Assessing Violence Risk and Psychopathy in Juvenile and Adult Offenders: A Survey of Clinical Practices

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Jodi L. Viljoen,[1] Kaitlyn McLachlan,[1] and Gina M. Vincent[2]

Abstract

This study surveyed 199 forensic clinicians about the practices that they use in assessing violence risk in juvenile and adult offenders. Results indicated that the use of risk assessment and psychopathy tools was common. Although clinicians reported more routine use of psychopathy measures in adult risk assessments compared with juvenile risks assessments, 79% of clinicians reported using psychopathy measures at least once in a while in juvenile risk assessments. Extremely few clinicians, however, believe that juveniles should be labeled or referred to as psychopaths. Juvenile risk reports were more likely than adult reports to routinely discuss treatment and protective factors, and provide recommendations to reevaluate risk. The implications of these findings are discussed.

Keywords

risk assessment, forensic assessment, psychopathy, offenders, juvenile offenders

Mental health professionals frequently conduct assessments to determine the risk that an offender will reoffend (Borum & Verhaagen, 2006; Conroy & Murrie, 2007). Courts request these risk assessments to inform a number of legal decisions, such as sentencing, pretrial detention, sex offender commitment, and transfer to adult court. Because risk assessments can carry significant consequences, it is critical that the practices that clinicians use are sound and empirically supported.

Many authors strongly recommend the use of validated risk assessment tools in these assessments, given that there is evidence that unstructured clinical judgments have limited accuracy (Ægisdóttir et al., 2006; Grove, Zald, Lebow, Snitz, & Nelson, 2000; Hanson & Morton-Bourgon, 2009; Lidz, Mulvey, & Gardner, 1993; Quinsey, Harris, Rice, & Cormier, 2006; Tolman & Rotzien, 2007). According to surveys of clinical practice with adult populations (Archer, Buffington-Vollum, Stredny, & Handel, 2006; Tolman & Mullendore, 2003), some of the most commonly used risk assessment tools include the HCR-20 (Webster, Douglas, Eaves, & Hart, 1997), Violence Risk Appraisal Guide (VRAG; Harris, Rice, & Quinsey, 1993; Quinsey et al., 2006), Static-99 (Hanson & Thornton, 1999), and Level of Service Inventory (LSI; Andrews & Bonta, 1995).

Despite wide agreement that the use of risk assessment tools is desirable, there is debate as to which type of tool is preferable: structured professional judgment (SPJ) tools, in which clinicians make a structured professional judgment about overall risk level after systematically considering a set of risk factors, and/or actuarial tools, in which assessors derive a numerical risk score by algorithmically combining scores on risk factors (see Hart, Michie, & Cooke, 2007; Hilton, Harris, & Rice, 2006).

Related to this issue, there is debate regarding how risk should be optimally communicated, namely whether it should be communicated numerically, such as with probability estimates that are common within actuarial tools, and/or categorically, such as with low, moderate, or high judgments that are characteristic of SPJ tools (e.g., Hart et al., 2007; Hilton, Carter, Harris, & Sharpe, 2008; Monahan & Steadman, 1996; Slovic & Monahan, 1995; Slovic, Monahan, & MacGregor, 2000). Several studies have found that clinicians tend to prefer nonnumerical risk communication, and communication styles that identify risk factors and interventions (Heilbrun et al., 2004; Heilbrun, O'Neill, Strohman, Bowman, & Philipson, 2000; Heilbrun, Philipson, Berman, & Warren, 1999).

In addition to using specialized risk assessment tools, a number of scholars also recommend formally assessing

[1]Simon Fraser University, Burnaby, British Columbia, Canada
[2]University of Massachusetts Medical School, Worcester, MA, USA

Corresponding Author:
Jodi L. Viljoen, Department of Psychology, Simon Fraser University, RCB 5246 8888 University Drive, Burnaby, British Columbia V5A 1S6, Canada
Email: jviljoen@sfu.ca

psychopathy with adult populations (Gacono, 2000; Hart, 1998; Tolman & Rotzien, 2007). Lally (2003), for instance, found that most forensic diplomates considered the Hare Psychopathy Checklist–Revised (PCL-R) and Hare Psychopathy Checklist: Screening Version (PCL:SV) to be acceptable instruments for use in adult violence risk assessments, and several surveys have reported widespread use of these measures among forensic clinicians (Archer et al., 2006; Tolman & Mullendore, 2003). In fact, some authors argue that because psychopathy is a robust predictor of violence and reoffending, it would be unethical *not to* assess psychopathy in adults (Gacono, 2000; Hart, 1998).

At the same time, concerns have been raised regarding possible misapplications and misuses of psychopathy evidence (Edens, 2006; Edens & Petrila, 2006). Although psychopathy evidence has been introduced within numerous forensic contexts, there are some contexts in which it may be inappropriate or irrelevant, such as in death penalty decisions (Edens, Buffington-Vollum, Keilen, Roskamp, & Anthony, 2005; Edens, Colwell, Desforges, & Fernandez, 2005; Edens & Petrila, 2006). Several case reports and law reviews have highlighted examples in which incorrect or questionable inferences have been drawn from psychopathy assessments (DeMatteo & Edens, 2006; Edens, 2001, Edens, Skeem, Cruise, & Cauffman, 2001). In addition, a number of authors express concerns about the stigma associated with the use of the term "psychopath" (e.g., Cunningham & Reidy, 2001; Gendreau, Goggin, & Smith, 2002; Toch, 1998).

Concerns about stigma and misuse are particularly prominent within the literature on juvenile psychopathy. Many experts advise against labeling youth as "psychopaths" (Edens et al., 2001; Edens & Vincent, 2008). For instance, the manual for the Hare Psychopathy Checklist: Youth Version (PCL:YV; Forth, Kosson, & Hare, 2003) states, "It is inappropriate for clinicians or other professionals to label a youth as 'a psychopath'" (p. 17). However, some authors suggest that it may be useful to assess *psychopathic characteristics* in juveniles, while avoiding the label of "psychopath" (Vincent, 2006; Vitacco & Vincent, 2006). This is because there is evidence that psychopathic characteristics have moderate associations with violence and reoffending in juveniles (Edens, Campbell, & Weir, 2007; Leistico, Salekin, DeCoster, & Rogers, 2008). At this time, it is not clear how commonly clinicians assess psychopathy in youth or use the term *psychopath* in reference to a juvenile offender.

In general, despite the rapid growth in risk assessment research, we have remarkably little knowledge regarding clinical practices. Several important studies have examined the use of risk assessment and psychopathy tools in adult risk assessments (Archer et al., 2006; Tolman & Mullendore, 2003). However, research has not yet examined the use of such tools in *juvenile* risk assessments. In addition, despite current debates regarding actuarial and SPJ approaches, we do not have a clear sense of which type of risk assessment tool that clinicians prefer. We also lack basic information about the frequency and contexts in which forensic clinicians conduct juvenile and adult risk assessments, the various sources of information that clinicians use in assessing risk, and the components typically included in risk assessment reports. Finally, it is unclear what challenges and ethical issues clinicians encounter in conducting risk assessments.

In the present study, we examined the practices that clinicians use in assessing juvenile and adult offenders' reoffense risk so as to help provide an empirical basis for guiding improvements in practice. Specifically, comparing actual practices to research-based practice recommendations may reveal areas in which improvements are needed. In addition to contributing to our understanding of how clinicians assess risk, this study aimed to examine whether clinicians use different approaches in assessing risk in juveniles and adults. We hypothesized that clinicians would be less likely to use psychopathy measures and "psychopath" labels with juveniles, given the debate surrounding juvenile psychopathy. In addition, we anticipated that clinicians would place a greater focus on protective factors and treatment recommendations in juvenile risk assessments due to the greater rehabilitative focus within juvenile court. In our analyses, we also compared forensic diplomates and nondiplomates to determine whether this qualification was associated with different patterns of practice.

Method

Participants

Our full sample included 215 psychologists. Psychologists who conduct juvenile offender assessments completed the juvenile version of the survey ($n = 85$), whereas psychologists who conduct exclusively adult offender assessments completed the adult version of the survey ($n = 130$). Slightly more than half of the sample was male, and the large majority was non-Hispanic Caucasian (see Table 1). Most clinicians were trained in clinical or counseling psychology, although some had training in other types of psychology (e.g., experimental psychology, biopsychology).[1] On average, clinicians had more than 15 years of experience and had completed more than 200 risk assessments during the course of their career. Most clinicians worked in private practice but a sizable proportion worked in forensic/court clinics, jails, prisons, youth detention facilities, nonforensic mental health facilities, and academic settings. Clinicians who completed the juvenile version of the survey were more likely to work in private practice, $\chi^2(1, N = 215) = 5.89$, $p = .02$, $\varphi = .17$, and had conducted about half as many risk assessments in the past year and lifetime, $t(212) = 2.12$, $p = .035$, $d = .29$, and $t(195) = 1.93$, $p = .05$, $d = .27$, respectively.

Table 1. Sample Characteristics

	Juvenile Survey Respondents; n = 85 (%)	Adult Survey Respondents; n = 130 (%)
Age (years)	48.17 (SD = 11.81)	46.30 (SD = 12.12)
Male gender	58.8	60.0
Caucasian	92.9	89.2
Field		
Clinical psychology	89.4	79.2
Counseling Psychology	8.2	13.1
Other psychology	2.4	7.7
Highest degree		
PhD	74.1	75.4
PsyD	14.1	10.8
MA or MSc	8.2	10.8
Other	3.5	3.1
Setting of practice		
Forensic/court clinic	29.4	35.4
Private practice	60.0	43.1
Jail, prison, or youth detention center	21.2	26.2
Nonforensic mental health facility	11.8	22.3
Academic setting	23.5	17.7
Years of practice	20.22 (SD = 11.18)	16.04 (SD = 10.99)
Formal forensic training	42.4	45.4
Formal training with children or youth	69.4	—
Forensic diplomate	18.8	11.8
No. of risk assessments conducted in past year	18.24 (SD = 34.08)	29.31 (SD = 39.36)
No. risk assessments conducted in lifetime	204.38 (SD = 428.63)	429.48 (SD = 970.82)

Procedure

To obtain a sample of clinicians with experience assessing juvenile and adult offenders' reoffense risk, members from several professional organizations with special interests in forensic psychology were contacted, including the American Psychology–Law Society (AP-LS), the International Association of Forensic Mental Health Services (IAFMHS), and the Canadial Psychological Association–Criminal Justice Section (CPA-CJS). Members and diplomates listed in directories published online by the American Board of Forensic Psychology (ABFP) and American College of Forensic Psychology (ACFP) were also invited to participate. In total, 72.1% of our participants were members of the AP-LS (n = 155), 18.6% were members of the CPA-CJS (n = 40), 16.7% were members of the IAFMHS (n = 36), 14.4% were members of the ABFP (n = 31), and 1.9% were members of the ACFP (n = 4).

It is difficult to estimate the total number of potential respondents invited to complete the survey because some organizations were unable to specify the number of individuals receiving emails in their membership. Of the organizations from which membership number could be derived (IAFMHS, CPA-CJS, ABFP, ACFP), there were 793 invitations sent.[2] We asked individuals in the email invitation to click on a link if they did not conduct offender assessments; 69 individuals out of a total of 303 respondents indicated that they did not conduct offender assessments. Therefore, *at least* 22.8% of individuals who received the invitation, did not conduct assessments of offenders for the courts, and were therefore ineligible to participate. Furthermore, 21.4% of our sample (n = 50) had memberships in multiple organizations that were surveyed (e.g., AP-LS and IAFMHS). As such, the number of invitations sent is considerably higher than the number of potential respondents. Based on these figures, our best estimate is that our response rate was likely moderate (e.g., 30-60% range; see Archer et al., 2006; Chauhan, Reppucci, & Burnette, 2007; Rockett, Murrie, & Boccaccini, 2007; Salekin, Rogers, & Ustad, 2001, Salekin, Yff, Neumann, Leistico, & Zalot, 2002).

Members of IAFMHS, forensic diplomates, and clinicians listed in the ACFP directory were contacted directly by the research team via personalized email. They then received an email reminder at both 2 and 4 weeks following the initial invitation thanking them for their participation if they had responded, and requesting that they consider participating if they had not responded. This survey method was informed by procedures successfully used in other studies employing Web-based surveys (e.g., Joinson & Reips, 2005; Schaefer & Dillman, 1998). Some organizations, namely AP-LS and CPA-CJS, did not allow members to be directly contacted. Therefore, a representative of these organizations forwarded an invitation to participate to their members. These organizations did not permit email reminders to be sent. However, AP-LS members were provided an additional opportunity

to complete a paper version of the survey at the 2008 annual conference.[3]

In the invitation emails, clinicians were invited to participate in a survey on "forensic/court evaluations." We did not state that the survey focused on risk assessment because we wished to obtain an estimate of the proportion of clinicians who complete risk assessments.

Survey

The survey took approximately 15 to 20 minutes to complete, and was developed based on a review of key issues in the risk assessment field and forensic psychology literature (e.g., Borum & Verhaagen, 2006; Conroy & Murrie, 2007; Heilbrun, 2001; Grisso, 1998; Quinsey et al., 2006), as well as by examining practice surveys that have been conducted in other fields, particularly the child custody field (e.g,. Ackerman & Ackerman, 1997; Bow, 2006; Bow & Quinnell, 2001; Bow, Quinnell, Zaroff, & Assemany, 2002; Quinnell & Bow, 2001). A draft of the survey was sent to three forensic psychologists, who were experts in risk assessment, for their review and revised according to their feedback.

Survey sections. The survey had five major sections. The first section, Contexts of Risk Assessments, asked questions about the frequency and types of risk assessments that clinicians had conducted, their salary and employers, and the time it took to complete risk assessments in the typical risk assessments they conducted.

The second section, Testing and Other Sources of Information Used, included a list of 15 potential information sources (e.g., interviews with the offender, police records, risk assessment tools). Clinicians were asked whether they use these methods always (defined as 99% to 100% of the time), almost always (81% to 98% of the time), frequently (41% to 80% of the time), sometimes (11% to 40% of the time), once in a while or rarely (1% to 10% of the time), or never. In addition, clinicians were also asked to list the specific tests that they used always/almost always, frequently, or occasionally/once in awhile, and indicate whether they preferred SPJ and/or actuarial approaches. The researchers drew these response categories (e.g., frequently, 41% to 81% of the time) from previous surveys (Borum & Grisso, 1995; Jackson & Hess, 2007; Ryba, Cooper, & Zapf, 2003) to be consistent with others in the field.

The third section, Types of Information Used in Assessments, included a list of 19 potential report components (e.g., risk factors, protective factors, rationale for risk judgment, level of confidence in judgment; see the appendix for a complete list of items). For each of these components, a further description or definition was provided. Clinicians were asked whether they included these components in their reports always (99% to 100% of the time), almost always (81% to 98% of the time), frequently (41% to 80% of the time), sometimes (11% to 40% of the time), once in a while (1% to 10% of the time), or never. Clinicians were also asked how they communicate information about risk (i.e., dichotomous, categorical, or probabilistic estimates), and psychopathy (e.g., describe psychopathic characteristics, refer to offender as a psychopath).

In the fourth section, Challenges and Ethical Issues, respondents were asked several open-ended questions about challenges and ethical issues they encountered in conducting risk assessments. In the final section, Demographic Information, clinicians provided information about key demographic characteristics, such as age, gender, professional training, current position, and membership in professional organizations.

Juvenile and adult version. There were two survey versions, a juvenile version and an adult version. These two versions were identical except that the juvenile version asked about juvenile offenders, whereas the adult version asked about adult offenders. Many clinicians who evaluate juvenile offenders evaluate both juveniles and adults. For instance, in our survey, 37.7% (n = 29) of the clinicians who conduct juvenile risk assessments reported that they worked "mostly" with adolescents, whereas the rest indicated they spent "equal time" working with adolescents and adults (31.2%, n = 24), or that they work "mostly" with adults (31.2%, n = 24). Therefore, instructions indicated that clinicians who *ever* evaluate juvenile offenders were to complete the juvenile version; this included clinicians who assess juvenile offenders exclusively as well as clinicians who evaluate both juvenile and adult offenders. Clinicians who evaluate exclusively adult offenders completed the adult version of the survey.

The survey was clearly phrased so that clinicians who assess both juveniles and adults did not simply describe their general practices in assessing both of these groups but rather the specific practices that they use in assessing juveniles' risk. In particular, the introduction to the survey stated that the survey focused either specifically on juvenile offenders (juvenile version) or specifically on adult offenders (adult version). Also, each survey question included the term *juvenile* or *adolescent* offender in the juvenile version, and *adult offender* in the adult version.

Data Analysis

Chi-square analyses were used to test differences in the practices used in juvenile and adult risk assessments. While most questions had designated response options, two open-ended questions were included in the survey (i.e., "What are the biggest challenges and barriers you encounter in evaluating juvenile offenders' risk of violence/offending?" and "Have you had any ethical concerns related to assessments of juvenile offenders' risk of violence/offending?

Table 2. Contexts of Risk Assessments

	Juvenile Risk Assessments; $n = 77$ (%)	Adult Risk Assessments; $n = 122$ (%)	$\chi^2(1, N = 199)$	φ
Sentencing/disposition planning	83.1	51.6	20.26***	.32
Sentencing/disposition planning specifically individuals who have current charges/ convictions for sexual offenses	66.2	45.9	7.85**	.20
Transfer to criminal court or transfer back to juvenile court from adult court	53.2	—	—	—
Need to extend custodial commitment or implement some other continued custody (e.g., parole hearings)	31.2	58.2	13.82***	.26
Need for community services and possible diversion	45.5	45.1	0.003	.004
Need for pretrial detention	24.7	18.9	0.96	.07
Sex offender registration/notification	15.6	11.5	0.70	.06
Sex offender commitment	13.0	34.4	11.24**	.24
Competence to stand trial	2.6	8.2	2.61	.12
Not guilty by reason of insanity/criminal responsibility	1.3	7.4	3.65	.14

**$p < .01$. ***$p < .001$.

If yes or possibly, please describe the types of ethical concerns that you have had."). Two of the researchers classified responses to these questions into categories. Cases where discrepancies emerged were discussed and resolved by consensus.

Results

Contexts of Risk Assessments

Frequency and types of risk assessments. Almost all clinicians indicated that, in conducting forensic or court assessments of offenders, they had assessed the likelihood of risk of violence or reoffending (juvenile survey respondents—90.6%, $n = 77$; adult survey respondents—93.8%, $n = 122$). Risk was assessed in a number of different contexts, such as evaluations regarding sentencing and disposition planning and transfer of juveniles to or from criminal court (see Table 2). The remainder of the analyses focus on the practices used by the clinicians who conduct risk assessments ($n = 199$).

Referral sources. Many clinicians, including 69.4% ($n = 50$) of clinicians who conduct adult risk assessments and 62.4% ($n = 73$) of clinicians who conduct juvenile risk assessments, accepted referrals for risk assessments from multiple sources. The most common referral sources were judges (juvenile risk assessments—72.7%, $n = 56$; adult risk assessments—68.0, $n = 83$) and defense attorneys (juvenile survey respondents—68.8%, $n = 53$; adult survey respondents—60.7%, $n = 74$). Referrals from prosecutors (juvenile risk assessments—37.7%, $n = 29$; adult risk assessments—43.4%, $n = 53$) and probation or parole officers were also common (juvenile risk assessments—32.5%, $n = 25$; adult risk assessments—34.7%, $n = 42$). There were no significant differences in referral sources for juvenile and adult risk assessments.

Employers. Hourly wages for risk assessments ranged quite widely from \$0 to \$300 per hour (in U.S. dollars).[4] On average, hourly wages were approximately \$100 per hour (juvenile risk assessments—$M = 109.51$, $SD = 67.41$; adult risk assessments—$M = 97.77$, $SD = 73.06$). In comparison, a 2001 study reported that the average hourly wage for child custody evaluations in the United States was \$144 per hour (Bow & Quinnell, 2001). Hourly wages did not significantly differ for juvenile and adult risk assessments. However, clinicians who conduct juvenile risk assessments were significantly more likely to be employed as a contractor (76.6% vs. 50.8%), $\chi^2(1, N = 199) = 13.19$, $p < .001$, $\varphi = .26$.

Completion time. On average, clinicians spent approximately 15 hours conducting a risk assessment, including conducting interviews, obtaining and reviewing records, writing the report, etc. (juvenile risk assessments—$M = 14.11$, $SD = 9.16$; adult risk assessments—$M = 16.71$, $SD = 11.10$). Slightly more than half of clinicians said they were given deadlines for the risk assessment reports (juvenile survey respondents—62.3%, $n = 48$; adult survey respondents—66.4%, $n = 81$). Among those given deadlines, the average deadline was 28.25 days ($SD = 22.94$). Completion time and deadlines did not vary significantly for juvenile and adult risk assessments.

Table 3. Sources of Information Used Always or Almost Always in Assessments

	Juvenile Risk Assessments; $n = 77$ (%)	Adult Risk Assessments; $n = 122$ (%)	$\chi^2(1, N = 199)$	φ
Test use				
Risk assessment tools	61.0	75.4	4.62*	.15
Psychopathy tools	33.8	54.1	7.85**	.20
Mental health and psychopathology tests	83.1	46.7	26.24***	.36
Intellectual and cognitive tests	53.2	26.2	14.84***	.27
Interviews				
Offender being evaluated	98.7	92.6	3.65	.14
Caretaker	72.7	—	—	—
Other noncaretaker family member	24.7	—	—	—
School teacher	7.8	—	—	—
Family member (adult version)	—	13.9	—	—
Interview with probation/parole officer (if applicable)	35.1	18.9	6.60*	.18
Mental health service provider (if applicable)	31.6	37.7	0.77	.06
Records				
Police or law enforcement	88.3	91.0	0.37	.04
Mental health records (if applicable)	84.4	82.8	0.09	.02
School records (if applicable)	61.0	14.8	45.98***	.48
Social work records (if applicable)	62.3	47.5	4.15*	.14
Custodial/detention facility records (if applicable)	63.6	66.4	0.16	.03

Note: Some of these sources of information are not relevant in all cases. For instance, some offenders do not have mental health provider and have not had prior mental health services. Therefore, for these items, we specified that raters should rate these items based on cases in which this was applicable (i.e., if the offender had received mental health services).
*$p < .05$. **$p < .01$. ***$p < .001$.

Testing and Other Sources of Information Used

Interviews and record use. In conducting risk assessments, more than 90% of clinicians reported that they always or almost always (defined as 81% of the time or more) interview the offender (see Table 3). Also, approximately 73% of clinicians who were surveyed about juvenile risk assessments always or almost always interview youths' caretaker(s).[5] Although most clinicians obtain police or law enforcement records, approximately 10% of clinicians do not obtain this information always or almost always.

Overall test use. Clinicians were asked to rate how frequently they used the following broad categories of testing: tests to assess "risk for violence or offending (i.e., risk assessment tools)," "psychopathy or psychopathic characteristics," "mental health or psychopathology," and "intellectual and cognitive functioning." Overall, the use of risk assessment tools was common in our sample (see Table 3). Very few clinicians *never* use risk assessment tools in adult risk assessments (2.5%, $n = 3$) or juvenile risk assessments (2.6%, $n = 2$). However, clinicians were more likely to *always or almost always* use risk assessment tools in adult risk assessments than juvenile risk assessments. The use of psychopathy tools was also fairly common. Only 9.8% ($n = 12$) of clinicians *never* use psychopathy tools in adult risk assessments. Although the use of psychopathy tools was less common in juvenile risk assessments, 79.2% of clinicians ($n = 61$) reported that they used psychopathy tools at least *once in a while* in assessing juveniles' risk. Measures of psychopathology and intelligence were more commonly used in juvenile risk assessments than adult risk assessments.

Specific tests. In addition to rating their use of broad categories of tests (i.e., psychopathology tests, cognitive tests, risk assessment tools, and psychopathy tests), clinicians were asked to list the specific tests that they used always/almost always, frequently, or occasionally/once in awhile. Consistent with Archer et al. (2006), we calculated both the total number of times a test was mentioned (total mention score), and also calculated a weighted mention score, whereby tests were given more weight for greater intensity of use (i.e., 3 points for each respondent who used the test always/almost always, 2 points for each respondent who used the test frequently, and 1 point for each respondent who used the test occasionally). For juvenile clinicians, the most commonly used tests included the Wechsler Intelligence Scales, Minnesota Multiphasic Personality tests, and the Structured Assessment of Violence Risk in Youth (SAVRY; see Table 4). For adult clinicians, the most commonly used tests included the Hare Psychopathy Checklist tests, HCR-20, and the MMPI-II (see Table 5). It is important to note that this survey likely underestimates the use of specialized measures such as the Static-99 and SARA

Table 4. Most Common Tests Used in Juvenile Risk Assessments

	Always or Almost Always	Frequently	Sometimes or Once in a While	Total Mentions	Weighted Mentions	Proportion Who Use Test (%)
WISC-IV, WAIS-III, or WASI	28	22	8	58	136	75.3
MMPI-A or MMPI-2	34	8	9	51	127	66.2
SAVRY	19	6	2	27	71	35.1
MACI or MCMI-III	18	3	3	24	63	31.2
PCL:YV or PCL-R	7	3	10	20	37	26.0
WRAT-3 or WRAT-4	10	6	3	19	45	24.7
Rorschach	7	2	6	15	31	19.5
CBCL or YSR	4	6	1	11	25	14.3
Jesness	6	3	1	10	25	13.0
YLS/CMI	7	0	2	9	23	11.7
J-SOAP-II	5	2	0	7	19	9.1
MAYSI-2	6	1	0	7	20	9.1
ERASOR	4	2	1	7	17	9.1
KBIT	3	3	1	7	16	9.1

Note: WISC-IV = Wechsler Intelligence Scale for Children–IV (Wechsler, 2003); WAIS-III = Wechsler Adult Intelligence Scale–III (Wechsler, 1997); WASI = Wechsler Abbreviated Scale of Intelligence (Wechsler, 1999); MMPI-A = Minnesota Multiphasic Personality Inventory–Adolescent (Butcher et al., 1992); MMPI-II = Minnesota Multiphasic Personality Inventory–II (Hathaway & McKinley, 1989); SAVRY = Structured Assessment for Violence Risk in Youth (Borum, Bartel, & Forth, 2003); MACI = Millon Adolescent Clinical Inventory (Millon, Millon, & Davis, 1993); MCMI-III = Millon Clinical Multiaxial Inventory–III (Millon, 1994); WRAT-3 = Wide Range Achievement Test 3 (Wilkinson, 1993); PCL:YV = Hare Psychopathy Checklist: Youth Version (Forth, Kosson, & Hare, 2003); PCL-R = Hare Psychopathy Checklist–Revised (Hare, 1991, 2003); WRAT-4 = Wide Range Achievement Test 4 (Wilkinson & Robertson, 2006); Rorschach = Rorschach (Rorschach, 1942); CBCL = Child Behavior Checklist (Achenbach, 1992; Achenbach & Rescorla, 2001); YSR = Youth Self-Report (Achenbach, 1991; Achenbach & Rescorla, 2001); Jesness = Jesness Inventory (Jesness, 1996); YLS/CMI = Youth Level of Service/Case Management Inventory (Hoge, Andrews, & Leschied, 2002); J-SOAP-II = Juvenile Sex Offender Assessment Protocol (Prentky & Righthand, 2003); MAYSI-2 = Massachusetts Youth Screening Instrument–Version 2 (Grisso & Barnum, 2006); ERASOR = Estimate of Risk of Adolescent Sexual Offense Recidivism (Worling & Curwen, 2001); KBIT = Kaufman Brief Intelligence Test (Kaufman & Kaufman, 1990). Consistent with Archer, Buffington-Vollum, Stredny, and Handel (2006), we calculated a weighted mention score by assigning 3 points for each time a test was used always or almost always, 2 points for each time a test was used frequently, and 1 point for each time a test was used sometimes or once in a while.

because it did not focus on specific specialized forms of violence risk assessment such as sexual offending or domestic violence.

Preferences for SPJ and/or actuarial risk assessment tools. When asked whether they prefer actuarial tools, SPJ tools, both, or if they consider neither to be useful, only two clinicians reported that neither actuarial nor SPJ risk assessment tools were useful. Many clinicians expressed a belief that *both* SPJ and actuarial tools could be useful in juvenile risk assessments (61.0%, $n = 47$) and adult risk assessments (60.7%, $n = 74$). Clinicians were significantly more likely to prefer SPJ approaches in juvenile risk assessments than in adult risk assessments (juvenile risk assessments—31.2%, $n = 24$; adult risk assessments—15.6%, $n = 19$), $\chi^2(1, N = 199) = 6.78$, $p < .01$, $\varphi = .19$. In addition, they were significantly less likely to prefer actuarial approaches in juvenile risk assessments (juvenile risk assessments—6.5%, $n = 5$; adult risk assessments—22.1%, $n = 27$), $\chi^2(1, N = 199) = 8.55$, $p < .01$, $\varphi = .21$.

Views about the age at which psychopathy-related characteristics should be assessed. Respondents were asked, "In your opinion, what is the youngest age at which psychopathy-related traits should be assessed (in years)?" In the total sample, 12.8% ($n = 25$) believed that psychopathy-related traits should be assessed in individuals younger than 12, 49.2% ($n = 96$) believed that psychopathy-related traits should first be assessed somewhere between the ages of 12 and 17, and 37.9% ($n = 74$) believed these traits should not be assessed until adulthood (i.e., 18 years or older). Somewhat surprisingly, clinicians who conducted juvenile risk assessments (i.e., juvenile survey respondents) were significantly more likely than clinicians who assess exclusively adult offenders (i.e., adult survey respondents) to believe that psychopathy-related traits should be assessed in juveniles aged 17 years and younger (89.6% vs. 44.1%), $\chi^2(1, 195) = 41.04$, $p < .001$, $\varphi = .46$.

Reports Characteristics

Report lengths. The average report length was around 12 to 13 pages (juvenile risk assessments—$M = 12.22$, $SD = 9.28$; adult risk assessments—$M = 12.82$, $SD = 11.41$), with approximately 3 to 4 pages dedicated to the section on risk of violence or reoffending (juvenile risk assessments—$M = 3.22$, $SD = 3.25$; adult risk assessments—$M = 3.62$, $SD = 3.36$).

Report components. The most common components that were included always or almost always (i.e., 81% of the

Table 5. Most Common Tests Used in Adult Risk Assessments

	Always or Almost Always	Frequently	Sometimes or Once in a While	Total Mentions	Weighted Mentions	Proportion Who Use Test (%)
PCL-R or PCL:SV	54	13	12	79	200	64.8
HCR-20	46	5	0	51	148	41.8
MMPI-II	28	20	17	65	141	53.3
WAIS-III or WASI	15	12	27	54	96	44.3
Static-99	29	5	5	39	102	32.0
VRAG	27	3	4	34	91	27.9
PAI	12	7	7	26	57	21.3
MCMI-III	8	5	8	21	42	17.2
SVR-20	13	6	1	20	52	16.4
LSI-R or LSCMI	12	2	1	15	41	12.3
SORAG	11	2	1	14	38	11.5
SARA	4	2	5	11	21	9.0
SILS	5	4	2	11	25	9.0
Rorschach	6	2	2	10	24	8.2
Stable-2000 or Stable-2007	7	2	0	9	25	7.4

Note: PCL-R = Hare Psychopathy Checklist–Revised (Hare, 1991); PCL:SV = Hare Psychopathy Checklist–Revised: Screening Version (Hart, Cox, & Hare, 1995); HCR-20 = HCR-20 (Webster, Douglas, Eaves & Hart, 1997); MMPI-II = Minnesota Multiphasic Personality Inventory–2 (Hathaway & McKinley, 1989); WAIS-III = Wechsler Adult Intelligence Scale–III (Wechsler, 1997); WASI = Wechsler Abbreviated Scale of Intelligence (Wechsler, 1999); Static-99 = Static-99 (Hanson & Thornton, 1999); VRAG = Violence Risk Appraisal Guide (Quinsey, Harris, Rice, & Cormier, 1998); PAI = Personality Assessment Inventory (Morey, 2007); SVR-20 = Sexual Violence Risk–20 (Boer, Hart, Kropp, & Webster, 1997); MCMI-III = Millon Clinical Multiaxial Inventory–III (Millon, 1994); LSI-R = Level of Service Inventory–Revised (Andrews & Bonta, 1995); SORAG = Sex Offender Risk Appraisal Guide (Quinsey, Harris, Rice, & Cormier, 1998); SARA = Spousal Assault Risk Assessment Guide (Kropp, Hart, Webster, & Eaves, 1995); SILS = Shipley Institute of Living Scales (Shipley, 1940; Zachary, 1986); Stable-2000 and Stable-2007 (Hanson, Harris, Scott, & Helmus, 2007); Rorschach = Rorschach (Rorschach, 1942). Consistent with Archer, Buffington-Vollum, Stredny, and Handel (2006), we calculated a weighted mention score by assigning 3 points for each time a test was used always or almost always, 2 points for each time a test was used frequently, and 1 point for each time a test was used sometimes or once in a while.

time or more) in juvenile and adult risk assessment reports were descriptions of past violence and offending, risk factors, rationales for risk judgments, and protective factors (see Table 6). Relatively few clinicians indicated that they always or almost always discussed possible targets or timelines of violence/offending, the likely seriousness of future offenses, or their level of confidence in their judgments. Also, few clinicians made explicit recommendations regarding ultimate legal issues (e.g., whether an offender should be detained, transferred to adult court, etc.). Although many clinicians indicated that they discussed research at least once in a while (juvenile risk assessments—87.0%, $n = 67$; adult risk assessments—79.5%, $n = 97$), most clinicians did not routinely include this information in risk assessment reports. Juvenile risk assessment reports were significantly more likely than adult risk assessment reports to routinely include a discussion of protective factors, treatment recommendations, and judgments regarding risk level. Juvenile reports were also more likely to routinely include recommendations to reevaluate risk, and to discuss limitations of the risk assessment (see Table 6).

Communication about risk level. Most clinicians reported that they generally communicated risk in a categorical manner (see Table 7). However, approximately 13% of clinicians preferred to present results in a probabilistic manner, or using a combination of probabilistic and categorical communication. Juvenile risk assessment reports were significantly more likely than adult reports to use categorical risk communication approaches.

Communication about psychopathy. Clinicians were asked how they communicate psychopathy information in their assessment reports. In particular, we examined the degree to which clinicians explicitly use the term *psychopath* in their reports. Clinicians were presented with the following response options: 1. I state whether offender is or is not a psychopath; 2. I state if offender has characteristics associated with psychopathy and explicitly refer to these characteristics as psychopathy related; 3. I state if the offender has characteristics associated with psychopathy but do *not* explicitly refer to these characteristics as psychopathy related; 4. I do not include this information in my reports, but consider it in overall risk; and 5. I do not ever assess psychopathy. If clinicians checked multiple responses, they were coded only for the response reflecting the most explicit use of the term *psychopath* or *psychopathy*. For instance, if a clinician checked Options 2 and 3 (above) this was only counted once under Option 2, as this indicated a more explicit use of the term *psychopathy*. As shown in Table 8,

Table 6. Components Included in Reports

	Juvenile Risk Assessments; $n = 77$ (%)	Adult Risk Assessments; $n = 122$ (%)	$\chi^2(1, N = 217)$	φ
Past violence and offending	96.1	94.3	0.34	.04
Risk factors	94.8	93.4	0.15	.03
Protective factors	94.8	80.3	8.18**	.20
Judgment regarding risk level	74.0	86.1	4.52*	.15
Rationale for risk judgment	93.5	90.2	0.68	.06
Level of confidence in judgment	26.0	22.1	0.39	.04
Contexts under which offender is most likely to reoffend	58.4	60.7	0.10	.02
Types of future violence and offending	39.0	39.3	0.00	.00
Seriousness of future violence/offending	28.6	26.2	0.13	.03
Possible targets of future violence and offending	18.2	26.2	1.72	.09
Possible timeline of future violence and offending	11.7	16.4	0.84	.07
Treatment recommendations regarding violence and reoffense risk	89.6	65.6	14.50***	.27
Broader treatment recommendations	76.6	48.4	15.62***	.28
Placement recommendations	49.4	38.5	2.26	.11
Recommendations about supervision	59.7	45.9	3.62	.14
Explicit recommendation regarding the ultimate legal issue	20.8	18.0	0.23	.03
Recommendations to reevaluate risk	37.7	22.1	5.63*	.17
Limitations of judgments	78.9	56.6	10.34**	.23
Description of relevant research findings	31.2	27.9	0.25	.04

*$p < .05$. **$p < .01$. ***$p < .001$.

Table 7. Risk Communication

	Juvenile Risk Assessments; $n = 77$ (%)	Adult Risk Assessments; $n = 122$ (%)	$\chi^2(1, N = 199)$	φ
Dichotomous estimate	3.9	4.9	0.11	.02
Categorical estimate	88.3	73.0	6.69*	.18
Probabilistic estimate	2.6	9.8	3.78	.14
Categorical and probabilistic estimate	0.0	9.0	7.35**	.19
None of these approaches	5.2	3.3	0.45	.05

*$p < .05$. **$p < .01$.

Table 8. Communication About Psychopathy

	Juvenile Risk Assessments; $n = 77$ (%)	Adult Risk Assessments; $n = 122$ (%)	$\chi^2(1, N = 199)$	φ
I state whether offender is or is not a psychopath	2.6	41.0	36.04***	.43
I state if offender has characteristics associated with psychopathy and explicitly refer to these characteristics as psychopathy related	28.6	28.7	0.00	.00
I state if the offender has characteristics associated with psychopathy but do *not* explicitly refer to these characteristics as psychopathy related	45.5	28.7	5.82*	.17
I do not include this information in my reports, but consider it in overall risk	7.8	0.0	9.80**	.22
I do not ever assess psychopathy	11.7	0.0	14.94***	.27

*$p < .05$. **$p < .01$. ***$p < .001$.

only two clinicians indicated that they ever explicitly state whether or not a juvenile offender is a "psychopath" in their juvenile risk assessment reports. Instead, most clinicians who assess juveniles focus on describing whether the youth has psychopathy-related characteristics. Although it was more common to explicitly state whether or not an offender is a "psychopath" in adult risk assessment reports than in juvenile risk assessment reports, most clinicians who conduct adult assessments also appear to focus on describing psychopathy-related characteristics.

Views about the use of the term "Psychopath." In addition to asking clinicians about how they communicate psychopathy evidence in their reports, respondents were asked, in a separate question, whether they believed in general individuals (including adults) should ever be labeled or referred to as "psychopaths" if they meet criteria for psychopathy on a diagnostic tool. They were also asked the youngest age at which an individual should be referred to as a "psychopath." Many clinicians indicated that they oppose labeling anyone, including adults, as psychopaths (47.0%, $n = 94$), or are unsure about whether or not this is appropriate (39.2%, $n = 78$). Furthermore, only 7.8% ($n = 6$) of juvenile survey respondents and 11.5% ($n = 14$) of adult survey respondents believe that juveniles aged 17 years or younger should be referred to as "psychopaths."

Challenges and Ethical Issues

Challenges. The most common challenge described in conducting risk assessments was difficulty obtaining records and collateral information (50.8%, $n = 101$). A number of clinicians expressed concerns about having insufficient time to complete the evaluation (10.6%, $n = 21$), and about test limitations or the scientific validity of tools (8.5%, $n = 17$). In addition, some clinicians who were surveyed about adult risk assessments reported concerns about lack of examinee cooperation (9.5%, $n = 19$), and some clinicians who were surveyed about juvenile risk assessments reported concerns about lack of *parent or guardian* cooperation (4.5%, $n = 9$).

Ethical issues. Approximately two thirds of clinicians reported that they had ever had ethical concerns or possible ethical concerns related to assessments of offenders' risk of violence and reoffending (juvenile survey respondents—62.3%, $n = 48$; adult survey respondents—64.8%, $n = 79$). The most common concerns were that evaluations could be misused or lead to negative consequences (25.1%, $n = 50$), as well as concerns about accuracy and lack of information (23.6%, $n = 47$). A number of clinicians expressed concerns about unethical practices of other clinicians or conflicts with other clinicians (6.5%, $n = 13$) and the voluntariness of evaluations and consent (5.5%, $n = 11$).

Diplomate Status and Clinical Practices

We examined whether forensic diplomates differed from nondiplomates with respect to clinical practices (e.g., testing and other sources of information used in risk assessments, preferences for SPJ and/or actuarial tools, report characteristics, communication about risk and psychopathy). These analyses were run separately for juvenile and adult survey respondents. There were no differences in the practices of diplomates and nondiplomates for conducting *adult* risk assessments. However, with respect to *juvenile* risk assessments, diplomates were more likely than nondiplomates to always or almost always (i.e., 81% of the time or more) use risk assessment tools (86.7% vs. 56.9%), $\chi^2(1, N = 73) = 4.53$, $p < .05$, $\varphi = .25$; interview family members other than parents (46.7% vs. 19.0%), $\chi^2(1, N = 73) = 4.92$, $p < .05$, $\varphi = .26$; and examine school records (86.7% vs. 51.7%), $\chi^2(1, N = 73) = 6.01$, $p < .05$, $\varphi = .29$. Also, in writing juvenile risk assessment reports, diplomates were more likely to always or almost always describe the contexts under which youth would be most likely to reoffend (80.0% vs. 51.7%), $\chi^2(1, N = 73) = 3.90$, $p < .05$, $\varphi = .23$.

Clinician Age and Clinical Practices

We also compared the practices of younger and older clinicians as a proxy for recency of graduate training. The median age of our sample was 47 years. Therefore, younger clinicians were defined as those who were 47 years old or younger. We hypothesized that younger clinicians may be more likely to adopt approaches that are consistent with recent developments in the field (e.g., risk assessment tools) because of their more recent training. Among clinicians who were surveyed about adult risk assessments, younger clinicians were more likely to always or almost always (i.e., 81% of the time or more) use risk assessments tools (84.2% vs. 62.2%), $\chi^2(1, N = 102) = 6.40$, $p < .05$, $\varphi = .25$, interview family members (19.3% vs. 2.2%), $\chi^2(1, N = 102) = 7.06$, $p < .01$, $\varphi = .26$, and interview mental health service providers (43.9% vs. 24.4%), $\chi^2(1, N = 102) = 4.15$, $p < 05$, $\varphi = .20$. Also, they were more likely to include in their reports descriptions of possible victims (36.8% vs. 17.8%), $\chi^2(1, N = 102) = 4.49$, $p < .05$, $\varphi = .21$; recommendations regarding treatment of violence and reoffending (77.2% vs. 55.6%), $\chi^2(1, N = 102) = 5.38$, $p < .05$, $\varphi = .23$; and recommendations for treatment for broader issues (59.6% vs. 37.8%), $\chi^2(1, N = 102) = 4.81$, $p < .05$, $\varphi = .22$.

Among clinicians who conduct juvenile risk assessments, the pattern of results differed. Younger clinicians were *less* likely to always or almost always obtain school records (32.0% vs. 74.7%), $\chi^2(1, N = 64) = 11.21$, $p < .01$, $\varphi = .42$, social work records (40.0% vs. 71.8%), $\chi^2(1, N = 64) = 6.39$, $p < .05$, $\varphi = .32$, and custody records (40.0% vs. 69.2%),

$\chi^2(1, N = 64) = 5.34$, $p < .05$, $\varphi = .29$. In addition, younger clinicians were more likely to always or almost always include conclusions regarding risk level in their report (92.0% vs. 69.2%), $\chi^2(1, N = 64) = 4.62$ $p < .05$, $\varphi = .27$, and to consider psychopathy in their assessment but not explicitly include it in their report (20.0% vs. 2.6%), $\chi^2(1, N = 64) = 5.45$, $p < .05$, $\varphi = .29$.

Discussion

Although research on risk assessment has advanced considerably over the past several decades, we know little about practices that clinicians use in assessing offenders' risk. To help address this gap, we surveyed clinicians who were members of forensic professional organizations. Our results indicated that (a) forensic clinicians frequently assess risk of violence and offending, (b) the use of risk assessment tools is common, (c) clinicians commonly assess psychopathy in juveniles but there is consensus against labeling juveniles as psychopaths, and (d) although juvenile and adult risk assessment reports include similar components, they differ in several important ways. These primary findings are further described below. It is important to note that this study describes practices that clinicians typically use in assessing risk rather than revealing what are best practices. For instance, even if almost all clinicians adopt a particular approach, it does not mean that this approach is sound or appropriate. Therefore, in interpreting our findings, we discuss whether the practices that clinicians use are empirically supported and in line with ethical standards.

Primary Findings

Forensic clinicians frequently assess risk of violence and offending. More than 90% of clinicians indicated that they had assessed risk in their evaluations of juvenile or adult offenders. This finding emphasizes that it is important to understand the practices that clinicians use in assessing risk. Furthermore, given the frequency of risk assessments, it appears critical that all clinicians who evaluate offenders for the courts gain expertise in risk assessment.

Risk assessments arose in nearly every possible type of forensic evaluation, including assessments related to sentencing or disposition planning, transfer of juveniles to criminal court, extension of custodial commitment (e.g., parole hearings), diversion, pretrial detention, and sex offender registration and commitment. Somewhat surprisingly, risk assessments also sometimes arose in evaluations of competence to stand trial and pleas of not guilty by reason of insanity (NGRI). In certain instances, courts may ask clinicians to assess risk in cases involving competence or NGRI. For instance, in Washington state, evaluators are obligated to consider "whether the defendant is a threat to public safety" in conducting competence and NGRI evaluations (Revised Code of Washington, 10.77.060, n.d.). Although risk assessments may be relevant to decisions regarding whether an individual found NGRI or incompetent to stand trial should be hospitalized, risk is not directly relevant to the legal question of whether an individual is NGRI or incompetent. Therefore, clinicians should use caution in assessing risk in these circumstances. As indicated by professional practice guidelines and ethical standards, it is inappropriate and unethical to assess risk if it is not relevant to the legal issue at hand (see Committee on the Revision of the Ethical Guidelines for Forensic Psychology, 2008).

Use of risk assessment tools is common. More than half the clinicians in our sample use risk assessment tools *always or almost always* in risk assessments and less than 7% *never* use these tools. These findings are really quite remarkable, given that these tools only first emerged approximately 15 years ago (Borum, 1996). There is now a fairly significant body of research to support the use of certain risk assessment tools (see, e.g., Grisso, Vincent, & Seagrave, 2005; Jackson, 2008, for reviews). In fact, compared with unstructured clinical judgments, some tools have such strong support that clinicians who rely on unstructured judgments may be required to justify their decision to the courts.

Clinicians were less likely to use risk assessment tools in juvenile risk assessments than adult risk assessments, possibly because juvenile tools developed more recently and are less established. That being said, forensic diplomates (86%) were more likely than nondiplomates (57%) to routinely use these tools in juvenile risk assessments. As such, advanced training and qualifications may assist with the dissemination of juvenile risk assessment tools. Similarly, Tolman and Mullendore (2003) found that forensic diplomats were much more likely to use risk assessment tools than general clinicians.

Rather than blindly embracing risk assessment tools, it is important for clinicians to carefully consider whether a particular tool is appropriate to a particular assessment context (Committee on the Revision of the Ethical Guidelines for Forensic Psychology, 2008). Some tools may be appropriate in certain psycholegal contexts but not others (e.g., Edens & Petrila, 2006). Furthermore, although many tools may seem, on first glance, to have an impressive grounding in research, risk assessment tools vary considerably in terms of their research support. Therefore, clinicians should closely examine evidence for particular tools and be aware of potential limitations in tools.

For instance, many juvenile risk assessment tools still have no evidence of interrater reliability (Vincent, Terry, & Maney, 2009). Also, although the tools that survey respondents use the most frequently (e.g., SAVRY, YLS/CMI, HCR-20, Static-99, and VRAG) have considerable research support, most of extant research comes from studies in which

tools were coded from file information by graduate student raters. At this point, we have limited knowledge regarding the real-world use of tools. However, some research suggests that the interrater reliability and predictive validity of tools may sometimes be weaker in real-world clinical settings (Guy & Yusem, 2009). For instance, Murrie, Boccaccini, Johnson, and Janke (2008) conducted several recent studies that examined the assessments of opposing experts in sex offender commitment trials (see also Murrie et al., 2009). They found low rater agreement on the PCL-R and Minnesota Sex Offender Sex Offender Screening Tool–Revised, suggesting that scores may be influenced by adversarial allegiance.

In selecting tools, one choice that clinicians face is whether to adopt an SPJ tool or an actuarial risk assessment tool. The relative merits of these approaches have been debated. Some authors emphasize that SPJ tools allow clinicians to take into account case-specific information and focus on treatment-relevant variables (e.g., Douglas, Cox, & Webster, 1999; Douglas, Ogloff, & Hart, 2003). Other authors warn that any type of clinical judgment, including structured professional judgments, may be susceptible to biases (e.g., Hilton et al., 2006; Quinsey et al., 2006). A recent meta-analysis by Guy (2008) sheds some light on this issue, and reveals that SPJ tools perform comparably to actuarial tools in predictions of violence risk.

Although our respondents differed somewhat in their views, most clinicians believed that both types of tools can be useful. However, in juvenile risk assessments, SPJ tools were more commonly preferred than actuarial tools. In part, this may reflect the fact that few juvenile actuarial tools in circulation have been validated or studied cross-jurisdictions.[6] Also, it could reflect a different philosophy underlying juvenile assessment, such as an attraction to SPJ models because they may be more likely to include dynamic and treatment-related risk factors.

Psychopathy measures were common, including in juvenile risk assessments. Approximately 90% of clinicians in our sample reported that they use tests to measure psychopathy or psychopathic characteristics at least once in a while in adult risk assessments. The most common psychopathy measures, the PCL-R or PCL:SV, were used by 65% of clinicians. This is consistent with Tolman and Mullendore (2003), who found that 63% of forensic diplomats use the PCL-R in risk assessments.

Our results indicate that the use of psychopathy measures (i.e., PCL:YV) is also fairly common in *juvenile* risk assessments. Specifically, one third of clinicians use psychopathy measures always or almost always in assessing juveniles' risk, and 78% use these measures at least once in a while. Although many clinicians believe it is useful to assess psychopathic features in adolescents, very few clinicians believe that juveniles should be referred to as "psychopaths." Thus, clinicians appear to have heeded the warnings that some authors have made about labeling juveniles as "psychopaths" (e.g., Forth et al., 2003).

Given that the label of "psychopath" has not "gained general acceptance" when applied to youth, the use of "psychopath" labels may not pass the *Frye* test (*Frye v. United States*, 1923, p. 1014). The *Daubert* test (*Daubert v. Merrell Dow Pharmaceuticals*, 1993), which is now used in a number of states, considers the scientific validity of evidence in addition to its acceptance (Melton et al., 2007). Of relevance to the *Daubert* test, research raises some questions about the scientific validity of "psychopath" labels for youth. For instance, taxometric analysis indicates that psychopathy features fall along a continuum and there is not a clear class or taxon of juvenile "psychopaths" (Murrie, Marcus, et al., 2007). In addition, although juvenile psychopathy scores show moderate stability, "most individuals identified as psychopaths at age 13 will not receive such a diagnosis at age 24" (Lynam, Caspi, Moffitt, Loeber, & Stouthamer-Loeber, 2007, p. 162, see also Frick, Kimonis, Dandreaux, & Farell, 2003). Some studies also find that "psychopath" labels can lead to inferences that a youth is less treatable and/or more deserving of severe penalties (Chauhan et al., 2007; Jones & Cauffman, 2008; Rockett et al., 2007; Vidal & Skeem, 2007).

Given these factors, the practice of labeling juveniles as "psychopaths" may be difficult to defend. Instead, many clinicians prefer to describe the presence of psychopathic characteristics. Moreover, many clinicians (44.5%) did not explicitly refer to these characteristics as "psychopathic" characteristics but rather simply describe them without using this term. It should be noted that some of these same concerns about "psychopath" labels appear to apply to adults as well (e.g., Edens, Colwell, et al., 2005; Edens, Marcus, Lilienfeld, & Poythress, 2006). Indeed, 50% of clinicians in our sample oppose the use of the term "psychopath" for anyone, including adults. Therefore, it may be wise for clinicians to avoid the use of this term (Tolman & Rotzien, 2007).

At the same time, it remains unclear how clinicians should best include psychopathy information in juvenile or adult reports. Relatively small differences in communication practices may make a significant impact on court decisions. For instance, Boccaccini, Murrie, Clark, & Cornell (2008) found that using the colloquial term *psychopath* had a sizable impact on jury members but stating that a juvenile offender met diagnostic criteria for "psychopathy" had limited impact. Furthermore, although many of our survey respondents preferred to describe psychopathic characteristics rather than using the term *psychopath*, some research indicates that descriptions of psychopathic characteristics may be more influential than stating a youth meets diagnostic criteria for "psychopathy" (Boccaccini et al., 2008; Murrie, Boccaccini, McCoy, & Cornell, 2007; Murrie, Cornell, & McCoy, 2005; Rockett et al., 2007).

Juvenile and adult risk assessment reports differed in some respects. Juvenile and adult risk assessment reports were similar in length and appeared to include similar components, such as descriptions of past violence and offending, risk factors, rationales for risk judgments, and protective factors. Despite these similarities, juvenile and adult reports differed in a number of ways, suggesting that clinicians approach juvenile and adult risk assessments somewhat differently.

First, clinicians were more likely to routinely discuss treatment issues in juvenile risk assessment reports, potentially because of the greater emphasis on rehabilitation and the obligation of the juvenile justice system to protect youths in their care (Grisso, 2004). Second, consistent with the focus on protective factors within the child clinical and developmental literatures (e.g., Garmezy, Masten, & Tellegen, 1984; Jessor, Van Den Bos, Vanderryn, Costa, & Turbin, 1995; Luthar & Zigler, 1991; Rutter, 1987), clinicians were more likely to routinely describe protective factors in juvenile reports. Third, juvenile risk assessment reports were more likely to contain recommendations to reevaluate risk. Given the enormous developmental changes that occur during adolescence, juveniles' risk may be seen as particularly dynamic (e.g., Borum & Verhaagen, 2006; Caldwell, 2002; Grisso, 1998; Vitacco & Vincent 2006; Worling & Curwen, 2001). Fourth, juvenile reports were more likely to routinely discuss the limitations of the risk assessments. Given that research on juvenile risk assessment is less advanced, limitations in this area are especially important to communicate.

To some extent, the differences in juvenile and adult risk assessments reflect legitimate differences which stem from the different psycholegal contexts of the evaluations. For instance, although the rehabilitation focus of juvenile courts has eroded somewhat, it remains a central consideration. Thus, it is not surprising that juvenile risk assessments place a greater focus on treatment and protective factors. However, the differences between juvenile and adult risk assessments also points to areas for improvement. For instance, despite calls for further attention to protective factors (Rogers, 2000), adult risk assessment appears to lag behind the juvenile assessment in this regard. Until recently, few adult tools have included protective factors. In contrast, juvenile tools (e.g., SAVRY) have included protective factors from the outset, thus facilitating the consideration of these factors. In part, this may be because juvenile tools developed at a later time and were thus able to learn from the adult literature.

Limitations and Future Research

Several limitations of this study are important to note. First, based on our estimates, our response rates were likely moderate. However, it was difficult to estimate exact response rates because only a subsample of members of surveyed organizations conduct risk assessments, and many clinicians had memberships in more than one of the organizations that we surveyed. Second, we chose to focus on practices used by psychologists who were members of forensic professional organizations, as these individuals are likely to conduct a significant number of offender risk assessments. However, a needed next step is to examine broader groups, including clinicians who are not members of professional organizations, as well as broader professional groups, such as psychiatrists. In addition, it will be important to examine how the nature or extent of forensic training (e.g., whether the clinician completed a specialized degree in forensic psychology or psychiatry) relates to the practices used.

Third, it is important to note that the practices that clinicians report using may differ somewhat from those they actually use (Nicholson & Norwood, 2000). As such, future studies should examine clinical reports firsthand (see Amenta, 2006; Grann & Pallvik, 2002). Finally, although we choose to conduct a broad survey of risk assessment practices, future research would benefit by delving more deeply into specific issues. For instance, it would be useful to gain a more detailed understanding of how evaluators make choices regarding SPJ and actuarial tools in specific contexts.

Emerging Best Practice Standards

It is clear that clinicians who conduct risk assessments have a challenging and important role. Reassuringly, our survey respondents appear to use a number of practices that are consistent with current empirical findings and ethical standards. For instance, the use of validated risk assessment tools was common. Also, consistent with warnings in the field, most clinicians avoid labeling juveniles as psychopaths.

At the same time, through comparisons of actual practices to ethical standards and research-based practice recommendations, our results point to several areas for possible improvement. First, although many clinicians discuss the limitations of their risk assessments at least once in awhile, we encourage the *routine* discussion of limitations. In forensic contexts there is often an urge to portray oneself and one's field in a desirable light (Edens, 2006; Grisso & Vincent, 2005). However, even the best available risk assessment methods do not yield perfect results. Our obligation to communicate limitations in our methods is clearly emphasized in ethical and professional practice standards (American Psychological Association, 2002; Committee on the Revision of the Specialty Guidelines for Forensic Psychology, 2008).

Second, it is critical that clinicians are thorough and persistent in their efforts to ensure that they have the information needed to conduct a sound assessment (Heilbrun, 2001; Tolman & Rotzien, 2007). Obtaining relevant records and

information was the single most common challenge that clinicians reported. Within our sample, 10% of clinicians do not routinely (i.e., 81% or more often) obtain police or law enforcement records, and a sizable proportion of clinicians do not routinely interview juveniles' caretakers; these findings raise some concerns.

Third, although many clinicians discuss research findings at least once in a while in their reports, it is desirable to aspire to an even greater integration of research findings in reports and testimony (see Tolman & Rotzien, 2007). For instance, it may be useful to educate the courts regarding validity of various risk assessment approaches, and risk factors for reoffending. Finally, given that adult risk assessment reports are less likely than juvenile reports to include protective factors and treatment recommendations these are areas for possible improvement (see Rogers, 2000). Recently developed tools, such as the Short-Term Assessment of Risk and Treatability (Webster, Martin, Brink, Nicholls, & Middleton, 2004), may help enable a greater focus on protective factors and treatment considerations in adult assessments.

Overall, although there are areas for improvement, the practices of our sample appear fairly consistent with research-based recommendations and ethical standards. However, it is important to note that our respondents were members of forensic professional organizations. Therefore, the standards of practice described here may be higher than those of clinicians who are not members of such organizations. As Otto and Heilbrun (2002) describe, managed health care and decreased mental health funding has driven clinicians toward the forensic field for financial reasons; some of these clinicians may lack the requisite knowledge and training.

To help ensure high standards of practice, it may be useful for the field to develop a set of practice guidelines, such as those developed for child custody evaluations (e.g., American Academy of Child and Adolescent Psychiatry; 1997a; American Psychological Association, 1994) and child abuse evaluations (e.g., American Academy of Child and Adolescent Psychiatry, 1997b; American Psychological Association's Committee on Professional Practice and Standards, 1999). Furthermore, to ensure progress in the risk assessment field, researchers must continue to conduct clinically relevant studies. At this time, there is a particular need for research that facilitates the translation of empirical knowledge to real-world clinical practice.

Appendix

Components of Risk Assessment Reports: Juvenile Version of the Survey

Past violence/offending: including acts which did and did not lead to formal charges

"Risk factors" for violence/reoffending: description of factors that may increase the likelihood that the child/adolescent will engage in future violence/offending

"Protective factors": factors that may help reduce the likelihood that a child/adolescent will engage in future violence/reoffending

Conclusion regarding youth's level of risk: such as a statement that a youth is "moderate" risk, or that he or she has a 60% chance of reoffending

Level of confidence in risk judgment: such as a statement like "I am very confident that the child/adolescent poses a high risk of future violence"

Contexts under which the youth is most likely to reoffend: such as a statement like "if the youth returned home he would pose a high risk for future violence, but if placed in a secure treatment program his risk for violence may be lower"

Rationale for judgment about risk level: description of information and factors that led to your judgment

Types of future violence/offending: description of the types of violence/offending that the child/adolescent is most likely to engage in

Level of seriousness of future violence/offending: description of the level of seriousness of violence/offending that the child/adolescent is most likely to engage in

Possible victims of future violence/offending: description of likely possible victims of the child's/adolescent's future violence/offending

Possible timeline of future violence/offending: description of the time period during which the child/adolescent is most likely to engage in violence/offending, such as "during the next 6 months the youth poses a particularly high risk"

Recommendations regarding treatment of violence/offending: description of the types of treatments/interventions that would be most beneficial in reducing the likelihood that the child/adolescent will engage in future violence/offending

Recommendations regarding broader treatment issues: description of other types of treatments/interventions that would be beneficial, including treatments that are not directly targeted at reducing violence/offending

Recommendations regarding placements: description of placement(s) that are likely to be preferable for the child/adolescent, such as whether he or she should be placed at home or in a residential treatment program

Recommendations regarding supervision level: description of the level of supervision that a child/adolescent requires, such as whether he or she requires intensive supervision

(continued)

Appendix (continued)

Explicit recommendation regarding the ultimate legal issue: explicit recommendations regarding the key legal issue the court is determining, such as whether or not the youth should be detained, etc. (e.g., such as stating "this youth should/should not be detained")

Recommendation to reevaluate risk in the future: a clear statement that the child's or adolescent's risk should be reevaluated

Explicit description of relevant research findings: such as a description of how research informed the methods that were used or the judgments that were made

Note: The adult version of the survey had identical components pertaining to adults.

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Notes

1. Although a number of psychiatrists responded to our survey (n = 16), these individuals were not included in our sample. There are reasons to believe that psychiatrists may use different practices that psychologists, such as being less likely to use testing. However, the sample size of psychiatrists was not large enough to examine separately. Similarly, there was one respondent who was trained as a nurse and two respondents who were trained as social workers; these individuals were not included in the sample.
2. The number of individuals receiving the AP-LS email could not be specifically determined because some members elect not to receive emails (Jennifer Groscup, personal communication, September 4, 2008).
3. A number of AP-LS members were not able to access the online survey link that was sent to them in the initial email. Therefore, this link was resent.
4. Participants estimated their hourly rate based on the currency used in their country. We converted these figures on August 9, 2008 using the universal currency converter at http://www.xe.com/ucc/.
5. For adult clinicians, this question was worded as interviews with "family members" rather than interviewers with "caretakers" or "other noncaretaker family members."
6. Many adolescent risk tools, including the SAVRY, ERASOR, and EARL-20B, are based on an SPJ model. Although the YLS/CMI does not provide numerical estimates of reoffense probability, some have referred to it as an adjusted actuarial tool, as it classifies youth into categories based on algorithmically derived scores, while allowing for a "professional override" option (Vincent, 2006). The authors of the Juvenile Sex Offender Assessment Protocol–II (J-SOAP-II) describe that, as data on this tool accumulate, they hope to provide probabilistic estimates, but at the present time, the J-SOAP-II is not an actuarial tool (Prentky & Righthand, 2003).

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