

## Chapter 10: Preparing Practitioners for Assessing and Managing Risk

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### Introduction

This chapter is intended to provide a practice-oriented guide to preparing practitioners across a variety of helping professions who must address different forms of risk in their work. Therefore risk in this chapter is broadly defined, and an effort is made to avoid focusing exclusively on a specific professional discipline or a particular area of risk. The present chapter does not provide a review of the scientific literature for any particular area of risk assessment or risk management. Nor does it specify the content for specific types of risk assessment, which can be found in other chapters of this book.

In taking this approach, the chapter describes a process of preparing staff to approach their responsibilities in relation to risk in their particular practice, organisation or role. This process identifies different components of knowledge, training and expertise that should be acquired for practitioners to function consistently and effectively in assessing and managing risk.

Although a general approach is taken here to issues of preparing workers in a variety of disciplines and professional roles, it must be noted that certain areas of risk assessment have a more highly developed methodology and more substantial empirical foundation than others. Areas such as sexual offending and violent offending have specific risk assessment measures with standardized procedures. A considerable body of research literature supports a few of these measures. The qualifications required to utilize such procedures usually include focused training by those with recognized expertise, and sometimes include having an advanced degree in one of several professional disciplines. In some instances there is an assumption of knowledge of psychometric and statistical principles, as well as an understanding of the underlying clinical concepts that are being measured.

By necessity then, some of the risk assessment instruments or procedures cited as examples in the following discussion may not be appropriate for all practitioners across the varied array of professionals who are dealing with risk in their work. However, the use of structured data-gathering methods can lead to a more comprehensive assessment and ensure that essential areas are evaluated, thereby facilitating more accurate and reliable judgments

(Borum, 1996). Standardized risk assessment procedures may also assist in alerting practitioners to cases where more specialized assessments should be conducted. The principles of preparation for taking a systematic and empirically validated approach should apply across a wide range of workers with responsibilities associated with the risks presented by their clients.

This chapter is arranged in a way that divides the process of acquiring the necessary skills and expertise into different components or stages. In reality, these components are interconnected, and remain active throughout an individual's ongoing professional development. The field is evolving at such a rate that one never actually arrives at a state of mastery for very long, so it is incumbent on all professionals to remain knowledgeable about the latest technical and conceptual advances in risk assessment and management. With these caveats in mind, the process begins with the technical aspects of preparation.

## **Technical Training in Risk Assessment**

As noted above, and demonstrated in other chapters of this book, several areas of risk assessment now include standardized measures that have been empirically determined to have a specific association with outcomes such as sexual or violent reoffending. Some of the more recent work in these areas has focused on both static and dynamic variables. Static variables are factors that don't change over time but are predictive of future risk, such as developmental experiences, offence history, or past performance in treatment or supervision programmes. These variables help to identify individuals who have higher levels of risk, but they don't tell us much about what can be done to reduce the risk. Dynamic factors are those that can change. These are sometimes divided into stable dynamic factors that change only slowly, such as intimacy deficits, social influence, and attitudes that support violence, and acute dynamic factors that can change more quickly, such as substance abuse, negative mood, and access to victims. Stable and acute dynamic factors are associated with the degree of present risk, and can provide targets for intervention to reduce risk.

Ideally, combinations of these variables have been analyzed statistically over time on large samples of individuals for whom risk is a concern, such as offenders and forensic psychiatric patients, and instruments have been constructed from those variables showing the highest association with subsequent dangerous acts. Examples of such instruments include the Level of Service Inventory, Revised (LSI-R; Andrews & Bonta, 1995) for general criminal offenders, the STATIC-99 (Hanson & Thornton, 2000; Doren, 2004), the Sex Offender Need Assessment Rating (SONAR; Hanson

& Harris, 2001), and the Sex Offender Risk Appraisal Guide (SORAG; Quinsey, Harris, Rice, & Cormier, 1998) for sexual offenders, the Violence Risk Appraisal Guide (VRAG; Harris, Rice, & Quinsey, 1993) for violent offenders with mental disorders, the HCR-20 (Webster, Douglas, Eaves, & Hart, 1997) for psychiatric patients, and the Spousal Assault Risk Assessment Guide (Kropp, Hart, Webster and Eaves, 1994) for cases of spousal abuse. More recently, Harris, Rice and Camilleri (2004) have successfully applied the VRAG to nonforensic psychiatric patients to both sexes, suggesting that the predictors and causes of violence may be more general rather than specific to particular populations. Instruments such as the LSI-R, HCR-20 and SONAR offer the advantage of assessing areas that may serve as targets for interventions to reduce risk.

An element common to many risk assessment schemes is the construct of psychopathy. Measures of psychopathy developed by Robert Hare and colleagues include the revised Psychopathy Checklist (PCL-R; Hare, 2003), and Psychopathy Checklist Screening Version (PCL:SV; Hart, Cox, & Hare, 1995). While not developed as risk assessment measures per se, these instruments have nonetheless shown high levels of association with future dangerous acts in a variety of contexts. These instruments represent some of the best established and most widely utilized measures of risk currently available. There is also a more recently developed Psychopathy Checklist Youth Version (PCL:YV; Forth, Kosson, & Hare, 2003), although this measure awaits further research into its association with risk.

Each of these measures utilizes a highly structured approach to risk assessment, following standardized data collection and scoring procedures. As in any standardized assessment procedure, one must be familiar with the appropriate or required sources of information. Most of these instruments cannot be scored in the absence of adequate documentation, including such sources as arrest and conviction history, compliance with previous supervision or treatment programmes, developmental history, and collateral information from those familiar with the individual's behaviour, such as family and institutional or supervisory staff. Basing one's ratings solely on the individual's self-report information is expressly prohibited for instruments such as the PCL-R or PCL:SV, while others such as the STATIC-99 cannot be accurately completed without official documentation of offence history.

Beyond having access to the necessary sources of information for completion of standardized risk assessment measures, practitioners must be adequately trained to render reliable and therefore valid scores. This training includes an understanding of the concepts underlying the items, the operational definition for each item, and the specific criteria by which scores or ratings are assigned to each item. It is also necessary to be aware of

the groups from whom normative data have been derived, and thereby the possible limitations to generalizing results from a measure to the clients to whom one will be applying the measure in one's own practice. This is especially true in New Zealand, when most of the risk assessment measures have been developed and normed on populations in North American and Europe. While there is research emerging in New Zealand that appears to validate the use of such measures (e.g. Wilson, 2003), it is important to be mindful of the degree to which obtained scores in local populations translate into the same level of risk demonstrated during an instrument's development elsewhere.

Training in most of these measures takes the form of a half-day to several day workshop provided by trainers who are themselves thoroughly familiar and experienced in the use of the instrument. Such training usually involves didactic presentation of background and psychometric information, combined with exercises to provide first-hand experience in the application of the scoring procedures to sample cases. Optimally, trainees are required to demonstrate performance to a specified criteria (e.g. scoring within one or two points of an established score on the training cases) before they are considered competent to begin using the measure under supervision (Hare, 2003; Gacono and Hutton, 1994; Belfrage, 1998). Where this demonstration of performance is not required, there is no way to ensure that the measure will be used reliably in the field following the training. Unreliable scores on risk assessment measures may sometimes be worse than not using such an instrument at all. In such cases it may appear that a scientifically grounded procedure was used to estimate risk, with all the apparent validity and confidence that can accrue to such an approach, when in fact the resulting risk estimation is inaccurate. In cases where a person's liberty or another's safety is at stake, such misapplications of risk assessment technology may be associated with high personal, financial, and societal costs.

## **Clinical Experience and Supervision in Risk Assessment**

While an initial demonstration of scoring to criteria following training with a particular risk assessment procedure is necessary, it is not sufficient. Translating the foundation gained in training to one's practice in the field requires the accumulation of experience with a variety of cases under the supervision of someone with the necessary expertise to ensure reliability. Inevitably, the first few cases one encounters following training will deviate from the training cases in some significant way, and it will be necessary to apply the scoring criteria in a way that remains standardized and accurately reflects the underlying concept that is known to be associated with risk.

Submitting assessment results for the review of someone with established expertise and experience will allow the practitioner to develop his or her independent skills in the use of a measure.

Once such skills are developed, there remains a need to periodically review one's procedures and scoring with others who have adequate skills in the measure being used. While an initial level of skill in following standardized procedures and rendering reliable scores may have been demonstrated, all practitioners are prone to develop idiosyncratic interpretations of criteria over time based on the unique features of the client population they serve, using their own operational definitions of the underlying concepts being measured. Periodically submitting a sample of one's assessments to a qualified supervisor or consultant, or setting up a network of peer supervision to compare cases and scoring decisions can guard against this drift from the initial criteria. It is important to bear in mind, however, that someone with established expertise should be included in this review process periodically to ensure the fidelity of one's assessment results to the original criteria established for a given measure.

### **Skill in Case Formulation**

Beyond the technical skills needed to adhere to the standardized utilization of risk assessment measures across their client population, practitioners need to develop skill in individualized case formulation. Specifically, practitioners need to be able to conceptualize cases coherently, based on some identifiable theoretical framework, and where appropriate supported by relevant research. While it is not necessary for the field as a whole to rely exclusively on any single theoretical approach, approaches such as those based on cognitive-behavioural theories are more easily operationalized in ways that can be standardized and measured. These approaches have more empirical support from research studies, and can more readily be applied consistently across clients. The absence of a theoretical framework to provide coherence to the case formulation presents the risk that assessment findings will lack integration and fail to provide an adequate means of understanding a given individual's likely functioning under different environmental and interpersonal circumstances.

An important element in this understanding is an individual's personality features. It has been suggested that focusing on traits may be a more effective approach than personality disorder diagnosis, given the overlap in diagnostic criteria and the commonality of such relevant features as antagonism, hostility, and impulsivity (Beech & Ward, 2004). As it currently stands, personality disorders in general and psychopathic features in particular

have been included in several well established risk assessment schemes (e.g. HCR-20, LSI-R, SONAR, SORAG). Such personality features represent not only a marker of risk level in some contexts, but also bear on issues of treatment responsivity and the selection of treatment and case management approaches. Such clinical and case management issues as the client's ability to establish rapport, maintain a therapeutic alliance, and develop trust or empathy as mechanisms of change, will all hinge largely on the personality features of the individual client.

Experience suggests that case formulation, especially the assessment and integration of personality variables into a coherent explanatory framework, are areas that students and new practitioners often struggle with in their work with clients. It requires a degree of experience and sophistication that can only be acquired through focused efforts toward professional development. In light of this, educational and training programmes will benefit those entering the field by specifically teaching skills in the assessment of personality factors and case formulation. Upon completion of their formal educational and training programmes, new practitioners will need ongoing supervision and support in the expansion and refinement of these skills. Even those who have been practising for long periods, and have accumulated substantial experience in their field, will benefit from periodic group or peer supervision activities that compel a rigorous and coherent demonstration of case formulation. If left to work in relative isolation with the demands of a busy caseload, without active consultation or collaboration with peers, it is easy to focus more on the mechanical execution of one's clinical duties. This can lead to the possible deterioration of hard-gained skills, and consequently to less effective risk assessment and management practices.

Another area that is crucial to effective risk assessment and management is the writing of effective reports to communicate the case formulation, the associated level of risk, and possible intervention or management strategies. This is another area that students and new practitioners often struggle with. Even if one works in a solo private practice, it is important to convey risk assessment and management information to others involved in a client's care, both currently and in the future. If one is part of a health care, social service, or correctional organisation, it is necessary to effectively communicate both within one's own agency and across agencies in the broader network of care and supervisory services. This means presenting findings and recommendations clearly and unequivocally, in terms that can be understood by all potential users of the report. Experience in training advanced level students, supervising more junior practitioners, and utilizing a variety of professional reports over time suggests that there remains uneven attention paid to the development of effective report writing skills. While

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there is currently no consensus on the structure or content of an optimal reporting style across settings, the principles inherent in effective assessment and case formulation skills need to be reflected in the reports produced in the field, regardless of the particular practitioner or organisation. This is an area where more focused training and supervision could produce a range of benefits within the field.

### **Identification of Risk Factors Within an Etiological Framework**

Optimal risk assessment and management requires the extension of case formulation skills, whereby risk factors are identified within an etiological framework (Ward & Beech, 2004). While it is important to be aware of the static and dynamic factors associated with a given type of risk, these factors are most useful for risk management when they are formulated into a coherent set of inter-related causal mechanisms. This requires examination of several categories of contributing factors, including historical (e.g. offence history, past episodes of violence, previous treatment compliance and response, performance under supervision or parole) developmental (e.g. adverse developmental events, nature of family relationships, attachment style), cognitive (e.g. level of intelligence, cognitive distortions, attitudes supportive of criminality or violence), personality (e.g. psychopathy, or traits such as impulsivity and hostility) and clinical (e.g. psychiatric diagnosis, level of functioning, substance abuse).

In light of these individual factors, it is important to recognize that risk is contingent upon current situational or contextual variables. Even high risk cases will not be at extreme risk at all times, but will vary in their level of risk depending on such factors as access to victims, current level of alcohol or drug use, access to and compliance with treatment and supervision services, the nature of interpersonal relationships and support systems, and current mood states. Thus different individuals who have similar profiles in terms of their scores on various risk assessment measures will not necessarily respond in a similar way to the same interventions or risk management plan. The level of risk at any given time will arise out of an aetiological process determined by the interaction of individual characteristics and contextual factors.

Risk management is best served when risk assessments are prescriptive (Hart, 2001, in HCR-20 guide). The assessment should lead to concrete planning for ways to reduce or manage the individual's level of risk in their current situation, or in the environment they will face following release from a restricted or protective environment into the broader community. This requires risk factors to be integrated into an explanatory conceptualization

of the individual in a way that provides prescriptive conclusions tailored to that individual. Only when a practitioner has a practical understanding of the individual's environment, including the scope of factors likely to precipitate risk and the limitations of available factors mitigating risk, can risk management be effective.

Without an individualized approach that incorporates an integrated understanding of both individual factors and the environmental context, risk management becomes a mechanical, generic exercise, utilizing standard prescriptive statements that do not vary substantially from one client to the next. Such an approach is much less likely to be optimally successful in managing risk. This seems to be a common weakness in many risk assessment reports and treatment or management plans that are developed, especially by students and new practitioners. Standard or currently available interventions are included in the recommendations that are reported, often without an adequate underlying conceptualization that captures the unique etiology of the individual's risk.

Posing the question of why a particular individual has demonstrated risk behaviours in the past, and under what conditions are they likely to demonstrate such behaviours in the future, will assist in the development of plans that address specific causal dynamics that provide the primary targets for interventions to reduce risk. Rather than recommend, for example, that a client should attend an available course on anger management, it would be more helpful to delineate the causal factors in his violent or abusive behaviour (e.g. is the violence primarily instrumental or reactive aggression; does it stem from being emotionally labile after drinking, from perceived threats to his status or dominance, paranoid ideation about others intending him harm, an enjoyment of inflicting pain on others?). Treatment or intervention should also be based on a recognition of individual differences. Does the client have the intellectual capacity to benefit from standard cognitive approaches? What is the capacity for insight, and is there sufficient empathy for the recognition of harm to others to serve as a deterrent to future violence? Such questions should serve to tailor the treatment approach to the characteristics of the individual in a way that offers the best chance of a successful outcome.

Culture is another factor that should play a role in the assessment and case formulation process, as well as the intervention and case management process that follows. It is beyond the scope of the present chapter to provide a comprehensive or even adequate account of cultural considerations in New Zealand. Others have taken up the topic in more detail; such sources should be consulted regarding cultural issues (e.g. New Zealand Ministry of Health, 1998). It must suffice here to note that the individual's culture should always be considered throughout the clinical and case management process. For non-Maori practitioners working with Maori clients, consultation

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with tangata whenua with expertise in mental health and tikanga Maori should be a matter of routine. Organisations should have a roster of Maori staff or consultants with the necessary expertise to participate in the risk assessment and management process. Whenever possible, kaumatua should also be consulted, about both assessment procedures and case management plans. Where appropriate, whenua and iwi should be incorporated into the programme of intervention and management for each client, linking the individual with the Maori community and marae. Tangata Whenua should be contracted to provide cultural education and training as a regular part of an organisation's preparation of its staff to deal effectively with risk assessment and management.

### **Skill in Intervention and Case Management.**

Once an adequate assessment is completed that provides an etiological framework for understanding an individual's risk, it is necessary for the practitioner to have the necessary skills to provide relevant interventions and participate effectively in the overall case management. One of the most important roles of the case manager as risk manager is to help the client recognize and respond appropriately to high risk situations (Dvoskin & Steadman, 1994). The nature of the high risk situations will vary from client to client, based on the particular aetiology of their risk. Such basic skills as establishing rapport and maintaining a therapeutic alliance, or more specialized skills such as motivational interviewing, cognitive-behavioural techniques, or family interventions are crucial in risk management, and should be a part of practitioners' training and professional development.

Another aspect of risk assessment and management worth noting is that the process is ongoing. As alluded to earlier, risk is not static, even if some of the predictors of risk do not change over time. When a risk reduction or risk management plan is implemented, it requires periodic reassessment to gauge the response to treatment or other interventions, as well as possible changes in the stable and acute dynamic risk factors that contribute to the current level of risk. This reassessment is best conducted on a regular basis, the frequency being determined by the level of risk involved. For example, the most acutely suicidal cases on an inpatient unit may require continuous observation and monitoring, stepped down to every 15 minutes, then to hourly, and so on as the level of concern diminishes, until discharge is possible and a viable outpatient plan is developed. Sexual or violent offenders released to the community may require weekly or even more frequent monitoring initially, when known dynamic risk factors for their case can be evaluated and a determination made whether additional interventions are needed to contain risk.

Beyond basic clinical or therapeutic skills, effective intervention and case management requires a clear recognition that one is usually operating in the context of a larger system of care and supervision. It is common that individuals identified as presenting acute or chronically high levels of risk are involved with a variety of clinicians, social service personnel, and sometimes correctional or supervisory staff, from a variety of agencies. It is also common for these practitioners to have an incomplete awareness of the disparate policies, procedures, resources and limitations within their own sometimes large and diverse organisation. It is even more common for there to be limited awareness of these issues in the other organisations that may be involved in a given client's care. Without a clear understanding of these features of the larger system that is involved in the assessment and management of an individual's risk, it will be difficult to construct a risk management approach that is optimally effective within the available resources.

Yet experience suggests that such an understanding is often not systematically provided to practitioners as part of their orientation to the roles they are expected to play. It seems that new practitioners are expected to develop this understanding over time and with increasing experience within the system. Supervisors and more experienced staff can sometimes forget how unfamiliar the various resources and limitations of their organisation (and the organisations that one must collaborate with) can be to the uninitiated. To the extent that such parameters are known, they should routinely be provided to practitioners as part of the initial training within their organisation or scope of practice, and updated periodically as features of the system change.

It is important that risk assessment and management procedures, including periodic reassessment of risk, are incorporated into existing clinical practice routines whenever possible. Organisations sometimes appear to add layer upon layer of additional assessment and documentation requirements without recognizing opportunities to incorporate or update existing practices. This can lead to disjointed procedures that lack integration. Practitioners may also fail to embrace the new requirements if they feel as if such changes appear to simply be a quick fix to some bureaucratic or regulatory problem, rather than a legitimate improvement over previous procedures.

## **About Organisations**

Except for those professionals who work in an independent private practice, all of us work in some type of agency or organisation. Yet relatively little attention is sometimes paid to the effect of organisational structures and procedures on the effective provision of risk assessment and management,

either within an organisation or across different organisations that are involved in this endeavour. Supervisors and administrators can do a great deal to facilitate, or to impede, risk assessment and management. This influence ranges from such concrete and specific activities as providing adequate training and supervision in the risk assessment procedures to be utilized, to more diffuse effects such as the organisational culture that is established around client care.

Some of the organisational actions necessary in the specific area of risk assessment include a commitment to identifying and implementing the most current and effective risk assessment procedures available for a given type of risk. This will require bringing in qualified trainers to prepare staff in the technical aspects of risk assessment procedures, and providing an adequate base of training in the fundamental aspects of these techniques. If an organisation decides to use its own internal staff as trainers, then those staff should themselves be adequately trained and experienced to impart a standardized set of skills to those they train. Trainers must demonstrate that they are a credible source of expertise and inspire confidence in those they are training. Expecting someone to attend a brief workshop and then serve as the organisation's trainer will usually be insufficient to ensure that staff are adequately prepared to utilize the risk assessment skills they will need.

Beyond the initial training, staff will require ongoing supervision from someone of sufficient experience and expertise until at least such time that independent skills are well established (as described in the first section on technical training). If such expertise is not available within the organisation, efforts should be made to identify and contract with external consultants who can provide such supervision. Without adequate resources for staff to develop their own professional expertise in the technical aspects of risk assessment, problems of reduced reliability in assessment results will ensue, along with an increased probability of undesirable outcomes in risk management. In such situations, staff may not feel confident in the procedures, or may execute them in a perfunctory manner in keeping with their superficial level of preparation.

Another factor that can contribute to perfunctory or otherwise less adequate enactment of risk assessment procedures is the failure to incorporate any new measures into the existing clinical workload as much as possible. New assessment and documentation requirements should not be added to existing procedures in ways that are redundant or disconnected. Instead, ways should be found so that anything new can complement or replace previous aspects of the work process. Staff will soon begin to feel overburdened and underinvested if procedures are not integrated and clearly related to achieving desirable outcomes.

Effective assessment and management of risk requires communication, cooperation and coordination of care not only within a service or agency but also across the different organisations that are often involved. This coordination can be impeded by rigid or arbitrary delineations of responsibility, especially when this takes the form of battles over “turf” (e.g. who controls the process of decision making or resource allocation) or “passing the buck”. The latter is sometimes reflected in an apparent attitude of “he’s not our type of client”, which translates functionally into “he’s not our responsibility” or “it’s not our problem”. This approach may be modelled from the top down, so to speak, in an organisation. To the degree that open communication and cooperative efforts to coordinate care or supervision functions are presented as clear priorities, from administrators down through the supervisory chain, these qualities will be reflected by the organisation. Conversely, to the degree that they are not clearly made a priority within the organisation’s values, they will less often be demonstrated by the staff on the front lines of client care.

Even when cooperation and coordination of care is desired between departments or between organisations, often there is little formal opportunity to facilitate this goal. Such coordination does not just happen out of the good will among staff (although that helps), but needs to be explicitly planned for. As a part of the stock-taking an organisation should routinely undergo, the question should be posed, “What other organisations or services are involved in dealing with our high risk clients, and what mechanisms of communication and coordination do we have with them?” Without established channels of communication and planning between the various components of a client’s care network, there will be more gaps in service. Consequently, there are more opportunities for high risk cases to fall into these gaps, increasing the likelihood that their risk will be inadequately managed at some stage. Once again, this process must be initiated and supported from the executive level of an organisation, with support shown for the staff involved at every step of the process.

## **The Emerging Role of Practitioners in Interaction With Courts and Other Decision-making Bodies**

There has been an increase in recent years in the level of legislation aimed at increasing public protection, both in New Zealand and overseas. At the same time, there has been a heightened concern over protecting individual rights and the privacy of personal information. Partly as a result of these movements, there is an increased likelihood that workers in the fields of health and human services may be called upon to interact with courts or other

formal decision-making bodies. This is especially true for those professionals who work in roles associated with the Department of Corrections, Forensic Mental Health Services, or Child, Youth and Family Services. But it may also apply occasionally to workers in other areas and to those in private practice, particularly in cases where risk is acute and there is imminent danger to the client or a clear threat of danger to identifiable others. In such cases, decisions made, actions taken, and the documentation trail created may later come under scrutiny, especially if some form of harm subsequently occurs.

To work effectively at this interface between clinical practice and the legal system requires several elements in a practitioner's professional development. The process of receiving adequate training and supervision in risk assessment procedures has already been addressed. Reference has also been made to developing basic clinical and case management skills, which extend to a clear understanding of the resources and limitations within one's organisation. Ideally, a practitioner is also thoroughly familiar with the resources and limitations of other services or agencies available in the community. But risk management increasingly requires that practitioners also are familiar with relevant statutory and regulatory requirements, as well as professional codes of ethics and emerging guidelines that will delineate areas of required competence.

Some of the legal parameters related to assessing and managing risk are contained in such sources as (Sections 107 and 88 of the Sentencing Act; section 33 of the Evidence Amendment Act; Mental Health Act (1992); Code of Health and Disability Services Consumers' Rights (1996), Privacy Act (1993), Health Information Privacy Code (1994) and Health Regulations (1996) regarding retention of health information.

Areas that are still emerging from case law in New Zealand include the limitations of protected communication (draw from recent preventive detention case) and the circumstances that establish a duty to warn others of risks posed by a client.

A less formal but potentially important feature of dealing with cases that may end up in court is ensuring that one seeks adequate consultation when necessary and documents key interactions or communications. Without a clear paper trail of the process one uses to assess, report on, and communicate about a case, it can appear in court that inadequate deliberation was made or that sufficient safeguards were not taken to ensure compliance with requirements of confidentiality. This is especially true when a case is in some way adversarial, such as sentencing or release proceedings or custody disputes. One must be able to demonstrate that proper procedures were followed at each step in the process, with clear documentation to back it up (e.g. notes of consultation meetings or telephone conversations with supervisors or legal

advisors, e-mail exchanges, notes in the client's file). While organisations must ensure that there are adequate procedures in place, it is the individual practitioner who will potentially find themselves in court, needing to adequately explain and justify the actions they took or the recommendations they made.

Looking to other jurisdictions such as the United States, where the adversarial legal processes in some types of high risk cases have developed somewhat further, it is anticipated that challenges to practitioners' expertise will become increasingly sophisticated in New Zealand in the coming years. A clear example of this is in the area of the indefinite confinement of violent or sexual offenders. In California, for example, attorneys on both sides of such cases have become increasingly sophisticated at cross examining the training and experience of mental health professionals, and challenging their findings based on the latest technical and statistical reports from the professional literature. Skilled and experienced clinicians have appeared as expert witnesses on both sides of these cases, resulting in an environment in which one must be able to explain and defend one's conclusions by responding to detailed and complex questioning. Explanations given in court need to demonstrate a clear understanding of the statistical principles and research foundation upon which risk assessment findings were based, presented in terms that the court can readily comprehend.

Skill in this arena requires practice and confidence, in addition to the purely technical expertise involved. Professional development through focused training and supervision will be of great assistance to those who will be facing such courtroom situations. A network in which such practitioners can share their experiences and growing expertise in this area with others facing similar challenges will be of substantial benefit to those involved. Preparation and support should also come from the practitioner's organisation. Besides training in the technical procedures to be followed, practitioners need clear guidelines regarding issues such as obtaining releases of information, how to proceed in the absence of such consents, proper correspondence with attorneys, and when to seek and document consultation received from supervisors or legal advisors. Without such guidelines, inexperienced practitioners can find themselves in embarrassing and potentially damaging situations in the courtroom or within their organisation. Proactive planning and preparation is required on the part of any agency whose staff may be required to meet professional standards in roles that interact with the legal system.

Another consideration in legal and other decision-making procedures is that practitioners may enact different roles at different times. It is important to establish who the client is and the nature of the practitioner's legal and

ethical obligations to the person being assessed (Ogloff, 2001 in HCR-20 guide). In some cases the “client” is not the individual being assessed, but rather a third party such as the court or Parole Board that has ordered an evaluation and report. Issues such as informed consent, confidentiality, and privilege take on special significance in such circumstances. This issue of who is the client can be especially tricky when the practitioner is also involved in a treatment role, for example as a staff member on an inpatient treatment unit. The individual who has been assessed can easily feel betrayed or taken advantage of when someone who has been seen as a confidant in a clinical process becomes an evaluator and potential witness in an adversarial legal process. Being clear beforehand, and giving the individual being assessed an explicit understanding about the nature of the role one is enacting, allows the best opportunity to successfully negotiate these roles.

## Summary and Recommendations

Recent advances in the areas of risk assessment and risk management, combined with heightened concerns about protecting public safety, result in the need for a more focused and systematic approach to preparing practitioners to assess and manage a variety of risks. This preparation should begin in the educational and training programmes, with curricula that emphasize not only technical expertise in relevant measures and assessment procedures, but also case formulation and conceptualization skills. Effective risk management begins with technically correct assessment and clinically sound formulation.

Proficiency in the assessment of risk must be accompanied by ability to clearly communicate about risk. Good report writing that conveys essential information on risk and provides specific prescriptive statements about managing that risk for an individual client is crucial. To do this effectively requires not only assessment expertise, but also a thorough practical understanding of the environment in which the client must function, including the treatment, support, and supervision resources that can be brought to bear on risk management. Practitioners must have a working knowledge of their own role and limitations along with the resources available within the community if high risk cases are to be optimally served.

A comprehensive catalogue of relevant community resources, including definitions of their scopes of responsibility, access criteria, and referral procedures, would be of great practical value to those working in the fields that must assess and manage client risk. To the degree that such information can be organized, this catalogue of roles, resources and responsibilities should be a standard part of the orientation training provided to practitioners

across professional disciplines and organisations. Such knowledge should not be left to the variations of each practitioner's initiative in professional preparation, which may take years of experience to accumulate and may never become thorough or complete. Organizing such information will require communication and planning from the administrators and managers in the range of agencies involved in risk management activities in order to map the network of services and train their staff in this knowledge. In doing so, the importance of risk assessment and risk management must be recognized, modelled, and reinforced throughout the organisational chain of supervision.

Another sector involved in the advancement of risk assessment and management practices in New Zealand is the research community. University academic staff and those from such agencies as the Psychological Services of the Department of Corrections are involved in research into the application to New Zealand populations of standardized measures developed elsewhere. Studies are also underway to examine client characteristics and treatment variables associated with outcomes for violent and sexual offenders, including future risk of reoffending. The findings of these research efforts must be fed back into the educational programmes for emerging practitioners, and out into the various agencies involved with assessing and managing risk. It has been suggested elsewhere that larger facilities designate a "risk educator" to keep track of current research and conduct periodic training updates (Monahan, 1993). Because the body of research knowledge in risk assessment is developing so rapidly, continuing education programmes are essential for maintaining competence in this area.

It has also been noted that risk reduction strategies may be most effective when they are the product of cooperation among clinicians, researchers, and administrators (Douglas et al. 2001). This seems like an especially sound approach for New Zealand, where there are clear opportunities for communication and collaboration on a more manageable scale than in larger and more fragmented societal contexts such as the United States. A coordinated effort involving education, research, and clinical practice guidelines could significantly advance the practice of risk assessment and management here, setting a standard that is second to none.