Dealing With Dangerousness: Community Risk Management Strategies With Violent Offenders

VERNON L. QUINSEY
WILLIAM D. WALKER

This chapter concerns the community supervision and treatment of persons whose histories of violent misbehaviors raise serious societal concerns about their commission of further violent acts. For ease of exposition, these persons will be referred to as "offenders," although some (such as violent psychiatric patients) have not been convicted of any crime, despite their violent histories. In addition, because most of these offenders are male, "offenders" will be referred to as males throughout this chapter.

Typically, problems in offender management surface when an offender is considered for release from an institution in which he was initially placed because of some violent behavior. It is difficult to strike the proper balance between the offender's civil liberties and community

AUTHORS' NOTE: Preparation of this chapter was supported by a contract with the Kingston Psychiatric Hospital. We wish to thank C. Earls, G. Harris, and M. Rice for their comments on an earlier version of this chapter. Address correspondence to V. L. Quinsey, Psychology Department, Queen's University, Kingston, Ontario, K7L 3N6.

244
safety; that is, to answer the questions of who should be released and when. Such decisions must be made with little help from the literature on the prediction of violence. Basically, this literature asserts that, although certain historical variables statistically predict future violence, a large proportion of offenders, perhaps the majority, who are assessed as dangerous (by whatever method) in fact turn out to have been inaccurately judged to be dangerous (false positives). Regardless of the scientific defensibility of these predictions, however, they are ubiquitous and there is a very real political need for decision makers to appear to have done a proper and careful "scientific" assessment in case the offender commits a further violent act that becomes public knowledge.

Persons who are responsible for the community management of offenders with histories of serious aggressive behaviors, sex offenses, or firesetting often greet their task with a mixture of worry and despair. And no wonder; much of the scientific literature argues that neither treatment nor supervision has demonstrable effects on recidivism, and thus it is often unclear to practitioners what should be done with or for the offender. In any event, the resources and expertise available for specific programming are often slender.

The community serves as the final common path for patients discharged from psychiatric facilities, developmentally handicapped persons discharged from institutions, and inmates released from correctional institutions. Within the psychiatric hospital system, the "revolving door" syndrome of frequent short hospital admissions is well known. Within the system for the developmentally handicapped, policies of normalization and deinstitutionalization have resulted in large numbers of developmentally handicapped individuals living in the community with varying amounts of support. Similarly, because of probation and parole orders, large numbers of convicted offenders live in the community under supervision.

It is striking that the issues involved in managing or reducing the risk of violence posed by offenders in these three traditionally separate human service sectors are almost identical. These similarities are ironic given the great attention paid to making the initial disposition to a particular human service system and the difficulties in dealing with persons who do not fit neatly within any one of the three, such as dually diagnosed persons or mentally disordered offenders. This concern with initial placement, as reflected in such legal dispositions as "not guilty by reason of insanity," is based not so much on the behaviors that initially led to institutionalization or the kind of programs that are actually delivered within a sector, but rather the perceived appropriateness of the
confine and medicate, confine and train, or confine and punish paradigms traditionally characterizing the three human service sectors.

This is not, of course, to assert that the same proportions of offenders in each of these sectors pose a risk for violence or that the type of violent behavior of concern is necessarily of the same kind or severity. Although one associates propensities for violence primarily with the criminal justice system, the proportion of persons posing such a risk within any service sector is dependent on a variety of substantively uninteresting bureaucratic and legal arrangements within particular jurisdictions (e.g., Axelson & Wahl, in press). This is summed up for mental health and corrections by Penrose’s Law, which asserts that the number of persons in the mental health and correctional systems is a constant (Penrose, 1939). Although in fact only a minority of offenders within any of the three service sectors pose a high risk of exhibiting serious violent behaviors, there are a sufficient number in each that the absolute number living in the community is large.

The purpose of this chapter is to argue that community risk management can be improved by combining what is already known from three areas of inquiry: The prediction of violence, the study of decision making and clinical judgment, and the literature on treatment outcome and program evaluation. It will be argued that, although these literatures certainly can (and have) induced therapeutic and supervisory nihilism among practitioners, more recent developments offer grounds for some optimism, particularly when an integrative approach is taken.

**Predicting Violent Recidivism and Community Supervision**

The prediction of both general and violent criminal recidivism of persons released from correctional and psychiatric institutions has received extensive study (for reviews see Gabor, 1986; Monahan, 1981; Quinsey, 1984; Waller, 1974; Webster & Menzies, 1987). Enough work has been completed to establish a general consensus within the research community about the classes of variables that are valid predictors of recidivism and the degree to which they are related to the criterion behaviors of interest.

American and Canadian studies of released inmates (for a list contact the senior author) agree that youthfulness and number of previous convictions are positively related to the probability of criminal recidivism. Most studies have found that recidivism rates are inversely
related to offense severity. However, because of the relative rarity of serious offenses against the person, most studies of criminal recidivism, even those with large samples, essentially examine predictors of robbery, breaking and entering, and other property crimes. This is an important problem because there is evidence that the variables that predict violent crimes against the person are different than those that predict general (both violent and nonviolent) recidivism (Holland, Holt, & Brewer, 1978; Mandelzys, 1979; Nuffield, 1982).

Other predictors, including age at first arrest, criminal versatility (variety of offending), alcohol abuse, and low educational attainment, are usually found to be positively but more weakly related to recidivism rates. Although there are conflicting findings on the relation between institutional behavior and postrelease recidivism, escape and escape attempts have consistently been found to be related to higher recidivism rates. A number of investigators have combined these and related predictors in various ways to obtain summary scores that are more closely related to recidivism than any predictor taken singly. Those developed in Canada include the general recidivism and violent recidivism scales of Nuffield (1982), the Level of Supervision Inventory (Andrews, Kiessling, Mickus, & Robinson, 1986; Bonta & Motiuk, 1985), and the Psychopathy Checklist (Hare, Chapter 13 this volume).

Studies of offenders released from or assessed in psychiatric institutions (for a list contact the senior author) have reached essentially the same conclusions as those drawn on the basis of inmate follow-up studies. Previous criminal history emerges as the best single variable predictor of subsequent recidivism and violent recidivism. Typically, a diagnosis of personality disorder is associated with higher recidivism than a diagnosis of psychosis. Psychopathy, as defined by the Hare Checklist, emerges as a good predictor of both general and violent recidivism just as it does in correctional samples (Harris, Rice, & Cormier, 1991).

The identification of robust and theoretically interpretable predictors of violent recidivism encourages their exploration as moderators or typological variables. Although many investigators have argued that typologies of offenders should be developed for which different predictive variables would be relevant (e.g., Deitz, 1985; Mandelzys, 1979; Quinsey & Maguire, 1986), this work has not proceeded very far until recently. One particularly good candidate for such a typological scheme is psychopathy because of its close association with instrumental and predatory violent recidivism. As an illustrative thought experiment, one can contrast the types of predictive variables likely to prove useful with
overcontrolled-hostile men characterized by extreme acts of aggression directed at family members or close associates, lack of criminal history, and severe assertive deficits (Megargee, Cook, & Mendelsohn, 1967; Quinsey, Maguire, & Varney, 1983) with psychopaths characterized by versatile criminal histories, violence for instrumental purposes committed against strangers, and exploitative life-style.

Further conceptual work, however, is needed before psychopathy can be employed in intervention work. It is not clear whether its categorical nature is relevant (Harris, Rice, & Quinsey, in press a), whether the temperament factor of the Psychopathy Checklist should be considered independently of its criminal history factor, and how Checklist scores should be considered in relation to supervision and treatment. Psychopathy could be interpreted as influencing responsivity to treatment, mediating compliance, or both.

Regrettably, however, there remains a yawning chasm between the bulk of the empirical prediction literature and practical violent offender release policies. Barring recent exceptions, the empirical literature deals almost exclusively with static or “tombstone” predictors such as age, offense history, and length of institutionalization. Because both community and institutional service providers require information about predictors that they can modify in order to plan interventions effectively, the bulk of this empirical follow-up literature is essentially irrelevant to them, particularly inasmuch as so few offenders are institutionalized under indeterminate conditions. For the vast majority of offenders, the question is not whether they will be released but when.

The gap between the needs of program managers and the dominant focus of the empirical literature is most readily apparent in an area where one might least expect it: The prediction of violent reoffending among mentally disordered offenders. Although mentally disordered offenders are typically dealt with by mental health professionals working in a psychiatric hospital system that explicitly espouses a treatment-rehabilitation model, of 28 follow-up studies of released mentally disordered offenders identified in a recent review of this literature, 25 employed only static predictors and only 3 (of which 2 were essentially pilot investigations) attempted to predict recidivism from measures of therapeutic change (Quinsey, 1988).

With respect to violent recidivism, the inability of most of the prediction literature to inform treatment and release policies is even more pronounced. Under many circumstances the probability of violent recidivism is low. This welcome infrequency of postrelease violence means that efforts to predict it inevitably result in unacceptably high
rates of false positives. Much of this literature appears to suggest that the optimal prediction for violent offenders is that none of them are dangerous; treatments designed to reduce violent recidivism, therefore, are superfluous and supervision unnecessary.

However, contrary to the impression given by the prediction literature, the base rate of violence is sometimes high enough to make predictions well worth while (e.g., Harris, Rice, & Quinsey, in press b). First, it is certain that the base rate of violent behavior has often been underestimated by recidivism research because investigators have used lists of criminal charges ("rap sheet" data) instead of police descriptions of the behaviors involved, follow-up periods that are too short (because serious violent crimes are often low frequency phenomena), and unlikely populations of offenders (e.g., old persons). For a discussion of these and other interpretive problems see Gordon, 1977; Quinsey, 1980; Quinsey & Maguire, 1986). Offenders likely to exhibit high base rates of violent behaviors include those with lengthy histories of violent crime (e.g., Walker, Hammond, & Steer, 1967), psychopaths (e.g., Hare & McPherson, 1984), and persons repeatedly passed over for release when held under fully indeterminate conditions (Quinsey, 1980; Quinsey, & Maguire, 1986).

Thus the bulk of the follow-up literature provides very little information for choosing appropriate programs for violent offenders or in making decisions based upon offender change. All of the above leads to a reconsideration of what might be done to reduce recidivism; that is, not so much how to predict it (except to identify high-risk groups as opposed to individuals) but how to reduce or prevent it in the community. The key, therefore, lies in the effectiveness of postrelease supervision and treatment.

We are not the first to arrive at this conclusion. In the preface to Waller's (1974) book on prison releasees, Edwards (p. vii) states:

What is called for is a major realignment of the time and energies of those engaged in the fields of correction and related organizations towards the alleviation of those problems associated with employment, family and community relationships, and alcoholism which are at the root of most failures following release.

It is, of course, difficult to know what sorts of community programs need to be developed in the absence of knowing the antecedents of recidivism. Antecedents in this context means specifiable dynamic conditions of the offender or identifiable environmental events that precede recidivism. Antecedent conditions are, therefore, variables that
supervisory authorities or offenders themselves could potentially do something about in order to prevent the commission of a criminal act. Static personal characteristics of offenders are useful in this context as variables that define the risk group to which an offender belongs and as moderator variables, that is, variables that determine the manner in which antecedents affect behavior.

Determinants of sexual reoffending among 136 child molestors and 64 rapists have been examined in detail by Pithers, Kashima, Cumming, Beal, and Buell (1988). Nearly 90% of their sample of sex offenders reported experiencing strong emotional states before relapse (the commission of a new sex offense): 94% of the rapists reported feeling anger, usually occasioned by interpersonal conflict; 46% of the child molesters reported experiencing anxiety and 38% reported depression (these emotional states appeared to be related to social disaffiliation). The chain leading to relapse seemed to begin with negative affect leading to paraphilic sexual fantasies, then cognitive distortions, and, finally, passive planning just prior to the offense. Frisbie (1969), based on 550 interviews of 311 child molesters under supervision, concluded that, in addition to alcohol abuse, factors predicting recidivism were "the desire for and selection of physically immature children as sexual objects, unorthodox ethical values, and grave difficulties in establishing meaningful relationships with adult females on a mature basis" (p. 223). The similarities between Frisbie's observations and those of Pithers et al. (fantasies, disaffiliation, and cognitive distortion) are striking. Planning and behavioral rehearsal as antecedents to serious sexual offenses have also been noted by MacCulloch, Snowden, Wood, and Mills (1983). It is of interest in the present context that Frisbie (1969) was surprised at how much her interviewees would disclose to a project interviewer; because of their home visits, the research team was often aware of impending relapse before the parole authorities.

The use of dynamic theoretically chosen predictors of recidivism among sex offenders has proven useful. For example, follow-up studies of patients released from a maximum security psychiatric institution have shown that phallicometric measures of sexual preference predict new sexual convictions among both rapists (Rice, Harris, & Quinsey, 1990) and child molesters (Rice, Quinsey, & Harris, 1991).

With respect to the antecedents of supervisory failure in the form of general recidivism, Waller (1974) found that lack of employment, undesirable associates, fighting, not seeing one's children, and frequent drinking predicted reoffending. Hart, Kropp, and Hare (1988) also observed that instability in both employment and relationships during
the follow-up period predicted reoffending. Recently, more direct evidence relating to the usefulness of identifying antecedents of general recidivism has been provided (Andrews, 1982, 1989). Motiuk and Porporino (1989), for example, have shown that parole officers' crude assessment of parolees' needs at the beginning of supervision was more accurate in predicting general recidivism than the well validated Nuffield Scale (Nuffield, 1982) for evaluating risk based on criminal history. The needs that demonstrated predictive validity were: criminal companions, alcohol/drug use, instability in living arrangement, and lack of responsiveness to supervision. The finding that postrelease factors are closely related to recidivism is extremely important because they provide potential targets for both supervision and intervention. The combination of traditional static predictors with dynamic predictors, measured postrelease, appears very promising.

Although it is obvious that a great deal of work remains to be accomplished, a clear picture is emerging of the approach to be taken if prediction research is to inform supervisory and release policies. It involves first, the further identification of factors that determine risk and, therefore, whether an offender requires supervision, and, second, the establishment of links between postrelease dynamic variables and violent crime. It is highly likely that some of these antecedents are specific to certain types of offenders. In short, prediction research should be used to establish theories of recidivism for homogeneous groups of offenders that can be tested by the evaluation of specific interventions.

Clinical Judgment

The past quarter century of research has severely shaken confidence in the accuracy of clinical judgment both in absolute terms and in comparison to actuarial models (Dawes, 1989; Meehl, 1986). This research will not be reviewed here except where it bears upon the prediction of violent behavior or the treatment of offenders (for a recent review of the clinical appraisal of dangerousness see Webster & Menzies, 1987). Early research indirectly evaluated assessments of dangerousness by following offenders who were released from secure psychiatric institutions because of court orders (Steadman & Cocozza, 1974; Thornberry & Jacoby, 1979). Because these offenders were at least implicitly considered to be dangerous, their very low rates of violent recidivism spoke
to the conservative bias of clinical judgment. Similarly, a statistical model derived from forensic clinicians' predictions of violence was not significantly related to violent recidivism for a sample of offenders released from a maximum security psychiatric sample (Quinsey & Maguire, 1986).

In a study that controlled the amount and kind of clinical file information available to forensic psychiatrists who were asked to make predictions of future violent behavior and mock release decisions concerning mentally disordered offenders (Quinsey & Ambtman, 1979), it was found that the clinicians showed low rates of agreement with each other on the patients' dangerousness and based their appraisal primarily on the seriousness of the index offense. The average of the psychiatrists' judgments closely corresponded to those of high school teachers who were asked to rate the same clinical material. The lack of difference between clinicians' and lay peoples' appraisals of dangerousness has also been demonstrated in ratings of fictitious case histories (Quinsey & Cyr, 1986) and the low amount of interclinician congruence has been replicated in studies of actual case conferences (Quinsey & Ambtman, 1978; Quinsey & Maguire, 1983, 1986; Menzies, Webster, & Sepejak, 1985).

Of the variety of clinical prediction tasks, it would be expected that violence prediction would be among the most problematic because of the low base rate of violent behavior. Human judges are known to be insensitive to differing base rates under a variety of conditions, such as when they are asked to assess the likelihood of some event given the base rate of the alternatives plus worthless diagnostic information (Kahneman & Tversky, 1973). For example, subjects may be asked to guess whether a person is an engineering or arts student based upon a physical description and a specification of what proportion of students are in engineering or arts. The Kahneman and Tversky task actually requires subjects to postdict rather than predict because they are asked, for example, whether a person is an engineer or arts student instead of whether a person will become an engineer or arts student. Prediction tasks (those that inquire about future events such as violent behavior) appear to lead to even greater departure from base rates under the worthless information condition than the formally identical postdiction tasks of Kahneman and Tversky with both student and forensic clinician subjects (Preston & Quinsey, 1990).

Despite the kind of evidence presented here that documents the unreliability and poor validity of clinical appraisals of dangerousness, these clinical appraisals continue to be the dominant method of making
dispositional decisions pertaining to security and supervision within the corrections/criminal justice system, psychiatric hospitals, and the system for the developmentally handicapped.

One might expect forensic clinicians on the basis of their training to do better in assessing the treatability of offenders and in selecting specific treatments for them than in assessing dangerousness. Although there are fewer data on this form of judgment than on the clinical prediction of violence, what data exist are even more discouraging. Quinsey and Maguire (1983) studied 200 consecutive court remands to a maximum security psychiatric facility. The treatability of each offender was independently rated by forensic clinicians after each case conference preceding his return to the court. The clinicians showed poorer agreement on the rating of general treatability than they did on the dangerousness of these offenders. Interclinician agreement on ratings of the efficacy of discrete types of treatment were extremely low, with the exception of neuroleptic medication. Agreement did not improve when the most senior or the most optimistic pair of clinicians was compared. In general, clinicians were extremely pessimistic about the prospects for treatment, especially for offenders diagnosed as personality disordered as opposed to psychotic.

Quinsey and Cyr (1986) constructed fictitious case histories of offenders and had them evaluated by clinicians and laypersons. Half of the offenders' histories were crime free and essentially normal (the index offense was out of character and severely provoked) and half contained descriptions of many acts that were similar to but less serious than the index offense (suggesting a diagnosis of personality disorder and an internal attribution). Clinicians and laypersons made similar judgments. Ratings of dangerousness were negatively correlated with ratings of treatability and the normal offenders were judged to be more treatable than those with lengthy histories of similar behaviors.

Fortunately, it has been shown to be possible for clinicians and decision makers to improve the quality of their decisions through the use of actuarial information. Gottfredson, Wilkins, and Hoffman (1978) have shown how actuarial predictions of risk (a salient factor score) can be used by parole authorities in establishing a range of sentence for each risk category. Using Gottfredson's scheme, parole authorities can simply select the midpoint of the range of sentence lengths appropriate to a given offender's risk category or instead elect to use their judgment to increase or decrease the time served from the midpoint within the range. More rarely, they may choose to go outside the normal range by exercising a clinical override provision, providing they articulate specific reasons for
so doing. This scheme for structuring discretion makes the basis for the decisions explicit (and thus open to examination and revision), and anchors or calibrates the decision makers by focusing their attention on specific base rates or risk values. In addition, this strategy preserves the involvement of human decision makers while aiding their judgment. Ongoing computerized feedback could be used with such a system to indicate to decision makers whether they exhibit conservative or liberal bias relative to their peers or the model itself and the degree of rigidity in their implicit decision policy by examining the variance in their recommended sentence lengths. Such a method could, in principle, be elaborated to combine static and dynamic variables into a release, supervision, and treatment plan. Essentially, the idea is to develop an “expert system” to aid, but not dictate to, clinical decision makers.

**Treatment**

Intervention is usually bound to prediction. Given that a person possesses characteristics that predict a high probability of further violent behavior, societal options are limited to incapacitation or treatment. It is clear that successful treatment, unlike incapacitation, serves both the interests of society and the individual offender. Incapacitation is also an apocalyptic alternative: What of the false positives generated by the most accurate of the present generation of actuarial-clinical prediction models? Given the options, these offenders must be confined until age takes them out of the high-risk category.

One of the few ethical ways in which the base rate problem can be addressed is through the design of interventions that are positive enough (i.e., neither aversive nor intrusive) and inexpensive enough that they can be implemented for an entire high-risk group. The cost of this strategy is that a substantial number of false positives have to receive a given intervention in order to ensure that all of the true positives have received it. A simple example of this strategy involves airport security procedures. Extremely few passengers that pass through airport screening are carrying weapons but everyone is treated as though this is a real possibility; such screening is socially acceptable because it is brief, benign, and reasonably effective. A more closely related example is the program developed in Norway by Olweus (Chapter 5 this volume), who administered a program to reduce bullying to an entire population of
children. The nature of the program was such that there was no problem with nonbullying children receiving it.

Treatment is also bound to prediction in another way. The evidence with respect to the efficacy of interventions designed to reduce general recidivism among correctional populations suggests that efficacy is determined in part by whether the interventions are focused on high-risk cases and actually target dynamic risk factors or "criminogenic needs" (Andrews, 1982, 1989). This means that interventions designed to reduce recidivism should be both reserved for high risk cases and individualized so as to target idiosyncratic risk factors.

However, recidivism follow-up studies employing only static risk and/or institutional treatment predictors leave it both empirically and conceptually unclear, as Mandelzys (1979) has pointed out, how much criminal recidivism is a result of unresolved problems within a released offender that could have been addressed during a period of incarceration and what proportion of new offenses are caused by new environmental or offender problems. Of course, the longer the time between release and recidivism, the less likely a within-institution intervention will be relevant. Another way of thinking about this issue is that recidivism studies do not evaluate the effects of institutional interventions directly but rather their generalization and maintenance because the intervention and the measurement of its effects occur in different settings (Gottschalk, Davidson, Mayer, & Gensheimer, 1987). Moreover, the recent literature on psychological and behavioral interventions for delinquents and adult offenders strongly suggests that treatment effects seldom generalize across settings (Braukmann & Wolf, 1987; Milan, 1987a, 1987b; Rice, Quinsey, & Houghton, 1990). The unequivocal conclusion from this literature is that interventions must occur in the settings in which the behaviors of concern occur. In offender programming, therefore, interventions that are designed to reduce postrelease recidivism must continue in the community. This conclusion requires that the purpose of intervention be reconceptualized from attempting to produce a cure from a temporally restricted treatment given in an institutional environment to enhancing long-term adjustment through continuing intervention (e.g., Kazdin, 1987).

It is of interest that this conclusion has been arrived at in several different areas of psychopathology at about the same time. Consider the treatment of schizophrenia. This area is interesting both because the disorder (or, more correctly, the construct) has some genetic and physiological determinants and because schizophrenia is part of the cause of some offenders'
violent behaviors or, at least, part of the context in which the violent behaviors must be addressed. Schizophrenic offenders are, of course, most common in secure psychiatric hospitals. It is well known that phenothiazines are the treatment of choice for active schizophrenic symptoms (such as delusions and hallucinations), particularly in the acute phase of the illness. It is less well accepted, although well documented, that social learning programs can be very effective with chronic, severe, and assaultive schizophrenic patients (Paul & Lentz, 1977).

The problem of schizophrenic relapse and readmission following even successful treatment has proven to be an intractable problem until recently (see Paul & Lentz, 1977, for a review). Demographic and symptom-severity data gathered in-hospital typically predict little of the variance in readmission data (e.g., Abramowitz, Tupin, & Berger, 1984). The prevailing view that relapse is usually caused by medication noncompliance now appears to be incorrect (Hogarty et al., 1986). Although a complete theory of relapse is not yet developed, recent evidence obtained prospectively indicates that specific stressful events (outside the subjects' control and independent of their illness) are related to subsequent relapse among schizophrenic patients (Ventura, Nuechterlein, Lukoff, & Hardesty, 1989). In line with this finding, a number of studies have observed much higher relapse rates among schizophrenics released to families high in "expressed emotion"; that is, highly critical of and sometimes hostile toward the identified patient. Further work has shown that educational and behavioral interventions focused on helping high-risk families deal with their schizophrenic relatives and social skill training of the patients can markedly lower relapse rates (Falloon et al., 1985; Hogarty et al., 1986; Liberman, 1988). The relevance of the expressed emotion variable is readily apparent to any clinician who has worked with schizophrenic murderers found not guilty by reason of insanity.

Lukoff, Liberman, and Nuechterlein (1986) have described a system of ongoing symptom monitoring for determining when to alter drug levels, psychosocial programs, and amount of supervision for schizophrenic patients that is similar in spirit to what is required for the community management of high-risk offenders, whether schizophrenic or not. There is also some evidence that uncontrollable adverse events causing significant disruption in a person's life increase the risk of developing depression (e.g., Swindle, Cronkite, & Moos, 1989). The potential relevance of this observation to the supervision and treatment of violent offenders is illustrated by Cote and Hodgins (1992) who found that a representative sample of Canadian homicide offenders
suffered significantly more frequently from depression associated with alcohol abuse than other prison inmates and that the depression antedated the murder for 83% of these offenders.

Alcohol abuse is a common antecedent of violent crime and an extremely high proportion of correctional inmates have alcohol and drug abuse problems (Ross & Lightfoot, 1985). One of the most promising approaches to substance abuse in recent years is relapse prevention, an approach that teaches clients to avoid idiosyncratic high-risk situations and to cope with them if they cannot avoid or escape them (e.g., Brownell, Marlatt, Lichenstein, & Wilson, 1986). The relapse prevention approach is explicitly rehabilitative and does not purport to offer a cure for the problem. This approach has recently been adapted for use in treating sex offenders, teaching coping skills to deal with the antecedents of sexual crime described earlier in the section on prediction (Pithers et al., 1988).

Our argument is that if more effective programs for violent offenders are to be developed, the rehabilitative focus found in the treatment of other and related problems should be adopted. The problem of violence is not unique except in that it requires incapacitation in extremely high-risk cases, such as serial murderers (because no conceivable treatment outcome could give a decision maker sufficient confidence to recommend release), and levels of supervision, such as electronic monitoring for high-risk cases, not usually required for other sorts of problems.

The costs of not basing interventions on the scientific literature can be high because programs developed using incorrect theoretical models can not only be ineffective (Gendreau & Andrews, 1989), they can actually increase recidivism. For example, Andrews (1982) points out that evocative or insight-oriented therapeutic models have been associated with increased recidivism rates among criminal offenders. Wormith (1984) found that recidivism rates were positively related to inmate self-esteem under conditions where the inmates maintained procriminal attitudes. Harris et al. (1991) have recently reported that violent recidivism was higher among psychopaths exposed to a rigorous milieu therapy program in a secure psychiatric facility than among psychopaths placed in correctional facilities. The reverse was true for nonpsychopaths.

The treatment literature suggests that outcome is improved when specific problems affecting recidivism or relapse among specific kinds of offenders, patients, or clients are addressed on an ongoing basis as they arise. Careful problem or risk factor identification and monitoring of individuals is one of the keys to successful supervision and intervention. Problem, need, or dynamic risk factors, however, can also be used to
facilitate treatment and supervision practices through the development of overall treatment programs and policies.

In a maximum security psychiatric facility, Rice and Harris (1988) used a Problem Survey (Quinsey, Cyr, & Lavallee, 1988) to assess the frequency with which patients exhibited various problem behaviors (e.g., assaultiveness, litigiousness, suspiciousness, depression, poor self-care, alcohol abuse) in the community or in the institution by soliciting clinical staff opinions. Using factor analysis, these problems were combined into problem scales (such as, positive psychotic symptoms and institutional management problems) and then submitted to cluster analyses to identify homogeneous groups of patients that shared similar problem distributions.

Patient groups identified by their unique problem distributions were labeled as: good institutional citizens, social isolates, personality disorders, institutional management problems, institutionalized psychotics, psychotics, and the developmentally handicapped. An organizational structure for the institution was developed by determining first which problems had living unit implications (level of functioning and assaultiveness) and which patient types required similar or compatible programs. The power of this approach lies in the fact that programs are not delivered to problems but to patients. For a fuller discussion of the treatment implications of this approach see Rice, Harris, Quinsey, and Cyr (1990).

The next steps suggested by this approach are to use actual measurement of these problem areas instead of a survey methodology, to examine the interaction of static risk factors with patient type in predicting violent behavior, and to evaluate treatment and supervisory programs designed to reduce violent recidivism for each type of offender.

Conclusions

In conclusion, the literature on the prediction of violence suggests that high-risk groups can be established on the basis of combinations of static variables. Predictive power is considerably enhanced by the inclusion of dynamic variables that are measured in the postrelease community environment. Actuarial models incorporating static and dynamic variables can be used to aid decision makers in establishing the level and type of supervision required for a given offender and a specification of what must be accomplished through treatment to reduce the amount of supervision required. Problems or dynamic risk factors
can be used to establish groups of offenders for which particular types of treatment and supervisory programs are likely to be appropriate. A supervision/treatment plan established in such a way is an instantiation of a more general theory pertaining to the proximal causes of violent crime.

Effective policies for the community supervision and treatment of persons with violent histories thus require the integration of findings and concepts from the literatures on the prediction of violent behavior, clinical judgment, and intervention evaluation. Some of the problems dealing with persons assessed as dangerous may be overcome with a reconceptualization based upon an integration of these literatures. In this approach to risk management and rehabilitation: (a) Actuarial data are explicitly used to guide clinical appraisals of dangerousness, (b) postrelease risk assessment is performed on an ongoing basis and linked to supervisory decisions, (c) alterable risk factors are identified postrelease and targeted for intervention, and (d) treatment and supervision strategies are developed for homogeneous groups of offenders identified on the basis of their shared risk factors.

References


Harris, G. T., Rice, M. E., & Quinsey, V. L. (in press a). *Psychopathy as a taxon: Evidence that psychopaths are a discrete class*.


Aggression and Violence Throughout the Life Span

Ray DeV. Peters
Robert J. McMahon
Vernon L. Quinsey
editors

SAGE Publications
International Educational and Professional Publisher
Newbury Park  London  New Delhi