multiple severe symptoms established to a "preponderance of the evidence" standard should be coded as "1/2." Do not code this risk factor as "-" simply on the basis of inadequate data. In the latter case, code it as "N/I." The code "-" should be reserved for those cases in which the evaluator is persuaded "beyond a reasonable doubt" that <u>no</u> active symptom of a major mental disorder is present.

3. **Command hallucinations to harm others and/or paranoia/persecutory delusions**. Command auditory hallucinations to harm others, besides having intuitive clinical relevance to violence, are one of the few symptoms of mental illness significantly associated with future violence in the MacArthur Violence Risk Assessment Study. Active delusions of persecution have also been related to aggression against perceived threats. A "+" is coded if the evaluatee currently indicates or has indicated recently (past month) that he/she has auditory hallucinations commanding him/her to harm or kill someone else and/or persecutory delusions or significant paranoia which raise the risk of the person acting aggressively toward perceived threats. If the case in which it is suspected that the evaluatee is having command hallucinations to harm others and/or persecutory delusions , but has learned not to admit to them, a "1/2" should be scored (e.g., evaluatee is observed responding to seemingly internal commands on the unit). A "-" is reserved for cases in which the evidence indicates "beyond a reasonable doubt" that the evaluatee is not experiencing command hallucinations to harm others or persecutory delusions. Absent adequate information, a "N/I" should be scored. Please note that this item does not include command hallucinations to harm self – which of course would be part of an assessment of danger to self but are not associated with risk of danger to others.

4. **Clinically significant anger/agitation**. Scoring of this item relies heavily on clinical judgment. The item refers to recent (past month) behavioral manifestation of anger and/or agitation. That is, the RAC is interested in the acute or "state" aspect of anger/agitation, not anger/agitation as a "trait". Clinical causes of the anger/agitation may range from substance abuse, to organic brain damage, to acute mania, to paranoid states, and to personality features. Although it would be ideal to assess the evaluatee with a formal instrument for measuring anger (e.g., Novaco's Anger Scale or Spielberger's State-Trait Anger Inventory), this is not practical in many forensic assessment settings. There are no good paper-and-pencil measures of agitation. Moreover, paper-and-pencil inventories for measuring anger tap only one source of information about anger, the evaluatee's self report, which is subject to a variety of distorting influences or response sets. If a self-report inventory is used, it is still necessary to supplement it with behavioral observations in a controlled setting and with collateral reports. Ultimately, the evaluator must decide whether the evaluatee's anger/agitation is clinically significant. Again, this is an inherently clinical judgment. A key part of the clinical assessment is identifying the source of the evaluatee's distress. In most cases, it should be possible to identify with whom (or what) the evaluatee is angry. The source(s) of anger should be listed and the evaluatee's ideations and intentions regarding the source(s) need to be explored, in order to score item #6. Score this item as "+" when the evaluatee's anger/agitation is a clinically significant risk factor "beyond a reasonable doubt". When it is more likely than not a significant risk factor then score it a "1/2." When it is clinically absent score it "-." When there is insufficient data to render a clinical opinion about the evaluatee's anger/agitation, then score it "N/I."

5. **Clinically significant impulsivity/disinhibition**. This clinical construct has recently emerged as an important dynamic risk factor. In some cases, it also has a static aspect (e.g., ADHD; many cases of organic brain damage; chronic stimulant abuse; chronic hypomania). The RAC focuses on the "state" aspect of the construct; namely, the status of this condition over the past month. Scoring of this item follows the same basic logic as that described for item #4. It is ultimately a clinical judgment call. Although there are self-report inventories for assessing impulsivity (e.g., the Barratt Impulsiveness Scale), they are not sufficiently validated to be recommended as clinical assessment tools. There are no formal measures of "disinhibition". The best assessment of impulsivity/disinhibition is the clinician's judgment from the usual sources: interview, collateral reports, testing, and behavioral observation in a controlled setting. Actual coding of this risk factor follows the logic of item #4. It is important that the evaluator list the facts and observations (evidence) that lead to his or her coding decision.

6. **Threats or urges to harm others**. This is a fairly straightforward clinical inquiry into harmful (including sexually aggressive) thoughts or urges. This is different from item #3, which addresses hallucinations commanding one to harm others. Item #6 does not require a psychotic basis and includes more general urges or threats to hurt someone else. Scoring the item requires that the clinician determine whether the ideation or urges are serious. Safety considerations suggest that it is better to over-score this item than under-score it. That is, this item aims to enhance *sensitivity* over *specificity*. Self-report is important in scoring this item, but also consider second-hand sources of information indicating that the evaluatee has threatened them (e.g., family members indicate that patient has called and threatened them or someone else). Based on the information obtained to score this item, the evaluator may determine he/she has a Tarasoff duty. In certain cases, the evaluator's risk management recommendations will

largely be comprised of interventions designed to prevent the evaluatee's violence toward a particular person or class of persons. Score it "+" when there is evidence beyond a reasonable doubt that there is a definite ideation or urge to harm a specific person or class of persons. Score it "1/2" when there is a preponderance of evidence for harmful thoughts or urges toward a specific person or class of persons, or a vague idea or urge to harm without an identifiable victim or class of victims. Score it "-" only when careful evaluation fails to reveal that the evaluatee experiences harmful thoughts or urges. When there is insufficient information, as will sometimes be the case, score it "N/I." If the evaluatee scores "+" or "1/2," then identify the potential victims in the space provided.

7. **Recent (last month) violent act(s) toward people or property**. This item addresses whether the evaluatee engaged in any violent acts towards persons or towards property (malicious destruction of property) sometime in about the last month. The definition of violence toward people is borrowed from the HCR-20. Violence is defined as actual, attempted, or threatened harm to a person or persons (e.g., hitting, slapping, throwing objects at someone, punching, kicking, biting, scratching, cutting, shooting, stabbing, etc.). Threats of harm must be clear and unambiguous (e.g., "I am going to kill you!") rather than vague statements of hostility (e.g., insults). The resulting damage to a victim is not the defining feature of a violent act, rather it is the act itself (e.g., someone who shoots a gun into a crowd of people but harms no one has committed a violent act.). All sexual assaults should be considered violent acts (e.g., actual or attempted sexual contact with a person who does not provide consent or who is unable to provide consent). The instant offense (or basis for civil commitment) counts if the act occurred within about the past month. Make sure you consider incident reports from jail, if the evaluatee has recently been jailed. Score this item as "+" when the act(s) occurred beyond a reasonable doubt. When the act(s) more likely than not did occur, then score it "1/2." When you are quite sure (beyond a reasonable doubt) that no such acts(s) occurred the score it "-," otherwise score it "N/I."

8. **Absence of insight into mental illness and/ or the need for treatment**. Scoring this item requires clinical judgment based on behavioral evidence as well as self-report data. For this item, the evaluatee's attitude toward present clinical opinions and future treatment is critical. Often it helps to ask the evaluatee what plans they have for seeking future treatment and why, or why not, they want/need treatment. This includes the need to continue to take medication and maintain contacts with mental health providers after discharge. Poor (but weakly present) insight should be scored "1/2." No (or almost no) insight should be scored "+." Fair insight or better should be scored "-. ' Reserve the score of "N/I" for situations in which there is little or no clinical data on this issue.

9. **Present non-compliance with recommended treatment**. Compliance means substantial compliance, not perfect compliance. Score this risk factor "+" when the evaluatee has been offered treatment and flatly rejected it. Score this factor "1/2" when the evaluatee begins treatment and then voluntarily discontinues it, or when the evaluatee begrudgingly accepts (or is unable to consent to) treatment that is court- ordered or otherwise coerced, or when the evaluatee expresses ambivalence about accepted treatment. Score it "-" when the evaluatee voluntarily consents to treatment; other wise score it "N/I."

10. **Poor motivation in current and future treatment**. While related to items #8 and #9, this item specifically addresses the evaluatee's motivation in treatment for mental illness, including substance abuse. This item addresses both motivation in current treatment (e.g., medication, group psychotherapy) and motivation to participate in future treatment (e.g., attend AA meetings in the community). While the evaluatee may be compliant with their treatment plan (e.g., takes medications regularly, attends most of groups), their motivation may be poor (e.g., falls asleep in group, does not participate in treatment team meetings, states that the only reason he/she takes medication is because he/she has to). If the individual clearly shows no, or almost no, motivation in their current treatment, or no motivation to continue treatment, if they were not so highly supervised, score the item "+." If the evaluatee shows poor (but not absent) motivation to participate in their current or future treatment, score the item "1/2," and if the evaluate shows fair or better motivation, score the item "-." Reserve the score of "N/I" for situations in which there is little or no clinical data on this issue.

11. **Poor response to current treatment (after adequate trial).** Sometimes an adequate amount of treatment has little or no effect upon major symptoms of a mental illness. When this involves major risk-related symptoms identified in items #2 - #5, then score this item as "+." When treatment has been helpful but there is still some appreciable risk, then score it "1/2." When treatment has eradicated the key risk-related mental symptoms, or

caused the symptoms to be manageable without appreciable risk, then score the item "-", otherwise score the item "N/I."

12. **Does not demonstrate an understanding of the warning signs for relapse of mental illness and addiction**. Recognition of the warning signs of mental illness and addiction stems from cognitive-behavioral relapse prevention theory. Namely, this item addresses whether or not the evaluatee is able to list and describe the people, places, things, situations, thoughts, and feelings that precipitated their symptoms of mental illness and addiction, in the past. It is related to their general insight into their mental illness, but more specifically addresses the acknowledgment of triggers of their mental decompensation in the past, particularly preceding their recent offense. It is important that the evaluatee is able to accurately identify his/her relapse warning signs for his/her individual life and circumstances, not just spout off a list of generic signs that may not apply to him/her. If the evaluatee has a little to no understanding of the warning signs for relapse, score the item a "+." If their understanding is marginal or too general, score the item a "1/2," and if their understanding is fair to good, score the item a "-." The absent of necessary clinical data scores this item a "N/I."

13. **Cannot plan for dealing with warning signs of relapse of mental illness and addiction**. This item is the second part of item #12. Whereas, some evaluatees may understand the warning signs for relapse, they may not have an adequate plan in place for what to do when they notice these warning signs. This item addresses the presence and adequacy of a plan the individual has for dealing with their warning signs. This is known to many service recipients as a "relapse prevention plan," and can include interventions such as calling a trusted friend or sponsor, contacting their case manager, speaking to their doctor about changes or increases in their medication, attending more AA meetings, voluntarily entering the hospital, etc. Information for this item should primarily come from self-report. Group therapists and nursing staff are often very helpful in this regard, so as to communicate what service recipients tell them in treatment settings. To score this item, the evaluator should consider both the presence of a relapse prevention plan, how realistic it is, and to what extent it will adequately prevent the evaluatee from further relapse. If the evaluatee has no relapse prevention plans in place, score the item a "+." If the evaluate has a vague relapse prevention plan or a plan that is need of revision because it is not realistic or appropriate, score this item a "1/2." If the evaluate has a reasonable and beneficial relapse prevention plan in place to deal with warning signs of relapse, score this item a "-." The absence of necessary clinical data, scores this item a "N/I."

14. **Unrealistic, inadequate, after-care plan (regardless of cause)**. The quality of an evaluatee's plans after release, from a more-restrictive to a less-restrictive environment, is related to risk (see Andrews and Bonta, 1994, 1995). Aftercare plans include a whole assortment of items, including but not limited to: mental health follow-up, case management services, housing, food, social support, income, employment, participation in drug and alcohol treatment, etc. This item is different from item #13, which specifically addresses plans for dealing with warning signs of mental illness and addiction. It is important to not only judge the adequacy of the evaluatee's personally identified plan, but to also judge the likelihood that the plan(s) can actually be implemented and maintained. A portion of this evaluation clearly involves an assessment of the adequacy of resources in the proposed less-restrictive treatment setting. It is indeed possible for the evaluatee to describe adequate reasonable plans that cannot be implemented due to lack of resources or lack of cooperation of necessary others in the less-restrictive setting. Score this item "+" when the plan is clearly inadequate in concept or availability of resources. Score this item "1/2" when the plan is marginal in design, or there is doubt that one important plan resource that is logically related to risk-management will be available. Score this item "-" if the evaluatee describes a clinically sound plan that has a good chance to be actually implemented (e.g., evidence of commitment of resources to the evaluatee). Score this item as "N/I" when there is insufficient information to assess the evaluatee's plan due to a lack of information about the availability of resources. Do <u>not</u> score the item as "N/I" if the evaluatee does not know or refuses to tell you his or her plan. In the latter event the proper score is "+."

15. **Absence of healthy, supportive social/interpersonal relationships**. Like many of the dynamic risk factors, this item requires much clinical judgment. There are two key elements: (1) whether the evaluatee has a network of family and friends: and (2) the *quality* of the evaluatee's relationships with key persons in the network. Problems can arise from a simple absence of a psychosocial network or they can arise from the *presence* of a pathological psychosocial network when the evaluatee has troubled relationships with family and friends. Many violent crimes are committed against family or friends in the context of a severely strained, conflicted relationship. This can be a

major dynamic risk factor for inter-personal violence. It has an important qualitative dimension that the scoring system cannot address. If the evaluatee has (or after release will have) little or no psychosocial support, score this item "+." Also, if the evaluatee has (or will have) one or more seriously troubled relationships with members of his or her psychosocial network, then score this item "+." A troubled relationship is one in which violence has occurred in the past or one in which there is a high potential for violence. If the evaluatee has a below average psychosocial network (definitely present but weak) or if the evaluatee has mild to moderate interpersonal conflicts with important members of that network then score this item "1/2." When there is insufficient information about the evaluatee's social/inter-personal life, score this item "N/I." Score the item "-" only when the evaluatee's psychosocial network is intact and psychologically healthy.

16. **Criminal living partners/anti-social peer group**. This item requires knowledge about the evaluatee's spouse, relatives, close friends and peer group. For fairly obvious reasons, persons who regularly socialize and identify with criminal groups are at greater risk for engaging in criminal behavior. The influence is likely to be manifest mainly when the evaluatee is actively socializing with such persons. Assessing this item requires information about where and with whom the evaluatee is going to be living, working, and socializing. When there is strong evidence that the evaluatee is going to resume living in a social environment that contains individuals with substantial criminal histories with whom the evaluatee has established close bonds, then score this item "+." When the available data suggests that the evaluatee will, more likely than not, return to such an environment, then score this item "1/2." When the data suggests that the evaluatee does not have a proclivity towards socializing with criminal groups, or s/he will not be residing in an environment that exposes him or her to such a risk, then score this item "-." Otherwise, score it "N/I."

17. **Criminal attitudes/thinking**. Criminal attitudes are belief systems and values that rationalize or justify criminal behavior, or justify a lifestyle that, in part, involves criminal behavior. Individuals with this type of attitude may be diagnosed with Antisocial Personality Disorder, although this item deals with antisocial attitudes in a state like rather than trait like fashion. Criminal attitudes allow the perpetrator of a criminal act to feel good about the act as opposed to bad. Such criminal attitudes may include: a view that the world is a "dog eat dog" place where everyone is out to get everything they can, by whatever means possible; the notion that crime victims deserve or want to be victimized; that only fools are honest; that anyone who holds a regular 9-5 "straight" job is a chump; that criminal behavior is the only way to make a living in an unfair unjust world; that empathy is a sign of weakness; that violence or threatened violence is the only way to get others to do what you want, etc. Andrews and Bonta theorize that these sorts of attitudes/cognitions are important dynamic factors that underlie criminal behavior. From a cognitive-behavioral point of view, criminogenic belief systems represent important targets for intervention. Gendreau's Criminal Sentiments Scale (CSS), one of the few measures of this construct, has shown some promise and may offer evaluators one source of data on this risk factor; or at least it may be useful as an initial screen that may be used to identify issues worth following up on clinical interview or a means by which to create a semi-structured interview on this issue. Another instrument is the Measures of Criminal Attitudes and Associates (MCAA; Mills & Kroner, 1999). Initial validation of the MCAA is promising. Pure clinical assessment of this item largely involves clinical judgment. Here it is important that the evaluator have some working experience with offender populations, for without that experience s/he may fail to ask the right sort of questions and follow-up questions necessary to assess this item. When such antisocial attitudes or beliefs are unambiguously present, then score this item "+." When the beliefs or attitudes are present to some degree, but are not predominant, then score this item "1/2." When no such attitudes are demonstrable (or inferable from behavioral patterns) then score this item "-." When there is little or no clinical data about whether the evaluatee possesses this characteristic score the item "N/I."

18. **High risk of exposure to psychosocial stressors and/or de-stabilizing influences**. Destabilizing influences are those influences that have been historically associated with the evaluatee's past criminality or psychiatric decompensation. Knowledge of the evaluatee's past patterns of maladjustment is important in scoring this item. Psychosocial stressors could include health problems, physical disability, employment difficulties, death of loved ones, financial loss, major accident or victim of disaster, etc…) However, it also includes novel influences that could be reasonably expected to lead to destabilization, given what you know about the evaluatee. The number of such possible destabilizing influences is too large, and too idiosyncratic, to try to enumerate here. However, some common ones are: the return to an environment where there is a high potential for re-traumatization (PTSD

victims); re-exposure to drugs and alcohol (recovering drug and alcohol addicts); placement in a high-crime neighborhood; absence of sufficient social services (e.g., transportation) to make medication appointments; placement in a setting in which individuals undermine the evaluatee's treatment by encouraging non-compliance with treatment; pre-mature return to a demanding or highly stressful workplace, etc. When there is a very high likelihood that the evaluatee will, in your clinical opinion, be exposed to destabilizing influences or situations in the index environment (i.e., the current or expected placement environment), then score this item "+". When this is probable (more likely than not), then score it "1/2." When there is a very low (negligible) likelihood of such exposure, then score it "-." Otherwise, when there is insufficient information about the presence of destabilizing influences in the index environment, score it "N/I."

19. **Availability and interest in weapons**. Access to weapons is an important risk factor for violent crimes. This item asks two questions: (1) does the evaluatee have an interest in weapons (fantasizing about, interest in violent movie scenes with weapons, enjoys talking about weapons, etc)?; and (2) does the evaluatee have easy access to weapons (gun collection, likes to carry weapons, lives or works in an environment where there are lots of weapons)? This is especially important if the evaluatee has used weapons in past crimes. An excellent way to assess this item is via Meloy's "Weapons History Assessment Method" (Meloy, 1990), a short semi-structured clinical interview. When the evaluatee has easy access to weapons and a strong interest in them, then score this item "+." If the evaluate possesses weapons currently (e.g., found with a makeshift weapon in their room), or is likely to possess weapons once in a less restrictive environment, then score the item "+." When the evaluatee has neither access to weapons nor an interest in them, then score this item "-." When the evaluatee has some interest in weapons but not easy access to them, score it "1/2." Otherwise, score it "N/I". If the evaluatee possesses any weapons, then list them in the space provided.

20. **Problems with rule adherence.** Individuals who are either unable or unwilling to abide by rules and expectations in a structured setting should be considered likely to be unable or unwilling to abide by rules and expectations in the community, including aftercare plans, prohibitions against substance abuse, medication adherence and/or adherence to the expectations of a Mandatory Outpatient Treatment Plan. When the person has frequent violations of even "minor" rules, or violations of rules in a variety of settings (e.g. treatment mall, on the unit, during activities), then score the item "+." A score of "+" may also be given for a single violation associated with a major risk factor for aggression (e.g. drinking alcohol). When the individual has violated a few rules, score it "1/2" This item is scored "-" when the person does not have rule violations.

21. **Likelihood of non-adherence to conditions of release.** The likelihood of non-adherence to medication, treatment, prohibition of substance abuse or other conditions of release increases the likelihood of violent behavior and/or relapse of symptoms of mental illness. The likelihood of adherence to conditions of release may be estimated with a combination of review of the person's history of adherence to recommended treatment during previous periods in the community and adherence with/participation in current treatment activities. This item is scored "+" when the person has a history of non-adherence in the past and *some or significant* non-adherence with current treatment or significant non-adherence with current treatment despite there being no known history of non-adherence during previous periods in the community. This item may be scored "1/2" when the likelihood of non-adherence to conditions of release is unclear, such as when evidence of previous or current non-adherence is due to active symptoms of mental illness rather than problems with participation in treatment when the person is able to participate. This item is scored "-" when the person has no known history of non-adherence and is currently adherent or minor non-adherence in the past with current adherence.